Appendix 3

Medway NHS Foundation Trust

Medway Maritime Hospital

Quality Report

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Date of inspection visit: 23-25 April & 1 May 2014
Date of publication: 8 July 2014

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

Ratings

Overall rating for this hospital	Inadequate
Accident and emergency	Inadequate
Medical care	Requires improvement
Surgery	Inadequate
Critical care	Good
Maternity and family planning	Requires improvement
Services for children and young people	Good
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Medway Maritime Hospital provides acute services to a population of 400,000 people across Medway and Swale. The hospital has around 3,880 members of staff, supported by 700 volunteers.

The Medway Maritime Hospital site is home to a Macmillan Cancer Care unit, the West Kent Vascular Centre, an obstetrics theatre suite, a neonatal intensive care unit, a Fetal Medicine Centre, a dedicated stroke unit and the West Kent Centre for Urology.+

We carried out this comprehensive inspection because Medway NHS Foundation Trust was rated as high risk in the CQC's intelligent monitoring system and the trust had been placed into 'special measures' in July 2013 following a Keogh review. The inspection took place between 23 and 25 April 2014 and an unannounced inspection visit took place on 1 May 2014.

Overall, this hospital was rated as inadequate. We rated it good for being caring but improvement was required in providing effective care and being well-led. The safety of the hospital and being responsive to patients' needs were rated as inadequate.

We rated critical care and services for children and young people as good, but we rated end of life care, outpatients, medical, and maternity as requiring improvement. A&E and surgery were rated inadequate overall.

Our key findings were as follows:

- A&E made insufficient progress since the last CQC inspection in December 2013; compared with the maternity department making significant progress since the last inspection in August 2013.
- Mandatory training compliance and associated records were insufficient, with significant inconsistencies between local and central records. In addition, there was inconsistent knowledge regarding the availability of training, in particular relating to Deprivation of Liberty training.
- Flow throughout the hospital was not efficient, with a particular lack of speciality pull from A&E combined with a lack of proactive discharge.
- Data quality throughout the hospital was poor, resulting in the trust board taking assurance from data that was inconsistent and, at times, unreliable.
- Governance processes were not robust or standardised, and consequently resulted in difficulty in clarifying whether the themes and trends from aggregated data were reliable.
- Junior medical staffing was insufficient and consultants were not providing seven-day service.
- Nurse staffing was insufficient and, despite recent significant recruitment, there remained a significant reliance on agency staff, especially out of hours. There was also a significant reliance on medical locum doctors.
- While the culture within the hospital demonstrated the majority of the workforce were committed and took pride in their work, there was an evident presence of 'firefighting' and lack of objectivity, with a tendency to work locally in their 'own way'.
- The inconsistent leadership within the trust and recent instability in the trust's future was impacting on the hospital demonstrating collaborative and robust ward to board connection.

We saw several areas of outstanding practice including:

- Oliver Fisher Neonatal Intensive care Unit.
- Recent provision of the Bernard Dementia Unit.
- Improvements made by the maternity team since the last CQC inspection.
- WOW awards had been introduced, to enable patients and visitors to tell the trust about a member of staff who had delivered outstanding care.

Summary of findings

- Use of 'Schwartz Rounds' to provide a forum for staff to debrief and explore some 'challenging' or emotional experiences that they have encountered when caring for patients.

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

Importantly, the trust must:

- Urgently address its poor data quality issues.
- Urgently review and standardise risk management and governance both at a local level and trust wide to ensure there are robust processes from board to ward.
- Continue to actively monitor its HSMR trends, including ensuring that consistent, robust, minuted mortality and morbidity meetings are being undertaken in all departments.
- Ensure that the Vanguard unit is not used as overnight accommodation for patients.
- Address its escalation policy within the A&E department to avoid the need to 'stack' patients; this should include formal agreement with specialities regarding expected professional standards.
- Ensure that the initial assessments of all patients (including children) are in line with national standards.
- Address the concerns regarding patient flow through the hospital, including improving discharge processes.
- Update its major incident policy in the A&E department and ensure that staff are trained appropriately.
- Ensure that there are a sufficient number of nurses with paediatric expertise in the A&E department.
- Ensure that all equipment is in date and is checked consistently.
- Ensure that all fire exits are accessible at all times.
- Ensure that mental capacity assessments (MCA) are undertaken where appropriate and staff are adequately trained in MCA and Deprivation of Liberty.
- Commence robust audit theatre utilisation to ensure clear allocation of elective and emergency lists.
- Improve the quality of cancellation of operations reporting.
- Ensure that all wards have appropriate equipment to meet peoples care needs.
- Ensure departments are sufficiently staffed by competent staff with the right skill mix, including out of hours.
- Review the current training matrix for mandatory training and improve the recording system so that there is a comprehensive record of compliance with training trust wide.
- Ensure all staff are aware of their roles and responsibilities to report incidents and that they have access to Datix. Feedback mechanisms and review processes need to be sufficiently robust to ensure that all staff groups are learning from incidents.
- Ensure that Consultant surgeons are undertaking ward rounds at weekends.
- Review the medical oversight of the medical high dependency unit and lack of regular input from critical care directorate.
- Review the current arrangement for protected consultant presence on the labour ward including the supervision of trainees performing elective caesarean sections.

In addition the trust should:

- Review effectiveness of multidisciplinary team working hospital wide.
- Continue to work towards full provision of seven day services, including support services.
- Improve communication to staff regarding the use of staff car parking so that the improvement of parking availability for patients is fully implemented.
- Review outpatient department booking templates to ensure allocated time for clinic appointments are appropriate.
- Improve the end of life care out of hours for all patient groups.
- Ensure that there is a robust system in place for reviewing risk assessments to ensure they are reflective of the clinical condition of women who are using the maternity service.
- Review the Clinical Risk Management Strategy to ensure it accurately reflects the recent changes which have been made to how clinical risk is managed within the maternity department.

Summary of findings

- Ensure that local policies and protocols are reviewed to ensure they are consistent with national, best practice guidance throughout the hospital.
- Ensure that the staff who are responsible for taking blood samples from new born babies undertake revised training in the completion of blood sample labels to reduce the number of incidents whereby blood samples are rejected by the laboratory due to missing or incorrect information.
- Ensure that a formalised process is introduced for seeking feedback from patients and/or their parents/carers who use children's services to help improve the overall quality of the service.
- Improve support and communication with staff at all levels.
- Review the storage of medicines in theatres and the accident and emergency department.
- Review the effectiveness of medical notes library.
- Review processes and effectiveness of equipment library.
- Review the completeness of records including detaining patients, medicine administration record in accident and emergency department and patients' weight on admission on surgical wards for high risk patients.
- Ensure that all agency staff have completed an induction before they start work and ensure an audit trial of inductions is retained by ward areas.
- Review and improve availability of specialist nurses.
- Ensure a standard approach to mortality and morbidity activity and encourage independent review and provide appropriate audit trail.

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?
Accident and emergency	**Inadequate** 	The current service provided by the Accident and Emergency department is inadequate. Consistent attendance pressures combined with insufficient escalation processes resulted in patients being queued in corridors within the department and on occasion led to patients having to spend the night on trolleys in inappropriate areas. Although there had been a concerted effort by the department to improve this, we found during our inspection this was not sustained. Out of date equipment was found within the department and fire exits were blocked. There were significant concerns regarding the validity of data collection and reporting, for which no individual seemed to be accountable. There was a resignation amongst staff that there was nothing they were able to do to improve the circumstances except wait for the rebuild, for which funding has not been secured. The new leadership within the department was largely interim, and did not appear to have a consistent view as to how improvements to the department could be assured and maintained.
Medical care	**Requires improvement** 	Medical care and older people's care ran at high capacity. Nursing staff levels had been increased with active recruitment well under way. This meant that there were many new and newly qualified nurses on all the wards, as well as high use of agency nurses to cover remaining vacant posts. Nursing staff we spoke with expressed concerns regarding the skill mix on the medical and older people's wards. There were directorate processes in place for staff to escalate issues that affected safety. However, these were not always acted upon appropriately. We found that medical patients were regularly 'outliers' on surgical wards because of the lack of medical beds. This was a particular concern at night as there was only one registrar and one senior house officer (SHO) covering all the medical wards and 'outliers' across the hospital. Mandatory training compliance was poor, particularly among medical staff. Nursing ward managers consistently stated trust wide records

Summary of findings

were not current or accurate and consequently each ward manager developed local monitoring system, which were not standardised or co-ordinated trust-wide.
Patients told us that they received good care and that staff were kind. Staff demonstrated awareness of the importance of being open with patients and providing individualised care. However, many patients described experiences of delays in admission and discharge. We were unable to identify a strategy to manage the patient flow issues raised. There were some examples of good governance systems in place but they were not fully embedded across the directorate. There were also issues relating to poor data quality.

Surgery **Inadequate** 

Despite identifying pockets of very good clinical practice, we found surgical care at Medway did not sufficiently protect patients from risks of avoidable harm and abuse. We found patient flow within the surgical department was poorly managed, which often led to long delays in treatment and patients being cared for in inappropriate clinical areas. Data submitted to the CQC suggested low rates of operation cancellations. However, seven days' worth of handwritten emergency lists reviewed showed a high rate of procedure cancellation with an average of seven cases a day. Operating data was being collected in various forms of handwritten lists, diary notes, theatres lists and via an electronic system. There was no process to monitor the impact of frequent cancellations or delays on people's clinical outcome. It was also difficult to track the patient journey because emergency cases were moved to elective theatre lists and were not always easily identifiable as an emergency. Patients who had undergone surgery were being cared for in the recovery area for extended lengths of time due to a shortage of surgical beds on the wards. We were made aware of patients being returned to clinical areas that were inappropriate given the complexity of the patients' needs.
We identified high numbers of outstanding vacancies, a poor skill mix, a high volume of agency staff usage and a high patient volume that had a negative impact on the department. Some ward areas often relied solely on agency staff for

Summary of findings

night-time cover. Agency staff did not have access to electronic blood glucose monitoring machines, or IT systems including Datix (the hospital incident-reporting tool), which presented challenges in caring for patients and reporting incidents. We found inconsistencies in incident reporting throughout the department and staff told us that they rarely received feedback from the incidents they reported to senior staff. The staff we spoke to reported discrepancies in the way they were supported by their seniors. We found wards that had substandard or no equipment, such as hoists. We identified one ward using a room that did not have a call bell system to care for patients. Two ward areas used as escalation areas had poor environments and having an inappropriate staff skill mix.
While there was evidence of improvement in the quality of the patient record keeping, we found inconsistencies with routine recording. We also found inadequate medical cover that resulted in unnecessary delays in obtaining pain relief and clinical reviews, and had an impact on patient discharges.

Critical care

Good

Critical care followed national evidence-based care and treatment and carried out local audit activity to ensure compliance. Patients were comfortable and their nutrition and hydration adequately maintained. Patient outcomes were within expected ranges. Nurse staffing levels in critical care were in line with national standards, but there were concerns over the medical oversight within the medical HDU.
There was good multidisciplinary and multi-professional working in critical care, including allied health professional support and medical specialist input. At times, patient flow prevented timely discharge from a critical care area. There was good practice around consent and Mental Capacity Act assessments as well as the management of deteriorating patients.
Critical care staff followed the trust incident reporting system and demonstrated learning from incidents. Mortality and morbidity (M&M) meetings were held but not minuted, and staff were unable to show that learning took place. Critical care services

Summary of findings

were provided in a clean environment. However emergency equipment was not always checked in line with trust policy and not all medicines were stored in accordance with national regulations. Many members of staff were not up to date with infection control and other mandatory training. Staff appraisals were carried out regularly. New staff underwent trust induction to ensure that they were competent to work in critical care, although there were no specific guidelines for newly appointed critical care consultants.
Care and treatment delivered in critical care was compassionate and based on the individual needs of each patient and those close to them were involved in the planning of care and treatment. Staff were able to demonstrate that service planning and local governance and risk management activity was taking place, with comments and complaints discussed at meetings to promote learning. Leadership within the service was strong with a mostly cohesive culture.

Maternity and family planning

Requires improvement

Since our inspection of the maternity service in August 2013, we found there had been significant improvements in the overall care provided and there was a feeling of optimism and enhanced morale among the range of healthcare professionals working within the maternity service. However, because of the relative short time span between our previous inspection and this recent review, the overall changes to the service were still being embedded and it was evident that some improvement initiatives were still in their infancy with concerns about their long-term sustainability. The inspection team were impressed with the obvious improvements that had been made, and felt that the trajectory of the unit was very positive.
Care and treatment delivered to women throughout their pregnancy were compassionate and based on the individual needs of each woman. Women and those close to them were involved in the planning of their birth and were able to make individual choices on the care they wished to receive.
We found that not all clinical guidelines had been updated. The rates of caesarean sections and third and fourth degree perineal tears were higher than expected. There was a positive staff culture in

reporting clinical incidents. However, there had been changes to how incidents were reviewed and managed and there was some confusion among staff about the overall ownership of incidents. There was good multidisciplinary and multi-professional working between the maternity service, community midwifery service and the neonatal intensive care team.

The number of midwives to births was in line with national recommendations with an overall ratio of 1:29 being achieved during January, February and March 2014. We found that the availability of a consultant obstetrician on the delivery suite was not always consistent with the recorded 98 hours per week reported by the trust due to consultants being expected to cover the emergency gynaecology theatre.

Services for children and young people

Good

Care and treatment delivered across children's services was compassionate and based on the individual needs of each child. Children and those close to them such as their parents or carers were involved in the planning of care and treatment and were able to make individual choices on the care they wished to receive. Leadership within the service was strong with a mostly cohesive culture. There was evidence of public and staff engagement as well as innovation within the service.

Services for children and young people followed the trust incident reporting system and demonstrated learning from incidents that took place there. Mortality and morbidity (M&M) meetings were held and staff were able to demonstrate that learning from this meeting was taking place.

The children and young person's service was provided in a clean environment. Emergency equipment was always checked in line with trust policy and was readily accessible and available.

There was good practice around consent and the management of deteriorating patients. Nurse staffing levels in the NICU and on the children's ward were in line with national standards but there were medical staffing challenges due to changes in the provision of training posts.

Children's services followed national evidence-based care and treatment and carried out local audit activity to ensure compliance. The Oliver

Summary of findings

			Fisher Neonatal Unit was recognised as a positive outlier in three of four performance areas in the 2012 National Neonatal Audit Programme. There was good multidisciplinary and multi-professional working.
End of life care	**Requires improvement**		The end of life care clinical nurse specialist was available four days a week and worked in conjunction with the palliative care team, provided by Medway Community Healthcare, who were available Monday to Friday 9 to 5pm. Out of hours, the Wisdom hospice provided advice and support regarding palliative care. The palliative care consultant was onsite at four sessions a week and outside of these hours end of life care was provided by junior doctors within the hospital, who had limited capacity available to meet the needs of patients who were on a care pathway at the end of their life. The end of life care clinical nurse specialist demonstrated a high level of evidenced based specialist knowledge and worked effectively in conjunction with the palliative care team. 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. In 2013/2014 a total of 804 referrals were made to the end of life clinical nurse specialist and palliative care team. We saw evidence that urgent referrals were seen on the same day and medicines were provided in line with guidelines. They held a comprehensive weekly multi-disciplinary team (MDT) meeting. They had a fast track discharge process to meet the wishes and preferences of patients at the end of their life. DNACPR forms were not consistently completed and processes for completing mental capacity assessments were not clear or robust. The DNACPR decisions were not consistently discussed with patients or families. We observed the end of life care clinical nurse specialist and the palliative care team support and provide advice to other staff and they were highly regarded across the trust. They had development an end of life care plan and package providing a holistic

Summary of findings

			approach to patients receiving palliative or end of life care. Patients and families told us staff were caring and compassionate and treated patients with dignity and respect.
Outpatients	**Requires improvement**		All the patients we spoke with told us they felt they had been treated with dignity, and that they had found staff in the outpatients department (OPD) polite and caring. However, many patients complained to us about the waiting times in OPD clinics. Staff were reporting incidents and feedback and learning from incidents was discussed at weekly OPD meetings. There were systems in place to reduce the risk and spread of infection. Medicines were stored and administered safely. The department held its own training records which were up to date and demonstrated that most staff were up to date with their mandatory training. We found that booking templates did not always reflect the needs of the clinic and OPD staff were collecting data on waiting times and overbooked clinics, but they felt unable to make improvements to this area of the service. The trust was unable to provide a clear strategy for dealing with this issue. The electronic systems in place did not allow staff to tailor outpatient appointment letters that were fit for purpose. The trust was bringing in new systems to improve this. The trust had mostly met national targets for the two week wait target for patients with a suspected cancer. The 18 week targets had also mostly been met.

Inadequate

Medway Maritime Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients.

Contents

Detailed findings

Background to Medway Maritime Hospital

Medway NHS Foundation Trust has been a foundation trust since 1 April 2008. It employs almost 4,000 staff and has 594 beds. The trust's turnover is £252million with a £10 million deficit in 2013/14, and a significantly higher deficit anticipated in 2014/15.

Medway NHS Foundation Trust was placed into 'special measures' in July 2013 by Monitor in order to improve and rectify failings in patient care and governance as identified in the review under Professor Sir Bruce Keogh. Monitor had subsequently taken further enforcement action and in February 2014 they used their powers to appoint an interim Chairman and Chief Executive.

At the time of this inspection the executive team comprised of four permanent executive positions and three interim executives. The finance director was in the process of handing over to his replacement and the longest standing executive member had been in post since March 2013. The chairman was also an interim appointment following Monitors urgent action. The significant number of interim appointments presented challenges for consistent leadership. The trust had adopted a clinically led model and they were in the transition from eight directorates to four divisions.

The Medway NHS Foundation Trust has two registered locations the Woodlands Special Needs Nursery and The Medway Maritime Hospital. The hospital site is home to a Macmillan Cancer Care unit, the West Kent Vascular Centre, a state-of-the-art obstetrics theatre suite, the neonatal intensive care unit, a Fetal Medicine Centre, a dedicated stroke unit and the West Kent Centre for Urology.

Our inspection team

Our inspection team was led by:

Chair: Professor Edward Baker, Deputy Chief Inspector of Hospitals, Care Quality Commission

Head of Hospital Inspections: Heidi Smoult, Care Quality Commission

The team of 31 included CQC senior managers, inspectors and analysts, doctors, nurses, pharmacist, patients and public representatives, experts by experience and senior NHS managers.

How we carried out this inspection

To get to the heart of patients' 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 family planning
- Services for children and young people
- End of life care
- Outpatients.

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 the clinical commissioning group (CCG), Monitor, NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

Detailed findings

We held a listening event, in Gillingham on 23 April 2014, when people shared their views and experiences of the Medway Maritime Hospital. As some people were unable to attend the listening events, they shared their experiences via email or telephone.

We carried out the announced inspection visit between 23 and 25 April 2014. 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 all the 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 an unannounced inspection on 1 May 2014. We looked at how the hospital was run out of hours and, the levels and type of staff available and the care provided.

Facts and data about Medway Maritime Hospital

Context

- Foundation Trust since 1 April 2008
- 594 beds
- Serves a population of around 400,000
- Employs around 3,880 members of staff

Activity

- Inpatient admissions around 75,000 per annum including day case activity
- Outpatient attendances around 309,000 per annum
- Around 90,000 A&E attendances per annum
- Births around 5,730 per annum

Intelligent Monitoring – High risk (March 2014)

- Safe: Items = 8, Risks = 0, Elevated = 0, Score = 0
- Effective: Items = 31, Risks = 0, Elevated = 4, Score = 8
- Caring: Items = 18, Risks = 3, Elevated = 0, Score = 3
- Responsive: Items = 10, Risks = 1, Elevated = 0, Score = 1
- Well led: Items = 2, Risks = 2, Elevated = 2, Score = 6
- **Total:** Risks = 6, Elevated = 6, Score = 18

Key Intelligence Indicators

Safety

- 2 never events (1 surgical swab, 1 ureteric stent)
- STEIS 84 Serious Untoward Incidents (Dec 2012-Jan 2014)
- NRLS Deaths= 18; Severe= 26; Abuse= 34; Moderate= 205
- Infections
  - C-difficile: 17 = within expectation
  - MRSA: 1 = within expectation

Effective

- HSMR = elevated
- Endocrinology mortality = elevated
- GI: mortality = elevated
- Respiratory: mortality = elevated
- SHMI = within expected range

Caring

- Friends and Family Test = Performing below the England average for the Inpatient tests; Performing significantly below the national average for A&E
- Cancer Patient Experience = Of 69 the trust was in the top 20% nationally for 14 questions
- CQC Adult Inpatient Survey = Performed 'within expectations' for nine of the 10 questions

Responsive

- A&E 4 hour target = well below 95% in most of the previous 12 months
- A&E left without being seen = above national average

Well-led

- Staff survey 2013: Areas that scored worse than average include;
  - Appraisals
  - Training
  - Incident reporting
  - Bullying
  - Communication
  - Staff recommending the trust.

Detailed findings

Inspection history

- Inspection in August 2013 the trust was found to be in breach of regulations 10, 22 and 23 for Maternity Services
- Inspection in December 2013 the trust was found to be in breach of regulations 9 and 12 for the Accident and Emergency Department.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are able to collect sufficient evidence to rate effectiveness in either A&E or Outpatients.

Accident and emergency

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

Information about the service

The accident and emergency (A&E) department at Medway Maritime Hospital provides a 24-hour, seven-day a week service to the local area of approximately 400,000 people. It sees around 90,000 patients a year, of whom approximately 25% of which are children.

Patients present to the department either by walking into the reception area or arriving by ambulance. If a patient arrives in the department on foot, they are seen at the reception by a senior nurse who 'streams' them to the appropriate area. If a patient arrives by ambulance, they are transferred to the 'Senior Treatment and Review' (STAR) area, known as the Vanguard Unit (which is a temporary building leased to the trust by a private company). They are then transferred to the main A&E department.

The department itself consists of four main areas: 'paediatrics', 'minors', 'majors', and a resuscitation area with five beds, one of which is set up for paediatric emergencies. There is also an eight-bed observation ward for patients who need to be observed for longer than four hours but are unlikely to need admission (e.g. a patient with a head injury). In addition there is a co-located GP-led service run by the clinical commissioning group (CCG) which we did not inspect.

The A&E department is a member of a regional trauma network and a designated trauma unit. The hospital also provides acute stroke services and in hours coronary intervention for acute heart attacks.

Summary of findings

The current service provided by the Accident and Emergency department is inadequate. Consistent attendance pressures combined with insufficient escalation processes resulted in patients being queued in corridors within the department and on occasion led to patients having to spend the night on trolleys in inappropriate areas. Although there had been a concerted effort by the department to improve this, we found during our inspection this was not sustained. Out of date equipment was found within the department and fire exits were blocked. There were significant concerns regarding the validity of data collection and reporting, for which no individual seemed to be accountable. There was a resignation amongst staff that there was nothing they were able to do to improve the circumstances except wait for the rebuild, for which funding has not been secured. The new leadership within the department was largely interim, and did not appear to have a consistent view as to how improvements to the department could be assured and maintained.

Accident and emergency

Are accident and emergency services safe?

Inadequate

The A&E service at Medway Hospital did not sufficiently protect patients from risks of avoidable harm and abuse. The environment itself was cramped (in particular, the resuscitation and Vanguard areas) and fire exits were blocked. Incident reporting was not commonplace among medical staff and lessons did not appear to be sufficiently learned even after significant incidents. Equipment was found to be out of date and damaged, and the department was not seen to be consistently clean. A significant number of records were found to have incomplete documentation and in some cases medication was given without appropriate identification of the patient.

At times the department was very busy and patients were 'stacked' within the majors area. There was no clear line of responsibility for patient care and patients were waiting a long time for initial assessment and treatment when the STAR area was not functioning. In times of extreme stress (which occurred twice in the week of our inspection), patients were placed on trolleys overnight in the Vanguard Unit, without appropriate nursing assessments being made. Mental capacity assessments were not being undertaken appropriately. Only 62% of nursing staff had completed their child safeguarding training, despite the fact that the department saw over 20 000 children per year, and children were treated overnight in the main department by adult nurses.

Incidents, reporting and learning

- The trust reported seven serious incidents (SIs) relating to the A&E department to the Strategic Executive Information System (STEIS) between December 2012 and January 2014.
- In addition, the trust provided us with the A&E lists of incident reports from September 2013 to February 2014. In total, 1,942 incidents were reported. Eleven of these had resulted in death or stillbirth, and 15 in permanent damage. In the breakdown of the individual incidents, only 5 relating to permanent damage were specified (all relating to grade 3 or 4 pressure ulcers).
- We were provided with the root cause analysis (RCA) for three serious incidents that involved the A&E department (two from 2012 and one from October 2013). All involved women who were pregnant (one of whom was miscarrying) or had recently delivered. One of the analyses, which had listed greater awareness of the possibility of the underlying diagnosis (aortic dissection) as an action after the incident, did not have the A&E department on its distribution list.
- We asked staff directly if they reported incidents. They told us that they had been asked the same question by the department in advance of our visit. (As they had told the trust), they reported that the doctors rarely did because they felt there was little point (in that they did not receive acknowledgement or see change in practice as a result). However, the nurses did proactively report incidents.
- We saw evidence of incident reports and learning displayed in the coffee room and discussed at band 6/7 team meetings (although at irregular intervals).
- The department held its first mortality and morbidity meeting during the week before our inspection.

Cleanliness, infection control and hygiene

- During our inspection, we observed poor practice in the use of personal protective equipment, whereby not all staff were witnessed to be wearing gloves or washing their hands between patients.
- We observed layers of dust on top of uncovered blood bottles in the resuscitation storage area, as well as dirty trays.
- In order to get their patient onto an A&E trolley, a paramedic was witnessed to make up a bed in the department. Although the bed had been cleaned, the paramedic noticed that there were splashes of dried blood on the trolley arms. This was also noticed by our team in the Vanguard Unit, but it had to be pointed out to staff working there.
- We were shown the last cleaning audit, which had taken place in the department in November 2013. Overall, the department scored 74%, but some areas, including the trolley majors area was as low as 52%. We were not given details of subsequent follow-up audits.

Environment

- Overall, the A&E environment was found to be too small for the number of patients seen on a daily basis. This was especially the case in the resuscitation area, where the presence of several very unwell patients could have an impact on the standard of care that the team was

able to deliver. A significant rebuild was planned for the department, beginning with the paediatric area in June 2014. At the time of our inspection, the budget for the rest of the rebuild had not been confirmed.

- The Vanguard Unit was found to be very cramped, and although we were told that the area was suitable for four trolleys and two chairs, during the whole of our inspection (over three days), five trolleys and one chair were in use. In order to move patients in and out, the trolleys had to be manoeuvred and other patients disturbed. Both the fire exits were blocked. This was escalated immediately to the executive team. We were informed the following day that a risk assessment had been undertaken allowing for one of these exits to be blocked permanently, while the other fire exit was now unblocked.
- During our inspection, we were told by one patient that they had spent the night in the Vanguard Unit. This was investigated further and it was established that, on occasion, if the department was very full and there were no alternative beds in the trust, patients could be transferred from inside the A&E department back to the Vanguard Unit. Because the facility was not large enough for beds, patients slept on trolleys. It was not clear how often this was done (because no formal record was kept), but the trust acknowledged that it had occurred overnight on both the Tuesday and Wednesday during the week of the inspection. However the executive lead for operational performance in A&E was not aware this had occurred. No operational policy existed advocating the Vanguard Unit as overnight accommodation and, when questioned, the executive team (including the chief operating officer) was unaware of this practice.
- The fire exit for the resuscitation area was found to be blocked by three large metal crates. There was a sign behind one of them stating, 'This is a fire exit, do not obstruct.'

Equipment

- There was no anaesthetic equipment or portable ventilator in the resuscitation area (this equipment was provided when a cardiac arrest call was made in an emergency). Although most emergency procedure equipment was labelled and stored appropriately, the emergency caesarean section (c-section) equipment was found in an unmarked box on the floor of the storage room. Of note, there was a serious incident involving the need for an emergency c-section in the department six months ago, with a contributing factor being the lack of easily available emergency c-section equipment in the department.
- Equipment needed in the event of a cardiac arrest was not stored on suitable trolleys that would contain the equipment safely if it had to be moved. There was no agreed safety checklist for staff to follow for either the equipment or the resuscitation area.
- The inspection team found evidence of inadequate checking and recording of equipment. This was particularly the case in the resuscitation area. Again, faulty equipment was listed as a contributory factor in the serious incident mentioned earlier, alongside the fact that equipment was being checked by a non-clinical support worker. (Despite daily checks, a resuscitaire had been found to be non-functioning when needed in an emergency. It was condemned after the incident.) This practice of checking and recording equipment had not changed as a result of the incident.
- Out-of-date equipment (blood bottles) was found in the resuscitation store cupboard along with suction catheters with ripped packaging (jeopardising their sterility). On the second day of our inspection, out-of-date cannulas were found in the main emergency department. Suction catheters were also discovered on resuscitation trolleys attached via a hole piercing their sterile packaging.

Medicines

- On two out of the three days we visited, both fridges (containing drugs of abuse) in the department were found unlocked.
- Three sets of notes were found which showed that patients had been given medicines despite incomplete patient identification on the prescription chart.

Records

- We looked at over 50 sets of notes during our inspection (some were current; others were provided by the trust from the previous weekend).
- Ten of the sets of notes were significantly incomplete (missing most of the relevant documentation including, in some cases, the designation of the staff member reviewing the patient, or the time or date of the review). Fourteen were clinically inadequate in terms of the documentation of the care given. Sixteen showed good

care including excellent nursing documentation. This included one case in which a patient who was in the department for 19 hours was checked on every 30 minutes and turned every two hours.
- In all the paediatric proformas looked at (over 20), there was no indication of the designation of the clinician examining the child (in other words, whether it was a doctor or nurse, or their level of seniority).
- Risk assessments were not routinely undertaken in the department, despite many patients being there for over six hours (it is recommended by the Royal College of Nursing that, if patients are in an area for longer than six hours, a risk assessment for falls and pressure ulcers should be completed).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We had significant concerns about the manner in which capacity and risk assessments (of suicide) were both carried out and documented.
- A potentially very high suicide risk (a patient who presented with a significant paracetamol overdose after a recent bereavement) was allowed to leave without intervention by nursing staff. We reviewed the notes of this patient and there was no assessment of capacity and no risk assessment.
- There had been a recent incident reported to the National Reporting and Learning System (NRLS) that had resulted in severe harm to a patient. Lack of understanding of the Mental Capacity Act by nursing staff was cited as a contributing factor.
- According to the A&E mandatory training database, 81% of nurses had completed their Mental Capacity Act training. No such information was provided for medical staff.
- We were told by a senior member of the A&E staff that registered mental health nurses were rarely used in the department and that security staff were called on instead. This was corroborated by members of the security team.

Safeguarding

- After a recent CQC inspection specifically looking at child safeguarding practices, improvements had been made. A paediatric proforma had been developed that requested specific information to be sought. This included a box to check to confirm that staff had asked the person accompanying the child whether the child was on the local authority child protection risk register. There was no automatic check directly with the local authority.
- Sixty-two per cent of staff had undergone child safeguarding training.
- There was no adult safeguarding lead in the A&E department.

Mandatory training

- There was a significant disparity between the mandatory training figures provided centrally by the trust and those provided by the senior nursing staff in the A&E department. Child safeguarding had the lowest completion at 62%. However, both information governance and appraisal were at 89%.
- When asked, senior staff in the department were unable to provide us with mandatory training figures for medical staff.

Initial assessment and management of patients

- Patients arriving as a priority (blue light) call are transferred immediately through to the resuscitation area. Such calls are phoned through in advance so that an appropriate team are alerted and prepared for their arrival.
- Patients arriving in an ambulance between the hours of 9am and 8pm are seen on arrival by a middle grade (registrar) doctor in the Vanguard Unit. This process is known by the trust as Senior Treat And Review and this was witnessed to be working effectively. Initial assessment was well documented and allowed for early immediate treatment could be initiated early. If at that point the patient is identified to need urgent and more intensive intervention they are transferred though to the resuscitation area.
- Out of hours, the paramedics transfer their patient directly into the department where they are met by a clinical navigator.
- During part of our inspection the department was observed to be very busy. There were not sufficient cubicles to house all of the patients in the department and there was a delay in ambulance handover. In these situations, in order to allow ambulances offload patients and resume work patients are 'stacked'. This refers to a practice where trolleys are lined up within the department. If there were more than three such trolleys, there was a Hospital Ambulance Liaison Officer (HALO) who would supervise the patients. We were given

conflicting answers when we asked the nursing team (including the senior nurses), medical team (including the clinical lead) and the paramedics who had overall responsibility for patients in these circumstances. Although they were booked into the department, the nurses said that they did not provide care for these patients and treatment did not begin while a patient was in this area.

- We reviewed a set of notes from a patient who had been 'stacked'. These notes acknowledged that the patient had been incontinent but did not specify as to whether they had been washed or changed and, if that had occurred, what time it had been. This may have increased the risk to the patient of developing a pressure area.
- Patients who walked into the department were seen in the first instance by a senior nurse at the reception. They were streamed into the appropriate area (minors, majors or paediatric) depending on the urgency of their condition. Patients requiring an urgent review (for example, for chest pain) would undergo an ECG immediately.

Assessing and responding to deteriorating patients

- The national early warning score (NEWS) system was used throughout the department. A clear escalation procedure was printed on the front of the observation booklet. We found good use of the NEWS during our inspection.

Nursing staffing

- Information provided by the trust indicated that the establishment for the A&E department was 86.9 whole time equivalents (WTEs). It was not clear how this was calculated or what the threshold of safe staffing was. The recommended establishment for the department was documented as '0.0'. However, senior staff acknowledged that they were looking at the Royal College of Nursing's 'BEST' policy to understand their staffing needs.
- The trust was very open in acknowledging the need to rebalance the skill mix of the current rota because there were not enough experienced nurses on each shift. This was scored as 20 on the departmental risk register.
- All bank and agency staff received a local induction before starting their shift. Evidence of this was seen at the time of our inspection.
- The department had only four nurses with specific paediatric qualifications. When they were on shift, they would be assigned to the paediatric department. However, this was not staffed by appropriately trained nurses at all times. In recognition of this, there was a business case signed off to recruit nurses trained in caring for children, and the department was putting in place a training programme to further develop the skills of the nurses qualified to care for adults.
- Every shift the nurse in charge undertook two 'safety rounds'. This was observed during our visit, and involved ensuring that patients had received medication that had been prescribed.

Medical staffing

- The department currently has six WTE consultants, one of which was present in the unit from 8am until midnight Monday to Thursday, 8am until 10pm on Fridays and 9am until 7pm on Saturdays and Sundays.
- Overnight there are three middle grade and two other more junior doctors.
- According to the minutes from the A&E quality and safety group, an induction pack had been developed by A&E staff and the HR department because of the high number of locums used in the department. However, we were told by one of the consultants that this pack was rarely given to new members of staff.
- Handovers had been introduced in the past two weeks, consisting of four-hourly handovers (doctors only) at 8am, 12pm, 4pm and 8pm.

Major incident awareness and training

- The major incident policy was out of date, lacked detail and appeared to have been written from a risk management rather than a clinical perspective. In addition, staff we spoke to had a poor understanding of the policy (doctors in particular).
- The cupboards were well stocked with major incident equipment but they also contained non-major incident equipment (for example, chicken wire). The equipment was due to expire at the end of April 2014; the trust was aware of this and had already ordered replacements.

Security

- Some members of the nursing team said that there were few security staff in the department. However, junior staff including doctors told us they felt safe and supported, and both nursing and medical staff reported that the relationship between the A&E and security staff was good.

Accident and emergency

- In response to concerns raised within the department, extensive discussions were documented in the minutes of the A&E quality and safety meetings. They demonstrated improvements made as a result of those concerns.
- All security staff had undertaken control and restraint training. However, clinical staff were often unaware of the limits of the lawful restraint that security staff could use.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

There was insufficient evidence of adherence to either the National Institute for Health and Care Excellence (NICE) or the College of Emergency Medicine (CEM) guidelines. Although most of the national CEM audits had been contributed to, we saw no evidence of changes to practise as a result or an active local audit culture. There were a very limited number of departmental or trust protocols for staff to use for commonly seen conditions.

Evidence-based care and treatment

- Departmental policies were easily accessible on the shared drive that staff were aware of and reported they used. However, there was only a very limited range of A&E protocols available (five) only two that were specific to the department (asthma and management of cervical spine [c-spine] injuries). Also, the c-spine protocol was undated, with no details as to its authors.
- A further six trust guidelines were within the A&E folder (for example, pneumonia, sickle cell and needle stick) and there was reference to two NICE guidelines relating to A&E care.
- We found no reference to CEM standards or guidelines.
- We were presented with a sepsis audit that was undertaken as a result of concerns in the department about the management of sepsis and how this compared with CEM standards. Although significant improvement had been made, only 62% of patients received intravenous fluid within the first hour (the standard is for 75%) and 96% of patients received antibiotics in the department (standard, 100%). The audit did not assess the percentage of patients receiving antibiotics within one hour of arrival (standard, 50%).
- There were no other examples of audit activity that had resulted in re-audit or subsequent improvements with national or CEM guidelines.
- A sedation policy was written in response to a clinical incident in 2011. However, this had not been implemented. We were told that this was because trust management felt that it was too onerous to ensure compliance. Minutes from a quality and safety meeting in August 2013 stated that there was an urgent need for such guidance and that this would be updated (or developed) by the end of August 2013. There was no follow-up to this in subsequent minutes and no current guidance in use found during our inspection.

Pain relief

- The department did not undertake local audits assessing its effectiveness in treating pain.
- The CEM informed us that the department had taken part in the two national audits (Pain relief in Children and Renal Colic, both in 2011) that assessed effectiveness of pain relief. However, the trust was not able to provide us with their results or action plans in response to these audits.

Nutrition and hydration

- The trust had employed Band 1 staff to undertake food and drink rounds that took place every two hours 24 hours a day, seven days a week.

Patient outcomes

- The trust took part in 12 of the 16 national CEM audits which have been undertaken since 2009.
- We were provided with a summary document from their 2012 audits which was presented to their Quality Committee in April 2013. There was evidence of some improvement in most categories. However with regards to the care of children and management of fractured neck of femur (2 out of the 3 audits undertaken in 2012) they remained in the lower quartile for the majority of indicators.
- The summary report advised that they would repeat the audits within six months. We were not provided with evidence of this.

Accident and emergency

- The CEM recommends that the unplanned readmission rates for A&E departments should be between 1% and 5%. The national average is around 7%, which the trust has exceeded since July 2013. Their rate in January 2014 was 8.8%.

Competent staff

- Appraisals of both medical and nursing middle grades and consultants were being undertaken and staff spoke positively about the process.
- Nursing appraisals were at 89%.

Multidisciplinary working

- We did not witness comprehensive multidisciplinary team (MDT) working within the A&E department. Nursing and medical handovers were undertaken separately and there was currently no occupational therapy or physiotherapy input.
- From talking to staff, the four-hour access target was not owned by the MDT. We were told that the target was policed by the nursing staff and that medical staff did not engage in responsibility for the patient 'journey'.
- The hospital alcohol team could be accessed for support and, although the department did not collect data with regard to its input, reported that the team was available when required.

Are accident and emergency services caring?

Requires improvement

Evidence collected before our inspection and from speaking to patients during our inspection did not provide us with sufficient assurance that the A&E department at Medway was providing a consistently caring service. The department had worked hard to increase the NHS Friends and Family Test response rate (which was now above the national rate). However, the resultant scores were significantly below the national average. In addition, while we were witness to many episodes of caring interaction during our visit, feedback from individual patients and relatives (via interview and comment cards) was not universally positive, and in some cases demonstrably negative.

- Two questions in the Adult Inpatient Survey, CQC, 2013, related to people's experience in the A&E department ('While you were in the department, how much information about your condition did you receive?, and 'Were you given enough privacy when you were being examined or treated in the department?'). The department scored worse than most others in response to both of these questions.
- The trust performed significantly below the average for England for the Friends and Family Test. In December 2013 and January 2014, it scored -11 and 0 respectively, compared with the average for England of 56.6. The trust has, however, worked to increase the response rate, which was only 0.1% in October, and it is now above the average for England (17.4%) at 21%.

Compassionate care

- We witnessed many episodes of patient and staff interaction, during which staff showed caring attitudes towards patients.
- However, when asked, patients' reports about staff were mixed and some patients wrote to us on comment cards about the poor attitude of staff towards them. There was acknowledgement that the staff were very busy, but it was reported to us on more than one occasion that "staff treated me like an object".

Patient understanding and involvement

- The greatest number of complaints were centred around not just the long wait times but that patients were not kept informed of what was happening. Many patients were told that it would be within a certain time, when it resulted in being significantly longer; moreover, this was not relayed to them, which left them feeling frustrated.
- Several relatives we spoke to commented that they did not know what was happening to their relative regarding their diagnosis, investigations and treatment.

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

Inadequate

The A&E department required improvement to cope with its routine workload, but was currently inadequate in coping with surges of activity, which occurred on a regular and potentially anticipatory basis. Capacity within the

department was listed as the highest risk on the departmental risk register and seven incidents graded as 'high' impact had been reported in the preceding six months. The escalation protocol was insufficient and did not provide a sufficient or measurable, safe response, as shown by patients accommodated in the Vanguard Unit overnight and regular occurrences of stacking within the unit (when trolleys were placed in the main corridor of the department). The trust's process for pulling patients out of the department in a timely manner or while they were in the Vanguard Unit was insufficient, which resulted in further overcrowding.

Many of these issues were longstanding and had been brought to the trust's attention after a visit from the Emergency Care Intensive Support Team (ECIST) in May 2012, alongside suggestions of how to make improvements.

Service planning and delivery to meet the needs of local people

- The A&E department had a 'patient flow and escalation policy' that was initially developed in November 2013 by the general manager.
- The policy consisted of a description of who within the site team should be contacted when there were delays in patient flow. There was no internal monitoring to evaluate the effectiveness of this policy, and senior team members confirmed that it usually just involved contacting the consultant on call (who was at home out of hours).
- While we were in the department, we found one patient who had been waiting eight hours to be seen by a surgeon. According to the escalation policy, if there was an expected delay of over 30 minutes to be seen by a specialty doctor, the registrar should be bleeped twice at 15-minute intervals and then the specialty consultant should be contacted. There was no documentation recording that the policy had been followed in this instance.
- The ECIST team noted that delays in specialty reviews occurred often. It suggested that internal professional standards should be agreed with specialty teams in line with Royal College guidance to ensure that they reviewed patients within 30 minutes. We found no evidence that this advice had been followed.
- Access to specialist teams was fourth on the departmental trust risk register. From reviewing minutes from departmental meetings, this issue of delay was closed in August 2013 with the introduction of the STAR process given as the reason. It remained on the risk register, however.

Access and flow

- According to the NHS England winter pressures daily situation reports (SITREP) data, for the month of March 2013 the trust had 53 occurrences when ambulances waited more than 30 minutes to hand over. The trust told us that they had worked hard to improve their performance and March was a "good month for us". In January 2013, 170 ambulances had waited over 30 minutes.
- The trust had not consistently met the four-hour target set by the government to ensure that patients are admitted, transferred or discharged within this time. In January 2014, the results were as low as 73.7%. After a concerted effort to improve, the trust did meet the target in March 2014; this was the first time since November 2013.
- NHS England also required trusts to measure the percentage of emergency admissions waiting 4–12 hours from the decision to admit (DTA) until admitted. Information supplied to NHS England stated that no patients waited to be admitted from the DTA time. Evidence collected at the time of our inspection (via discussions with staff members) confirmed that this was not the case, and that this information had not actually been collected by the trust. Because the information was not available to the team presenting the data to NHS England, the team inserted a '0' in the data box. Members of the leadership team within the A&E were not aware that this practice was taking place.
- Similarly, the team presenting the data to NHS England was not routinely sent data about the total length of time patients spent in the department, although this information was needed to report the number of 12-hour breaches (the number of patients who waited longer than 12 hours from the DTA). Many sources told us that there had only been one 12-hour breach in the past year (in August 2013), but there was no way of corroborating this because the data was not collected by the trust.
- In addition, we were told by many sources (and witnessed ourselves) that there was often a delay of several hours before a DTA was made. Thus, a patient could be in the department for over 12 hours, but this

not be considered a 12-hour breach. It was not evident that the trust was routinely recording the number of times this occurred (although sometimes incident forms were completed).

- On the first morning of our inspection, we found 10 patients who had been in the department for over four hours. Four had exceeded 11 hours 30 minutes and two were over 13 hours. By the time we left the department, one patient had been in the department over 20 hours. The department confirmed that this was not considered to be a 12-hour breach.
- The national average for the percentage of patients who leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait) was between 2% and 3% (December 2012–December 2013). Medway had not dropped below 4%, and in July 2013 it was as high as 8%.
- Between September 2013 and February 2014, staff reported 11 incidents relating to capacity concerns within the department. Seven of these were graded as 'high'.
- The department was vulnerable to scrutiny regarding the quality of its data validation. This was shown by the absence of any data integrity protocol for the validation of four-hour breaches. At the time of our inspection, individuals performed validation on their own with no secondary check. This supported the concerns of senior staff regarding data integrity. These issues had been raised with the executive team before our visit. In addition to these concerns, the 2012 operational policy for the reception area appeared to suggest that no ambulance waited more than15 minutes from registration in that it stipulated that 'If the assessment time is over 15 minutes then 'add on' 15 minutes to the time the ambulance arrives then this is the registration time' and gives the example of 'e.g. Time at hospital 15:00hrs, Assessment. time 15.25, Arrival and reg. time 15:15hrs.'

Meeting people's individual needs

- During our inspection, we witnessed interactions with a patient with learning disabilities. The ambulance service had called ahead to ensure that a side room would be available because the patient was very nervous. This was organised. Also the trust's learning disability advocate attended to the patient very shortly after their arrival.
- There was no evidence of dementia screening being undertaken within the A&E department.
- There were longstanding concerns about the responsiveness of the psychiatric team to the needs of the department. This issue was listed as No. 9 on the departmental risk register. The latest update on the risk register stated that from February 2014 psychiatric liaison was available 24/7. There was no further information as to whether this had had the necessary impact. However, we found that breaches were still occurring due to delays in psychiatric care.
- The paediatric department was co-located with the minor injuries unit. Children presenting up until 8pm would be seen in that unit, which contained a small but separate waiting area. Out of these hours they would be seen in the main department alongside adult patients. On the morning of our inspection, we saw that a child was still in the majors department despite the fact that the paediatric department was open and staffed. None of the staff spoken to (including the nurse in charge and the paediatric sister) were not aware that the child was in the department.
- There were extensive plans to rebuild the paediatric department, which was due to start in June 2014. This would allow all children to be seen and treated in an appropriate environment irrespective of the time of day they attended.

Learning from complaints and concerns

The trust was unable to provide us with details of recent complaints to the A&E department or follow-up actions or changes to practice as a result. Minutes from the quality and safety group meetings documented that, since the split of the directorates in December 2012, records of complaints were no longer kept online. It was raised as an issue that this meant that the details of complaints could not be collated. We were given the minutes of six meetings in which the number of complaints was discussed only twice, and then only to state the number received in the preceding two months. From September 2013, there was no documentation on analysis of complaints received.

Accident and emergency

Are accident and emergency services well-led?

Inadequate

The leadership within the A&E department was not sufficiently established to ensure good patient experience and quality care. Universally throughout the department, aspirations for change and improvement came from the belief that the proposed departmental rebuild would provide a solution to the current inadequate levels of care provided to the local community. However, very little was articulated about the leadership within the department and its potential to deal with the issues it was currently facing, and the department mirrored the organisation in terms of core members of the leadership team being interim. The triumvirate vision was not aligned and at the time of the inspection there was a lack of ownership of the issues faced by the department. Staff appeared demoralised and at times resigned to their inability to improve the quality of care they were providing. This was borne out by the patient comments we received both orally and in writing throughout our inspection.

The significant data concerns found by the team could not be explained by the leadership and appeared to have been the first time that they were aware of these.

Vision and strategy for this service

- The future vision involving a rebuild of the department was well described by all members of staff. However, at the time of our inspection, this remained unfunded. Most members of staff we spoke to were unaware that this was the case.
- There was little acknowledgement that immediate changes could be undertaken to improve the quality of patient experience. With the exception of one member of staff, everyone stated that this could only occur when the department was expanded.

Governance, risk management and quality measurement

- Monthly departmental meetings were held (alternating between quality and safety). We were given minutes from six meetings held over the previous 10 months.
- There was a set agenda for each of these meetings with certain standing items.
- According to the minutes, the top five risks were discussed at each of the meetings. However, details of the discussions, including what was being done to mitigate the risks, were not documented. Over the course of several meetings, some of the ratings ascribed to the risks were changed. It was not clear how or why the decisions were made for this to occur.
- We saw two different versions of the risk register. While similar, questions had to be asked as to who owned and maintained the risk register, and how effective a tool it was to the department.

Leadership and culture within the service

- Oversight in the department was in the form of a triumvirate, including a medical lead (an A&E consultant), a nursing lead (an interim senior matron) and manager (an interim general manager for A&E).
- The senior matron had been in post one month and the general manager had been in post less than six months. They were both were interim positions.
- The triumvirate members were interviewed separately and the conclusion drawn by the inspection team was that their visions were not aligned and that there was a lack of joint ownership of the issues faced by the department
- There was a supernumerary nurse in charge (NIC) for each shift in the department. We were told and witnessed an over-reliance on the NIC especially when the department was under pressure. From talking to staff, it was clear that the four-hour access target was not owned by the multidisciplinary team. We were told that the target was policed by the nursing staff and that medical staff did not engage in responsibility for the patient journey.
- Significant and unrelenting pressure on the department had had an impact on the staff we spoke to and discussions revealed a tired and, in some cases, disengaged workforce.
- There was evidence of insufficient support for many of the longstanding staff members in leadership roles and during discussions some staff became tearful or apologetic for personal 'failings'.
- The high percentage of locum use contributed to the lack of cohesive working with the potential to have an impact on patient care and experience. At the same time, the vacancies within the consultant team resulted in an onerous rota that was potentially unsustainable.

Accident and emergency

- There was an unacceptable tolerance by the organisation of patients waiting longer than six hours to be allocated a bed or to complete their care. Staff were unable to identify who within the executive team was taking responsibility for this, despite an assurance from the executive team that it was happening. This was further evidenced by the fact that the Vanguard Unit had been operational as an overnight holding area during the time of our visit and it was our team that informed the executive body rather than their own internal processes or chains of command.

Public and staff engagement

- There was a public forum for the A&E department and this had been consulted regarding the planned rebuild.
- There was no evidence displayed in the department of changes made as a result of patient feedback (e.g. 'You said, We did').
- Friends and Family Test results were displayed in the waiting room only and junior doctors in particular were not aware of the relevance of poor results.

Innovation, improvement and sustainability

- There were extensive plans to restructure and rebuild the A&E environment and external health planners had been involved in the design of the new department to help meet the future needs for the department.
- Despite suggestions of improvement for the department by external reviews, there was little evidence that these had been taken on board or actioned.

Medical care (including older people's care)

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

Information about the service

Medway Maritime Hospital has 10 medical inpatient areas. These include acute medical units, specialist wards, general medical wards and facilities for the care of frail and older people. The hospital delivers medical specialties including stroke, cardiology, diabetes, gastroenterology and respiratory.

During the course of this inspection, we used a variety of ways to learn about these services. These included speaking with 35 patients and 14 relatives and visitors, as well as attending the listening event where members of the public were invited to share their experiences. We visited medical wards and observed care being delivered by staff. We spoke with nearly 60 members of staff including nursing and care staff, consultants and doctors in training, therapists, senior managers and support staff. A number of staff attended the focus groups and drop-in sessions where they could share their experience of working at the hospital with CQC. 11 sets of patient notes were examined.

We reviewed concerns that had been raised with CQC by patients and staff, both before and during the inspection. We also reviewed data and information provided by the trust and other stakeholders.

Summary of findings

Medical care and older people's care ran at high capacity. Nursing staff levels had been increased with active recruitment well under way. This meant that there were many new and newly qualified nurses on all the wards, as well as high use of agency nurses to cover remaining vacant posts. Nursing staff we spoke with expressed concerns regarding the skill mix on the medical and older people's wards. There were directorate processes in place for staff to escalate issues that affected safety. However, these were not always acted upon appropriately.

We found that medical patients were regularly 'outliers' on surgical wards because of the lack of medical beds. This was a particular concern at night as there was only one registrar and one senior house officer (SHO) covering all the medical wards and 'outliers' across the hospital.

Mandatory training compliance was poor, particularly among medical staff. Nursing ward managers consistently stated trust wide records were not current or accurate and consequently each ward manager developed local monitoring system, which were not standardised or co-ordinated trust-wide.

Patients told us that they received good care and that staff were kind. Staff demonstrated awareness of the importance of being open with patients and providing

Medical care (including older people's care)

individualised care. However, many patients described experiences of delays in admission and discharge. We were unable to identify a strategy to manage the patient flow issues raised.

There were some examples of good governance systems in place but they were not fully embedded across the directorate. There were also issues relating to poor data quality.

Are medical care services safe?

Requires improvement

The medical care services did not sufficiently protect patients from risks of avoidable harm and abuse. There were known high capacity concerns together with known staff shortages and a high use of agency staff. We found that staff within the medical care services did not always take appropriate action when ward and/or patient safety concerns were escalated using the directorate processes, and the incident reporting culture appeared to be more widespread amongst nursing staff as not all doctors had received training in using the DATIX system.

The management of access to mandatory training by nursing staff was variable. This meant that not all staff received their training.

Most staff were aware of, and reported incidents and serious incidents were well investigated. Aside from one exception ward areas were clean and all staff were observed to be compliant with good hand hygiene practice. Staff responded well to the Major Incident which was called during our unannounced inspection.

Incidents

- There was a trust electronic incident reporting system (Datix) in place that all staff we spoke with were aware of. Staff at all levels told us that they had reported incidents and most were trained and able to use the electronic system. Some staff were less confident about using it. A care support worker told us that they reported any incident to the ward manager who would input it onto the system for them. A junior doctor told us that they had not been trained to use the system but had found out about it for themselves and reported incidents regularly.
- We found a good knowledge and understanding of incidents that should be reported among the staff we spoke with. The online form used for reporting did not enable the directorate to collate numbers of reports by staff group, which could have provided an indication of training needs. However, we were shown individual reports that demonstrated reporting by nursing staff, therapists and medical staff. Anecdotally, it was felt that most incidents were reported by nursing staff. One senior sister told us, "I Datix everything."

- A variety of incident reporting took place relating to patient falls, medicine omissions, pressure ulcers, staffing levels and delays in diagnosis. We saw that there were monthly reports from the system for each medical ward and area. These formed part of the monthly one-to-one meetings between each ward manager and their matron. However, we saw that incidents were regularly discussed as they occurred when necessary. We saw discussion of incidents, actions and learning evidenced on sisters' meeting minutes. We saw copies of the directorate safety meeting minutes that showed incidents were discussed at that level.
- We were told that feedback and learning from incidents were included in ward meetings. In addition, we were told that each ward had a 'Better care together' folder that included safety reports, theme tracking and action plans from incidents. We saw the folders on Harvey and Keats Wards. These folders were available to all ward staff. The action plans were discussed at the sisters' meetings.
- We saw the completed investigations for five of the serious incidents the trust had reported to the National Strategic Executive Information System between December 2012 and January 2014 that related to the directorate of medicine. Three of these had resulted in death. Two had related to falls leading to fracture where both patients underwent surgery. One fall had been deemed avoidable and the other unavoidable. We saw that these had been investigated and that learning points and recommendations for action had been identified. During our visit, we found evidence that some of the recommended actions that had been taken: examples included staff training and a change of leadership on one of the wards. Slips, trips and falls accounted for most of the serious incidents reported during that period.
- Another serious incident investigation was currently under way relating to the out-of-hours transfer of a very sick patient to a medical ward that had already been identified as inappropriate because of both the high level of dependent patients already on the ward and reduced staffing. This was reported by the ward manager as soon as they became aware, and a patient safety case review was carried out by the ward manager, matron and a consultant physician.
- We were told that ward staff regularly carried out patient safety reviews when they identified a concern that patient safety may have been compromised. These did not always relate to a serious incident but could also be in response to a near miss. The purpose of the review was to quickly identify areas for change and learning at the ward level so that these could be put in place without delay. We saw evidence of the action plan put in place following this serious incident and the learning already disseminated to staff. This meant that staff were made aware of the patient safety issues without waiting for the conclusion of the full serious incident investigation, which could take some months to complete. The response to the wider issues regarding capacity and out-of-hours transfer of the patient was awaited as part of the full investigation.
- The recently appointed clinical director told us that he had introduced mortality and morbidity (M&M) meetings within his specialty of gastroenterology for the past two years. Stroke meetings were held every two weeks in which mortality rates were discussed. Otherwise such meetings did not take place within the directorate. During the past two months, there had been a monthly half-day to review governance and quality during which the clinical director had presented the M&M cases. It was proposed that all the speciality areas in medical care would present their cases and a rota was under development

Safety thermometer

- Wards we visited collected the NHS Safety Thermometer data and we saw records for the period April 2013 to March 2014. Examples of results for one ward showed that the C. difficile target was met throughout the period and the MRSA target for nine of the 12 months. However, the ward environment target of 95% was not met, although improvement was evident in scores increasing from 87% to 92% over the period. The number of patient falls showed a peak in October and November 2013 of nine and 12 respectively. These reduced immediately and were at five and three for February and March 2014 respectively. Medicine omissions were shown to be consistently high.
- In addition the wards had been completing a Ward to Board Assurance Framework since December 2013. This collected data under the four headings of safety, effectiveness, caring and well led. Some data collected was the same as for the safety thermometer but not all. Appraisals and some mandatory training were included. Only health and safety training had a target and that was 100%, with the ward result showing as 82% in

March 2014. The ward manager we spoke with was not certain of the purpose of completing both the Ward to Board and the safety thermometer but was doing so while awaiting further clarification.

- The trust-wide work on falls prevention and management had resulted in a general reduction in falls across the wards.
- The trust performed below the average for England for seven out of 13 months from November 2012 to November 2013 for new venous thromboembolisms (VTEs). A new checklist had been introduced for the doctors' ward rounds that identified where VTE risk assessments had not been completed. However, this was not in use consistently across all medical wards.
- Pressure care and prevention had improved with all incidents of pressure ulcer reported and investigated. New active mattresses had been supplied to the wards we visited, and these were an improvement in patient care. Turning charts were reviewed regularly by senior nursing staff.
- All wards used safety crosses displayed on the wall for each month, and these were visible to patients, visitors and staff on the wards. These showed the number of falls, pressure ulcers and infections such as MRSA and C. difficile that had occurred during the month and on what date. Some wards had additional charts – for example, for medicine omissions, mixed-sex bays and missing wrist name bands. We were told that these identified areas of concern to which staff could give extra attention. When relevant, results were fed into the safety thermometer and Ward to Board Assurance Framework, which in turn were submitted electronically to contribute to the trust data. We saw the results of these were monitored by ward managers and matrons.

Cleanliness, infection control and hygiene

- Overall, the standards of cleanliness and hygiene on the clinical areas we visited were adequate. Four ward areas were inspected specifically in respect of cleanliness. Three ward areas were cleaned to an acceptable standard. However, on Gundulph Ward, we found unacceptable levels of black dust on all high surfaces both on the ward and in the toilet and bathroom facilities.
- We saw that staff adhered to the 'bare below the elbows' policy. There were ample supplies of hand gel and we saw staff washing their hands regularly. Hand-washing posters were in all clinical areas. We saw that staff wore appropriate protective clothing. Cleaning staff seen were wearing protective clothing.
- Cleaning schedules were displayed on the wards we visited.
- Infection Control audits are carried out yearly with a 6 month update, audits are only carried out more frequently if an infection control issue is highlighted.
- On the wards visited, infection control audits were carried out every two to four months on the wards. The number of areas audited varied across the wards, as did the outcomes. For the month of March 2014, one ward only had hand hygiene (100%) and environment (79%) audit results. These were an improvement on the data provided for February 2014, which were 83% and 71% respectively, with an overall average of 74%. Another ward had hand hygiene (80%), commode (100%), environment (92%), housekeeping (93%) and observation (91%). We were given a large number of infection control audits. These showed good results, such as the acute medical unit (AMU) with 97% for sharps and waste, and Will Adams Ward with 100% for hand hygiene and documentation. There were also less good results, such as documentation for recording checks at 44% on Dickens Ward. Generally, the ward environments scored lower than other elements of the audits.
- We saw evidence of improvements from shared learning across the wards. One ward consistently scoring 100% for the commode audit shared their practice with others, which led to more wards scoring 100%.
- We were told of a recent deep clean undertaken in the coronary care unit (four beds). This meant that the unit decanted into a bay on one of the medical wards for two weeks. The infection control team carried out an audit of the four-bed medical bay and it was decided on the grounds of infection control risk and patient safety that the fourth bed would be removed for the second week. This meant a reduced availability of the service for the week but maintained safety for the three remaining beds. We found that this was not reported as an incident on the Datix system.
- MRSA and C. difficile rates for the trust were within expected limits. Healthcare-associated infections were included on the directorate risk register. In 2013, there were increased MRSA acquisitions that were managed by enhanced measures put in place with close

monitoring. Patients had checks on admission and weekly thereafter. The trust provided evidence of the measures, regular infection control audits and joint working with the wards concerned. The rates had reduced since.
- We saw the recently reviewed 'antimicrobial prescribing' policy and consultant physicians that we spoke with told us that this was helpful in the use of antibiotics.
- We saw evidence of compliance with isolation policies for three patients in side rooms.

Environment and equipment

- While some clinical areas were found to be spacious, such as the Sapphire ambulatory unit and the admission and discharge lounge, the wards were generally lacking in space and corridors were filled with equipment, chairs and waste containers. We saw that it was difficult for staff to always move between patients easily. It was difficult for porters and other staff when moving patients on beds in and out of ward areas because of the lack of space. Because of the activity of the hospital, the wards were generally full. There were limited toilet facilities in the AMU as well as cramped conditions, so that clinical staff had to search for space to sit and write up patient records.
- One ward reported a shortage of bariatric equipment. We found on other wards that broken hoists had not been replaced and that sling hoists were in short supply. We were told that equipment had improved for the falls service. Staff in other clinical areas such as AMU felt that there was sufficient equipment. The directorate had submitted a number of requests for equipment to the trust since January 2014. This was reflected on the directorate risk register. We were told that the physiotherapy department was well equipped.
- There were new competency-based training sheets for staff to complete for all equipment used.
- Resuscitation equipment in all areas we looked at was found to be regularly checked with emergency medicines available and in date. Oxygen and suction were available

Medicines

- Medicines were stored in locked cabinets in the clinical areas with medicines ordered by nursing staff through the hospital pharmacy. However, it was found that the controlled drugs cupboard in the coronary care unit had poor recording in the register. There had been no check of controlled drugs undertaken by a pharmacist for the past seven months despite their providing good cover and visiting the unit every day.
- We found good pharmacist cover in the AMU but there was concern as to whether this service would continue because it was funded by winter monies.
- There was a dedicated porter to take dispensed medicines to the wards – for example, for urgent prescriptions or discharge medicines. This service was valued by both pharmacy and ward staff.
- There were competency-based assessments for staff to complete before administering medicines.
- The medicine omission data that was collected and monitored was high and thus a concern. The wards had recently started work to reduce these in the same way previous work had reduced the numbers of falls and improved pressure ulcer care, but it was too soon to assess the impact of this.
- Incidents involving medicines and their management were well reported on the Datix system.

Records

- The patient records were in paper format with separate nursing notes kept at the bed or side room door. The records were generally well completed with some areas for improvement. For example, medical handover notes for patients to be seen out of hours were found slotted loosely in six sets of patient records. These notes included what actions had been taken out of hours.
- We found that patients had their care needs risk assessed and recorded in all the records we looked at. There were new nursing care plans that prompted appropriate risk assessments. There were pathways for conditions such as stroke that all members of the multidisciplinary team (MDT) wrote in.
- Care plans were checked by senior nurses on a regular basis during the week. One ward manager told us this was done every 72 hours, another that they did it twice a week. We saw evidence of these checks in some of the patient records we looked at. Any incomplete assessments or other record-keeping issues were noted on the care plan and passed to the relevant nurse for completion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told, and saw evidence of, high numbers of confused patients on the medical wards. An increasing

number of mental capacity assessments were needed and we were told that sometimes these could take some time to complete. However, we saw evidence of close working with the psychiatric team and were told that they were responsive when asked to review a patient.

- Staff we spoke with told us they had received Mental Capacity Act training, but we were not given evidence that this had been completed on all wards. Eighty-two per cent of staff were trained on one ward where this could be demonstrated.
- At the time of our inspection, Deprivation of Liberty Safeguards (DoLS) training was not part of the mandatory training package. That said, qualified nursing staff we spoke with demonstrated a good understanding of the safeguards. The ward managers we spoke with were aware of the recent changes following legal judgements.
- We tracked the record of a patient with a DoLS in place. We saw evidence of the mental capacity assessment undertaken. There were comprehensive DoLS authorisations in place and regular reviews, including family meetings, were recorded.
- Most patients we spoke with felt generally well informed and none identified any concerns with consent.

Safeguarding

- It was difficult to obtain definitive data on safeguarding training for all staff on all medical wards because there was no standardised system for the wards to collect this data. Tennyson Ward showed adult safeguarding at 76% and child protection at 79%. Harvey Ward demonstrated 100% of staff trained at Level 2 adult safeguarding and 59% at Level 2 children safeguarding, with training dates awaited for the rest of the staff.
- Staff we spoke with showed knowledge and understanding of safeguarding and how they would report concerns.

Mandatory training

- Trust data given to CQC showed 69% of non-medical staff in the directorate of medicine had completed their mandatory training at February 2014. This was a total figure with no breakdown by staff group or specific training.
- Ward managers told us, and we saw evidence, that the training data provided to them by the HR department was not current or accurate. They found it difficult to monitor and manage staff training from the central information they received. Therefore, each ward manager had to develop their own local monitoring system, which was not coordinated or standardised.
- The local ward-based systems did not therefore correlate with trust-wide data and could not provide assurance to the trust Board that all staff received mandatory training.
- Staff were responsible for booking themselves on the relevant training courses when due. If they did not attend, there was a process in place for follow-up. However, this was not consistently applied.
- When wards could provide evidence of training, we saw that fire training had been completed by all staff on Harvey Ward but by only 67% on Tennyson Ward. From the information we could obtain, Harvey Ward had achieved 100% for almost all mandatory training, with plans in place for the remainder. On Gundulph Ward, we were told that it was difficult to release staff for training so it was planned that trainers would come to the ward. Staff in the coronary care unit said that training was "a bit disjointed" and "could be managed better."
- We saw that new competency-based training sheets for equipment had been developed.

Management of deteriorating patients

- The national early warning score (NEWS) system was brought in in 2013 and was now available throughout the medical wards. We saw evidence that the system was used and relevant scores recorded.
- Some of the documents we saw from the serious incident investigations stated that nursing staff and junior doctors needed the confidence to identify and escalate patients appropriately.

Nursing staffing

- Staffing and recruitment were the second highest identified risk on the directorate risk register and were included on all the individual ward risk registers that we saw. There were a high number of vacancies across the directorate and a corresponding high use of agency staff.
- A patient dependency and acuity tool, had been used to establish staff numbers for each shift. There had been a staffing review and an increase in qualified staff on every ward. This increase had been funded for the day shifts. There was Board agreement for the extra night staff but no funding as yet. There had been continuous active recruitment to fill these posts.

Medical care (including older people's care)

- The wards had moved to working as three teams with three qualified nurses on each shift plus a Nurse in charge (NIC) for the day shifts. In addition, there should be three care support workers for the early and late shifts with two on the night shift. This was as a result of the Keogh mortality review and the trust moving to a ratio of 1 qualified nurse to 8 patients. The staff told us that this was a huge improvement because previously there had been two qualified nurses working half the ward each on wards that accommodated 23–27 patients.
- The trust had employed a number of nurses, some from overseas and some from other organisations such as nursing homes. This had resulted in concerns about skill mix on the wards because there were so many new and newly qualified nursing staff. All the staff we spoke with on every ward we visited said that this was a high risk, and that the experienced staff had an increased workload in supporting the new staff.
- In addition, shifts were regularly understaffed and NHS Professionals agency staff were not available, or were unwilling, to cover all the required shifts. This meant that staff reverted to working half the ward again.
- Gundulph Ward was inadequately staffed on 25 April 2014. There should have been four qualified and three care support workers but the actual staffing was three qualified and four care support workers for the early shift. The night shift should have had three qualified nurses plus two support staff but there were two qualified nurses plus two support staff. We saw the off-duty rota that correlated with what we were told and what was on the board.
- On 24 April 2014, the late shift on Keats Ward had one NIC supporting a new nurse from Spain plus two junior qualified nurses and one care support worker. There should have been one NIC, three qualified and two care support workers. There had also been an issue identified for the night shift because it would consist of one newly qualified nurse, two agency qualified nurses plus two agency care support workers. This meant that there was only one permanent member of staff on duty for the night, and that person was newly qualified. We observed the discussion with the site practitioner when this was highlighted as a concern. We were told that one of the agency staff would be swapped with another experienced permanent qualified nurse to support the newly qualified staff member for the night. When we visited the ward again on 25 April, we found that this swap had not occurred.
- We also visited a ward where the staffing was at full establishment. Harvey Ward was fully staffed on 24 April, including the charge nurse being supervisory. We were told that there were students waiting to join the ward and that they were aiming towards a ratio of 1:7.
- Some of the wards were working with NHS Professionals to train agency staff so that they worked exclusively on their ward for a year. This would provide better continuity and increasing experience on the ward while recruitment continued.
- To assist with bed capacity concerns, an escalation ward, Dickens, was opened in November 2013. However, at the time of its opening, there had been no establishment of staff allocated to it. Five months later, at the time of our inspection, all the qualified nurses on the day shift were agency staff. For three out of four nights there were no permanent staff on duty so they swapped with other wards, but these were also heavily reliant on agency staff at night.
- Matrons described the "constant juggling" to try and maintain safe staffing levels on all the wards.
- We saw an example of the agency staff induction booklet. Once completed, the ward kept a copy. Agency staff had to bring their copy as proof of having completed their induction when they worked on the wards. We did not see evidence of the system of checking staff competencies being used.

Nursing and medical handover

- End of the bed handovers took place at the beginning of each nursing shift. Individual patient risks were discussed – for example, falls and pressure areas. In addition, the wards had 'safety huddles' three times a day. We observed one safety huddle that 12 staff, including a doctor, attended at the nurses' station. The session was brief and focused. Discussion included turn charts for patients, feeding, discharges, missed medicines and any other individual needs.
- We observed a medical handover on the AMU when the overnight SHO presented the patients to the consultants and their teams. Patients were identified for specialty review – for example, respiratory or cardiac. The meeting was well attended and thorough. There were two handovers each day Monday to Friday.

Medical care (including older people's care)

- Not all patients were seen out of hours. A medical handover proforma was completed for patients who should be seen and these were collected by the on-call team at the beginning of their shift.
- Site practitioners ran the hospital at night, helped with general enquiries and advice, and attended the ward if there were problems.

Medical staffing

- From 9am to 5pm, Monday to Friday, all medical wards had consultant presence as well as middle grade and junior doctors. All patients were seen daily by either a consultant or registrar.
- One consultant from each specialty would review the medical outliers on surgical wards.
- There was one registrar and one SHO covering all medical wards and outliers in the hospital at nights.
- Weekend days had two registrars, two SHOs and two Foundation Year 1 doctors. There were two consultants in the mornings and one in the afternoon.
- The AMU had two consultants who covered 9am to 5pm Monday to Friday. There was a registrar and SHO for nights and weekends.
- Medical staff spoken with told us there was a general shortage of middle grade doctors with one long-term locum. The medical staffing officer confirmed that there were usually shortages of junior doctors in medicine.
- We were told that the two diabetic consultants struggled to see all the inpatients Monday to Friday. Another consultant said that their workload was very high with consistently long days worked. We were also told by one consultant that he came in over the long bank holiday weekend, when he was not on call, to review new and acutely sick patients.
- One junior doctor told us that they had put back their exams because of their heavy workload. Another said that they were experiencing difficulties in attending teaching sessions, or getting time off to take their exams. A middle grade doctor said that medical staffing had improved and they were able to attend teaching and undertake audit.

Major incident awareness and training

- During the unannounced visit, we attended a bed flow meeting that took place when the site practitioners for the night came on shift. During the meeting, the hospital was put on 'alert' to support a major incident. We saw staff following the major incident procedures with plans to cohort patients when possible to free up appropriate beds for the injured.
- The interim general manager worked with patient transport staff to expedite patient discharges to ease capacity.
- Staff demonstrated knowledge of their roles in the event of a major incident.
- The trust opened an escalation ward in November 2013 to assist with the winter pressures on the hospital. Even with this extra ward, significant capacity and patient flow issues were identified.

Are medical care services effective?

Requires improvement

The medical care services were not always effective. There were evidence-based policies in place but many local guidelines and procedures were not up to date. We were told that the trust IT systems were slow and difficult to navigate. This meant that locum doctors could not access them, particularly out of hours.

Although it has improved slightly, Medway Maritime hospital still has a significantly elevated Hospital Standardised Mortality Rate (HSMR). Two out of three mortality outliers (groups of conditions that have been identified as having higher mortality than expected) were for medical conditions. The trust undertook investigations into these, and concluded that although incorrect coding was a contributor there were also examples of sub-standard care provided. There are action plans in place to address these, though as mentioned it is still too early to assess their sustained improvement.

Evidence-based care and treatment

- We found that there were policies in the directorate based on the National Institute for Health and Care Excellence (NICE) and Royal College guidelines, such as the 'assessment, prevention and management of pressure ulcers' policy and one for acute kidney injury.
- There had been focused work on 'Think sepsis' to raise awareness on the wards. One ward showed us the sepsis box that contained everything needed and was stored on the resuscitation trolley. This meant that it was visible as a reminder when staff used the

emergency equipment as well as when they did the checks. The impact on outcomes was being monitored but it was too early to know whether there were sustainable improvements.
- We saw evidence that NICE guidelines were discussed at the directorate quality and safety meetings.
- We were told that guidelines were available electronically but that the IT systems were slow and unhelpful. In addition, locum and agency staff were not able to access them. Guidelines were frequently out of date in many of the specialty areas. A new IT system was due to be implemented that would contain the clinical guidelines. In preparation for this, guidelines were in process of being reviewed and updated. This work was to be completed by July 2014.
- We found evidence in patient records and care plans that local policies and procedures were followed.
- Clinical pathways such as for stroke care were in place and we saw evidence that they were followed.
- The trust provided evidence of audits undertaken across the specialties for 2013/2014. Some junior doctors said that they did not have time to undertake audits because of their heavy workload. There were audits planned for 2014 that would focus on sepsis and antibiotics.

Pain relief

- We saw that pain relief was prescribed and administered to patients in the records that we looked at.
- Patients that we spoke with told us that they were offered pain relief frequently and were pleased with the care they received in that regard.

Nutrition and hydration

- We saw that nutritional standards were displayed on the wards that we visited.
- We saw that a nutritional pathway, together with dietary and nutritional training, was in place in the stroke unit. This enabled swallow assessments to be undertaken within four hours.
- The nursing care plans included a malnutrition assessment. Completion of assessments was monitored by the reviews of notes that were undertaken by senior nursing staff at least twice a week. We saw evidence of the monitoring in the patient records we reviewed.
- The trust scored worse than other trusts in the 2013 CQC Adult Inpatient survey for the quality of food provided.
- On Tennyson Ward, we saw the knife and fork symbol on the board above a patient's bed. This indicated that the patient needed extra help with eating.
- Red trays, red mats and red lids for water jugs were all seen to be in use to highlight the kind of help individual patients required.
- We saw evidence of food and fluid intake being monitored when patients were identified as at risk.

Patient outcomes

- The trust had established a Mortality Working Party (MWP) in December 2012 in order to try and help them understand the reasons for their high HSMR. This consisted of senior clinicians from within the trust and their commissioning bodies, as well as members of the board. The trust acknowledges that despite the work undertaken since then, their HSMR has not significantly improved. Aside from fractured neck of femur, all of their 'biggest areas of concern' relate to primarily medical subspecialities (septicaemia, failure to recognise a deteriorating patient, chronic obstructive pulmonary disease, acute kidney failure, acute cerebrovascular disease).
- A 'Think Sepsis' protocol was re-launched and this, alongside the introduction of STAR (see the A&E report) allowing for early prescription of antibiotics and fluids has resulted in a reduction in crude mortality and SMR in patients with septicaemia.
- The trust has also made progress with COPD, for which it received an outlier alert from the CQC in November 2013. The action plan showed to the team outlined what actions were being taken to address this. This included an 'inreach' service to identify patients with COPD by the respiratory consultants.
- The hospital had also been identified as a mortality outlier for fluid and electrolyte disorders. The trust reviewed patient records and gave CQC their subsequent action plan. This will require ongoing monitoring to ensure that all of the actions are completed and have the expected impact on patient outcomes.
- The directorate participated in the enhanced quality (EQ) pathways for pneumonia and heart failure. There was an EQ nurse who collected the data and submitted it. The EQ year runs from January to December so had recently closed. The trust achieved quality standards on both pathways: heart failure as a high performer and

pneumonia as a moderate performer. It was collecting baseline information for an EQ acute kidney injury pathway and working with the EQ team on a potential COPD pathway.

- The trust contributes to the Sentinel Stroke National Audit Programme (SSNAP). The most recent audit (2013) awarded the trust grade E (the lowest of 5 grades A-E) for the services provided.
- Although the trust has a cardiac catheter lab, this functions only 9-5.30pm and is primarily for elective procedures. Emergency primary percutaneous coronary intervention (PCI) is undertaken by the William Harvey Hospital Ashford. Only 19% of patients admitted with an NSTEMI (a type of heart attack that does not require immediate intervention) was admitted to a cardiac ward. This is significantly below the national average.
- There was a dedicated physiotherapist on the AMU to facilitate admission to a ward or discharge from hospital when possible.
- The respiratory specialist nurse reviewed patients in A&E and described how she had changed the oxygen equipment at a patient's home so that they could be discharged directly from A&E.

Competent staff

- Staff said that they were given opportunities for professional development. The matron roles were undergoing development to enable matrons to work more collaboratively across the hospital. One said that they were studying for a postgraduate qualification that had been funded by the trust but no time had been provided to complete the work.
- There were a number of specialist nurses in the areas of diabetes, respiratory, falls and stroke.
- Most staff appeared to have received appraisals. Two wards we looked at demonstrated that almost all or most staff had received appraisals, and there were planned dates for the rest. Appraisal data was collected on the monthly Ward to Board Assurance Framework.
- Consultants we spoke with told us that there was funding for external continuous professional development (CPD) but that it was difficult to take the time. The deputy medical director confirmed that consultants had completed internal and external CPD. The clinical director for medicine described the conferences attended and the national and international presentations given over the past year.

Multidisciplinary working

- We saw evidence of much multidisciplinary working in the patient records we looked at, in discussion with staff and by observation.
- This included the interdisciplinary working on the stroke pathway between the hospital clinicians and the community trust specialist stroke and therapy team. The trust contracted their services and they integrated as a team on the ward.
- We also saw evidence of multidisciplinary working with physiotherapy, occupational therapy, dietetics, speech and language therapy and specialist nurses such as the falls and respiratory nurses. We saw that specialty referrals had been requested – for example, an orthopaedic review for a medical patient.
- The physicians worked closely with the GPs and nurses who led the rehabilitation units patients were discharged to. We saw evidence of discharge planning with them and also how a patient had been readmitted directly from the rehabilitation unit to a medical ward when their condition had deteriorated.
- Access to psychiatric input was good and we saw evidence of psychiatric involvement in the patient records we looked at.

Seven-day services

- Consultants were available on site from 9am to 5pm Monday to Friday, outside of these hours the general medical physicians provided an on-call service.
- At night, a registrar and SHO covered all medical wards and medical patients on the hospital site.
- At weekends, there were two consultants on site in the morning and one in the afternoon. Not all patients were seen at weekends but new patients and those acutely ill would be seen.
- The stroke service worked jointly with the other hospitals in Kent and Medway – four in all. They worked a rota to provide out-of-hours on-call cover by a senior doctor, consultant or staff grade for the whole area.
- Care of older patients received cover from the general medicine on-call team out of hours.
- At weekends and nights, a registrar provided cover for the AMU.
- We were told that an extra registrar had been put on shift from 3pm to 10pm to assist with the out- of-hours cover.

Medical care (including older people's care)

- Radiology and pathology services were available out of hours, although accessing radiology procedures had to be at registrar level. This could cause delay if the registrar was with another patient and could not contact the radiographer directly for some time.
- In addition, there was on-call support from a physiotherapist and a pharmacist.

Are medical care services caring?

Good

The medical care services were caring. Patients told us that they received good care and that staff were kind. We observed many examples of kindness, consideration and respect for patients' dignity. Staff demonstrated awareness of the importance of being open with patients and providing individualised care.

We found that good efforts were made to listen to patients and their families. Staff worked hard to keep patients informed in the clinical areas. Open visiting was in place for acutely unwell patients.

Compassionate care

- Data provided to CQC before the inspection indicated that the hospital was performing below the national average on the inpatient Friends and Family Test. Work had been undertaken since then with proactive initiatives such as texting patients to encourage participation in the Test. This was not done on the wards for older people. There had been improvement in all areas we looked at in both response rates and scores where it was likely or extremely likely that the ward would be recommended to others. The results were displayed on the wards.
- Patients we spoke with were generally complimentary about the care received and the attitude of the staff towards them. Patients commented on how busy the staff and the ward areas were. We received comments such as, "Everyone is so kind" and "What you read in the newspapers is a lot of eyewash. You couldn't be treated better."
- During our visits we saw that patients were treated kindly and with respect. We saw many examples of good care provided by nurses that included responding to requests for explanations and checking that patients were warm enough. We saw a junior doctor accompanying a confused older patient back to their bed, giving the time and care required.
- We saw that curtains were drawn to protect patients' privacy and dignity. We observed several occasions when patients were being transferred to another area on their bed when they were well covered with consideration shown.
- We saw that one patient's mother had open access to the ward to see her son and take him for walks to help his rehabilitation while waiting for an appropriate bed. Other patients who were acutely unwell could also receive family at any time.

Patient understanding and involvement

- Most patients reported feeling involved with their care and treatment. However, some felt that they lacked information and understanding of some investigations and treatment plans. One said that they felt "disempowered".
- The senior nurses undertook regular patient reviews to talk and listen to patients as well as to check their care plans.
- Patients had named nurses.

Emotional support

- The hospital provided a chaplaincy service for the support of patients.
- There was a recently appointed dementia and delirium nurse that staff felt was a support for patients.
- Staff working on the Bernard Dementia Unit had developed a 'buddy' programme for their patients. This was being rolled out to other wards to support patients living with dementia.

Are medical care services responsive?

Requires improvement

The medical care services were not always responsive. Patients gave examples of when they had experienced delays in admission or discharge. We were unable to identify a trust-wide strategy to manage the patient flow issues identified and the discharge team was very new in

post and had yet to make a significant and sustained impact on improving discharge processes. Due to capacity patients were often cared for on non-medical wards such as the surgical wards.

Service planning and delivery to meet the needs of local people

- Staff were constantly risk assessing their patients and trying to manage capacity issues. This was the concern raised by all staff we spoke with.
- We were told by both pharmacists and ward staff that medicines for discharge were not always written up in a timely manner and that this caused delays for patients and increased patient flow difficulties throughout the department.
- Consultant physicians were being recruited, particularly for the care of older people, to improve the medical cover.
- Patients told us, and we saw, that there were delays in their admission and discharge.
- There were medical outliers on surgical wards every day. We saw that there were 14 on the day of the unannounced visit.

Access and flow

- Bed occupancy and capacity were the highest risks on the directorate risk register. They were made worse by poor patient flow from A&E and the AMU as well as delays in discharging patients. There were some factors outside the control of the staff, such as a patient who had been ready for neurological rehabilitation for some time but was awaiting a bed in the unit. However, we were not able to determine a trust-wide strategy to improve patient flow when it was within the staff's control. Most of the wards were proactive in planning patient discharge but delays occurred due to discharge letters not being sent or prescriptions not being prepared. These delays had an impact on patients' length of stay.
- As a consequence, some patients were medical outliers on surgical wards. We were told that medical and surgical wards were paired up – for example Byron with Ocelot – with a consultant physician allocated to each surgical ward. Orthopaedic wards were not paired with medical wards. We were told of a medical patient admitted to an orthopaedic ward, that the medical team was not aware the patient was on that ward and that discharge was therefore delayed.
- Bed meetings (four times per day) and site safety meetings (twice daily) had improved the effective management of bed capacity. The bed census fed into the meetings and representatives from all wards attended. The meetings were run by the deputy director of nursing and considered patient dependency, MRSA, capacity, resources and patients' needs.
- We also heard of barriers to radiological procedures out of hours because all radiology requests had to be made by the registrar on call rather than the more junior doctors. These again had an impact on the time patients stayed in hospital and frequently wasted doctors' clinical time trying to work round them.
- We spoke with bed bureau clerks and saw that they 'juggled' beds constantly.
- The hospital pharmacy undertook audits that showed they dispensed the medicines to take home that had been written up within two hours for 90% of the requests.
- CQC data showed that bed occupancy was known to be high. Staff constantly raised this as a concern and risk.
- Staff told us that doctors were discouraged from reviewing medical patients in A&E but had to wait until they were admitted to the AMU. This restricted access to the appropriate medical specialty for assessment and diagnosis. Some of the patients we spoke with told us of delays they had experienced. We also saw examples in some of the patient records we reviewed.
- The results from the most recent CQC Adult Inpatient survey (2013) demonstrated that the trust scored worse than other trusts in respect to questions around delayed discharges.
- The integrated discharge team was run by a different provider and was a very new introduction to the trust. Ward staff passed issues affecting discharge to them – for example, working with social services. There was ongoing work on managing the process between the two providers as this service was still very much in its infancy.
- There was an electronically generated staff handover sheet and all staff had a printed copy of it. It was updated by each shift and past ones were kept to provide an audit trail and inform incident investigations. The handover sheet provided information on each patient that identified what was needed for their discharge. This meant that all staff had up-to-date

information on every patient on their ward and could work to facilitate discharge. Issues such as working with social services or chasing a rehabilitation bed could be passed to the integrated discharge team to resolve.
- Consultants from each specialty ward were allocated to the surgical ward except for orthopaedic wards where their medical outliers were. Monday to Friday these patients should be seen every day. Medical outliers were highlighted and moved to a medical bed as soon as possible. In addition, older patients on the medical wards were also transferred to appropriate wards when possible.
- Mixed-sex bays were breached on one ward during our visit. Patients would be moved into a side room as soon as possible. Other wards had male patients in side rooms on female wards and vice versa. This was not considered a breach because there were no mixed-sex bays on the ward. However, it meant that one toilet facility had to be changed to reflect both sexes on the ward. The trust also scored worse than other trusts in the CQC 2013 Adult Inpatient survey with respect to mixed sex accommodation.
- Harvey Ward was the stroke unit with 25 acute beds of which two were designated 'red beds' that would be freed up for emergency stroke patients as required. The ward was full with some non-stroke patients on the day of our visit. We saw the constant risk assessing of patients should the need arise to move a patient out in order to admit a stroke patient. We were told that this was a daily occurrence due to the pressure on beds. The directorate service managers and site practitioners dealt with such issues on the wards by, for example, chasing up rehabilitation beds for discharge to facilitate patient flow and take some of the pressure off the ward staff.
- We were told and saw that patients were moved quite frequently. They were also moved out of hours against national guidelines.

Meeting people's individual needs

- We saw staff provide an element of personal care that accommodated a patient's needs and calmed their anxieties.
- Staff we spoke with showed good awareness of the needs of homeless people and the support that might be needed before and at discharge.
- Hospital staff were able to offer translation services. There was access to an external service as well.
- Reports could be accessed to identify patients with learning disabilities who were awaiting discharge. This helped with individualised planning.
- The Bernard Dementia Unit had created an appropriate calm environment for patients with a pleasant sitting area for them to socialise in and do activities. Good practice was disseminated to the other wards for older people and medical wards.
- After a stroke meeting, it was agreed that two of the bathrooms on Harvey Ward would be made into walk-in showers. The change to one was nearing completion at the time of our visit. Staff also ensured that there was food available on the ward so that swallowing assessments could be undertaken at any time.
- The wards had patient information leaflets that were readily available.
- We saw posters inviting patients to comment, complain or compliment.
- Wards displayed 'You said, We did' information. This demonstrated listening to patients and taking action as appropriate

Learning from complaints and concerns

- Concerns were raised regarding the trust's complaints process. It was felt that it was not responsive enough for patients. At ward level, staff felt that they were improving this by meeting with patients and their families to try and understand the core issues of concern and what had gone wrong. We heard of positive meetings when staff had been able to put things right.
- One ward had a poster that invited patients and their families to raise any concerns or complaints before they left the ward. In this way, staff could try to resolve these in a timely manner.
- After the Keogh mortality review, the nursing staff wanted to develop an action plan that was relevant for them. They arranged an away day when they worked out their own quality improvement plan. We saw this plan. Senior nursing staff had been tasked with leading on different tasks within it. One such task was to develop staff photo boards for each ward and we saw that this was well under way.

Medical care (including older people's care)

Are medical care services well-led?

Requires improvement

The medical care services were not always well-led. The divisional structure had recently changed, and clear roles and devolvement of accountability was yet to be fully operational. We found some good governance systems in place but they were not fully embedded within the directorate. There were also issues in respect of poor data quality.

The lack of planned management time for the recently appointed clinical director to allow him to address governance, quality and safety issues was acknowledged to be of concern. Though staff we met were in the large, hardworking and passionate about services they were providing there was some acceptance of poor care as a result of the known capacity and staffing issues.

Vision and strategy for this service

- The deputy medical director and clinical director for medicine told us that they were moving to a divisional structure that would devolve power. New roles had been identified and job plans were currently being developed. It was not clear what funding had been agreed for this strategy.
- There were plans to develop a more robust governance system and processes with better participation from all staff, consultant physicians in particular.

Governance, risk management and quality measurement

- Recently the directorate had introduced a monthly half-day for governance and quality meetings, in line with the other directorates. This had been in place for two months. In addition, the previously separate quality meetings and safety meetings had been brought together since January 2014. We saw minutes from the January 2014 meeting and the agenda for the 30 April 2014 meeting. Attendance at the meetings was mandatory. Staff from clinical coding also attended the meeting to support the joint work on improving data quality.
- The head of nursing for the directorate was the governance lead and chaired the monthly meetings. There was an audit lead, patient safety lead and quality and safety coordinator for the directorate. We found that there was good engagement generally at ward level but it was not clear how much involvement senior clinicians had.
- There were standing agenda items in place that included a review of Dr Foster Intelligence, patient safety data such as infection control, cardiac arrest audits and patient safety reviews, patient experience and clinical effectiveness in relation to NICE guidance.
- When concerns were identified with, for example, mortality rates, a review or audit was planned. Recent reviews or audits undertaken included patients with chronic obstructive pulmonary disease (COPD) and a response sent to CQC. This identified issues with clinical coding and the quality of the data collected. There was some work being undertaken to try and improve this. One F1 doctor was auditing medical notes together with the discharge summaries, and taking into account the financial impact of inaccurate coding.
- Other junior doctors we spoke with gave varied responses regarding their ability to undertake clinical audit because of their heavy workloads.

Leadership of service

- The previous clinical director had stepped down in November 2013. Initially there were no applicants for their replacement. We were told that there was no management time for governance and safety within the clinical director job plan. However, a new clinical director had recently been appointed. The trust business director said that, while the job plan was currently being reviewed, there was no financial agreement for the extra management time required for the role. There was no time frame for when this might be resolved and it was acknowledged that this would have an impact on the incumbent's workload and ability to do the job.
- The clinical director led the first presentation of M&M cases and told us that this would rotate among all the specialty areas within medicine.
- The trust was in the process of moving to its new structure. There was a head of nursing – medicine and A&E in post who, together with the interim general manager, worked with the clinical director to oversee the directorate. We found that there were governance systems in place. The head of nursing had undertaken additional specific training in root cause analysis and investigations.

Medical care (including older people's care)

- We found good leadership among the matrons and ward managers we observed and spoke with. There was a belief that they could make a difference through governance.

Culture within the service

- We found that staff were positive and proud of the care they gave patients. All staff we spoke to wanted the hospital and their service to improve and worked very hard towards achieving this.
- However, we saw that there was constant crisis management and 'fire fighting' throughout every shift due to the bed occupancy and capacity issues. Therefore, staff appeared to be on a treadmill where they worked so hard to try and keep up with the workload. There seemed to be an acceptance of things as they were at the hospital level while so much effort was put into trying to make changes and improvements.
- All staff we spoke with described good team working and support from ward managers, matrons and consultants.
- We found a culture of incident reporting amongst the nursing staff, but this was seen as less important by the medical staff.
- We found some areas where there was a 'Being open' with patients and their families and this was developing.

Public and staff engagement

- The directorate undertook a variety of patient surveys.
- Staff listening events had been implemented.
- The 'Speak out safely' campaign featured in the Weekly Roundup publication within the directorate. This publication disseminated a variety of news and we saw that information on CQC focus groups for this inspection had been included.
- One ward manager told us they felt involved in the trust strategy and plans because they attended several meetings and the chief nurse encouraged their involvement. Another ward manager told us they were on the panel for reviewing the Monitor action plan and that they were working with clinicians at all levels.
- We found an internal Twitter account where anyone on the hospital IT system could put their ideas, and an 'Inspire Medway' volunteer army who met to try and work out solutions and ways to take ideas forward. Any changes made were also put on the 'Inspire Medway' internal intranet page.
- WOW awards had been introduced, which enabled patients and visitors to tell the trust about a member of staff who had delivered excellent and outstanding care.
- There was an 'Employee of the month' process in place.

Innovation, improvement and sustainability

- The proposals to develop the governance systems and processes that were in place to increase participation and engagement from all staff would lead to improvement. This should be sustainable but would depend on the clinical director being given the time to lead effectively.
- There was an equipment bid to turn one side room in the Stroke Unit into a 'red room' with telemedicine and facilities to administer thrombolysis. The stroke pathway was being updated for patients to come straight to the unit. They were aiming for the 'Golden Hour' for patients who fit the criteria for thrombolysis. This would help the patient flow in A&E as well.
- There was a volunteer buddy system developing in the Bernard Dementia Unit.

Surgery

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

Information about the service

The surgery department at Medway NHS Foundation Trust provides a range of surgical services to a population of 396,000. It delivers surgical specialties including colorectal, vascular, breast, gynaecology, urology, ear nose and throat, orthopaedics and obstetrics. 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 process 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.

Concerns had been raised with CQC by patients and staff before the inspection. These concerns related to the quality of care delivered, infection control, staffing levels, quality of records, long delays for surgery and discharge delays.

During this inspection, the surgical inspectors reviewed a total of 8 ward areas and the theatre department. We spoke to 32 staff, 15 patients, 8 relatives and attended a public listening event and 4 focus groups.

Summary of findings

Despite identifying pockets of very good clinical practice, we found surgical care at Medway did not sufficiently protect patients from risks of avoidable harm and abuse. We found patient flow within the surgical department was poorly managed, which often led to long delays in treatment and patients being cared for in inappropriate clinical areas. Data submitted to the CQC suggested low rates of operation cancellations. However, seven days' worth of handwritten emergency lists reviewed showed a high rate of procedure cancellation with an average of seven cases a day. Operating data was being collected in various forms of handwritten lists, diary notes, theatres lists and via an electronic system. There was no process to monitor the impact of frequent cancellations or delays on people's clinical outcome. It was also difficult to track the patient journey because emergency cases were moved to elective theatre lists and were not always easily identifiable as an emergency. Patients who had undergone surgery were being cared for in the recovery area for extended lengths of time due to a shortage of surgical beds on the wards. We were made aware of patients being returned to clinical areas that were inappropriate given the complexity of the patients' needs.

We identified high numbers of outstanding vacancies, a poor skill mix, a high volume of agency staff usage and a high patient volume that had a negative impact on the department. Some ward areas often relied solely on

agency staff for night-time cover. Agency staff did not have access to electronic blood glucose monitoring machines, or IT systems including Datix (the hospital incident-reporting tool), which presented challenges in caring for patients and reporting incidents. We found inconsistencies in incident reporting throughout the department and staff told us that they rarely received feedback from the incidents they reported to senior staff. The staff we spoke to reported discrepancies in the way they were supported by their seniors. We found wards that had substandard or no equipment, such as hoists. We identified one ward using a room that did not have a call bell system to care for patients. Two ward areas used as escalation areas had poor environments and having an inappropriate staff skill mix.

While there was evidence of improvement in the quality of the patient record keeping, we found inconsistencies with routine recording. We also found inadequate medical cover that resulted in unnecessary delays in obtaining pain relief and clinical reviews, and had an impact on patient discharges.

Are surgery services safe?

Inadequate

We recognised that the surgical department had made significant improvements in the delivery of care, quality of recording and clinical standards for patients. These related to patients who were at high risk of falls, required pressure area care, had an increased risk of venous thromboembolism (VTE) and required nutritional support, fluid and electrolyte management or infection control. However, the inspection identified significant concerns about patient flow, staffing levels and skill mix, and care being delivered in clinical areas lacking the appropriate equipment, all of which had a significant effect on patients' safety within the department.

We also identified some concerns relating to a lack of consistency in clinical incident reporting and feedback mechanisms. Several incidents were identified by the inspection team, but were only reported once they were pointed out to the Chief Nurse. Governance minutes also stated that incidents could be resolved locally rather than reporting them on Datix. We found checks to one fridge temperature had been falsified and when the trust was at high capacity patients were sometimes looked after in inappropriate areas. The department did not monitor the clinical impact of cancellations and delays in surgery. We also identified a lack consistency in formal data collection in relation to theatre use and productivity.

Although nursing recruitment was being undertaken there was acknowledgement that this was impacting on skill mix on some wards and not all staff were aware of the use of staffing acuity tools. Daily consultant led care was not embedded, and in minutes from the February (2014) governance meeting the governance lead for general surgery was recorded as stating of being 'in favour of relying more on the Registrars and trusting them to deal with patients'. This is not in line with national or best practice guidance that care should be consultant led and delivered.

We asked staff at different levels if they felt that the surgical department was safe. The responses we obtained varied slightly depending on staff group and position but the widely held view was that the service was not as safe as it should be.

Surgery

Incidents

- The trust reported two Never Events in the surgical department between December 2012 and January 2014. Both incidents were reviewed, fully investigated and had a recorded outcome and action plan in place.
- Staff used an electronic Datix system to record and report incidents. However, they reported variation in how incidents were reported, investigated and learned from, and they told us that "nothing happens" with the information collected. They felt this had led to inconsistencies in reporting and disillusionment for nursing and medical staff. We found that staff in some clinical areas managed their incident reviews in an efficient way, but there was no uniform approach to the reporting or learning from incidents throughout the directorate.
- Minutes from a governance meeting in January documented that 'staff should attempt to resolve issues before reporting it on Datix', while it is acknowledged that reporting incidents should not be used as a tool to attribute blame to different staff groups, it also needs to be recognised by the department that common themes may not be identified if there are inconsistent messages with regards to whether staff should be reporting incidents.
- During our inspection, we identified three significant events that were not reported as clinical incidents, and we discussed these with the chief nurse during the inspection. We identified a further three that we highlighted to staff during the inspection and two of these were recorded on the Datix system in the appropriate manner before we finished the site visits.
- One member of staff gave us a list of 40 incidents that they had reported on Datix between August 2013 and March 2014 that were "awaiting final review" by the matron for their clinical area. Most of the incidents logged related to safety concerns.
- Consultants and junior doctors told us that they did not use the Datix system to report clinical incidents, and student nurses were not sure if it was "their place" to report incidents given that they were the most junior members of the team. This meant that a significant proportion of the staff team did not use the hospital's own incident reporting tool. This suggests that the department might be under-reporting serious untoward incidents.
- The trust operated a mortality dashboard that focused on the top 20 diagnoses as a cause of death. This data was reviewed at executive level.
- The trust had enlisted the help of the clinical audit department to carry out random samples of hospital deaths and assess them against the Global Trigger Tool. This is in line with current best practice guidance.
- We identified one ward that was admitting patients to a side room that did not have a call bell system. Nurses had improvised by providing a bell for patients to ring if they needed help. However, in the absence of a proper call bell system, we considered the use of this room to be inappropriate.
- Governance minutes from November 2013 state 'call bells on Arethesua are still an issue'. The same statement was found in the minutes from February 2014.

Safety thermometer

- The clinical areas we visited were able to demonstrate routine data collection for the NHS Safety Thermometer.
- We saw that the trust had recently implemented a falls strategy that was having a positive impact and a reduction in the number of slips, trips and falls in the hospital. New initiatives included issuing patients with anti-slip stockings and giving sensor mats and bands to patients with dementia who were at high risk of wandering. We also saw one patient who was identified as at very high risk of falls being 'specialed' (that is, given one-to-one observation).
- Venous thromboembolism (VTE) data indicated that Medway had performed below the average for England for seven months of the year (2013) for the number of patients suffering from new VTE. The data showed a rise of 0.7% in August 2013.
- We saw that most patients had a VTE risk assessment completed and actioned. However, we identified two patients who did not receive appropriate VTE treatment during our inspection. One had been reviewed in A&E with a suspected pulmonary embolism (PE). This patient was reviewed by a consultant at 12am who stated in the notes "requires Clexene" (anti-coagulant). We returned to the ward at 5.45pm to review the progress of this patient and identified that the Clexene had not been administered. We saw from the medicine chart that a prescription was in place but had a

documented administration time of 6pm. We were unsure why this patient had to wait six hours from the initial consultant review to receive the anti-thrombolytic drug given their suspected diagnosis.

- On our unannounced inspection, we reviewed a random selection of four sets of notes in one clinical area. We identified one patient who had a documented VTE assessment completed but no action had been taken. This patient had a past medical history of deep vein thrombosis (DVT) and took warfarin (anti-coagulant medication) regularly before admission. This patient did not have an anti-coagulant prescribed and was not wearing TED (anti-embolus) stockings. We brought this to the attention of the nurse in charge (NIC) who prompted a surgical review. The reviewing doctor prescribed the relevant medication and the nurses ensured the patient was issued with TED stockings. The doctor who reviewed the patient confirmed that there was no clinical reason to omit an anti-coagulant or TED stockings in this instance. We saw documentary evidence in ward areas that demonstrated good clinical practice in relation to pressure area care. Patients had a risk assessment in place and, when a risk was identified, action was taken to ensure patients were regularly turned and that they had an appropriate pressure relief mattress. We were told that the hospital had invested heavily in new mattresses for all the beds, which had had a positive impact in reducing new pressure areas. We saw an ample supply of these mattresses. We also noted that patients who were identified as being high risk were turned regularly and had this intervention recorded consistently by nursing staff. Patients' pressure area risks were continuously reviewed.
- We could see from the pressure ulcer data supplied by the trust that the trust had performed below the England average of 0.5% for eight months of the year. In April and July 2013, it performed well above the England average by 1.1%. For patients aged over 70, it performed well above the England average by 2.3% in April 2013 and by 1.5% in July 2013. It performed below the England average by 0.6% four months of the year. However, it is important to note that the trust had no grade 3 or 4 pressure ulcers between January and March 2014 and a 25% reduction in grade 2 scores. This demonstrates that the new approach to pressure area care had improved patient care.
- Ward areas visibly displayed their safety thermometer data in areas that were accessible to patients and members of the public, and which promoted a transparent culture to reporting clinical standards.

Cleanliness, infection control and hygiene

- CQC received concerns from staff and members of the public about cleanliness at Medway Hospital before the inspection. The Royal College of Nursing also received reports of a lack of cleanliness in its theatres. However, for the duration of our inspection, we found the hospital and in particular the theatre area to be clean and adhering to local and national infection control policy and procedures.
- There were adequate systems in place to reduce the risk and spread of infection and all the clinical areas we visited appeared to be clean and tidy.
- We found local and national guidance for infection control was being followed and implemented at the trust.
- However, we noted that hand hygiene compliance was the lowest in the trust between April 2013 and March 2014 with the average score being 70%.
- The trust infection rates for C. difficile and MRSA lay within the statistically acceptable range taking into account the trust size and the national level of infection.
- The trust reported that it was meeting MRSA/C. difficile national infection rates. However, on our unannounced inspection, we became aware of a patient who was MRSA positive being cared for overnight in a bay with other patients. Standard MRSA precautions were not adhered to when caring for this patient. We were told that their positive MRSA status was not handed over during the transfer process and that staff were only made aware of this the next day.
- The clinical notes we reviewed contained evidence that patients were MRSA screened before admission and on admission if they did not go through the pre-assessment pathway.
- We found ample supply of alcohol gel for visitors and staff.
- All clinical areas had an adequate supply of personal protective equipment (PPE).
- We observed staff wearing PPE while delivering care.
- Ward areas displayed their environmental hygiene compliance scores.
- We saw that equipment was regularly cleaned and labelled to show it was ready for use.

- The trust employed a part-time infection control lead nurse to oversee standards at Medway. This post was supported by two nurses and a microbiologist.
- One-off prevalence studies of urinary tract infections (UTIs) showed the trust to be within national targets.
- There were two antimicrobial pharmacists and the stewardship group was very involved in monitoring compliance with procedures and processes regarding antibiotics.
- There were bi-annual environmental audits and the findings were actioned. There had been much improvement to environments with many areas being refurbished.

Environment and equipment

- We were told that the hospital operated a central equipment library. The staff we spoke to told us that obtaining equipment often proved problematic and that they experienced long delays in getting the items they required.
- We viewed a physiotherapy office that was being used to store equipment. When we asked why they needed to store the equipment in their office, staff explained that the delays in obtaining the equipment they needed had a direct impact on patients' care and delayed discharges. They felt it was more efficient to have a store of items they could access instantly.
- During our inspection, staff told us that they tried to keep some essential equipment in their clinical areas because of the delays and formalities of obtaining equipment.
- We saw that equipment was regularly cleared and labelled to identify it as ready for use.
- Resuscitation equipment in all areas was found to be regularly checked and emergency drug kits were found to be available and in-date.
- Each clinical area had an in-date anaphylaxis and sepsis box in line with local and best practice guidance.
- We identified three ward areas without a working hoist. We were told that staff borrowed the manual handling training hoist if they needed it. We considered this to be inadequate provision of equipment. We brought it to the attention of the chief nurse who confirmed that it would be addressed by the trust as a matter of priority.
- We were also made aware of the inadequate supply of functional theatre trolleys. The department had carried out a trial of new trolleys to see if they were suitable and had hoped that they would be purchased. We discussed the progress of this with the chief nurse and were told they were not on the procurement list but that the situation would be reviewed.
- We received information that one clinical area, which was never intended to be used to care for patients with increased care needs, did not have appropriate monitoring equipment available. We spoke to the staff working in this area and they confirmed that the information was accurate. We were told that inappropriate patient placements happened during busy times. It is important to note that we did not see any patient who required continuous monitoring in this area during the inspection, but we had concerns that patients requiring constant monitoring of their condition were cared for in an unsafe environment with staff who did not feel competent to meet their care needs.

Medicines

- Medicines were stored in locked cabinets within the surgical department. All medicines were ordered by nursing staff through the hospital's pharmacy.
- All staff received a competency-based assessment before administering medication. When a drug error was identified, staff received another drug competency assessment to ensure safety. This was demonstrated on the day of our inspection when we identified a drug error.
- Missed medication was monitored regularly as part of the safety thermometer checks. The pharmacy department was in the process of conducting a trust-wide audit of missed medication.
- We identified a drug error on a surgical ward during the inspection. A patient was receiving the wrong intravenous (IV) fluid without an infusion pump and had therefore received more that the prescribed amount of fluid in the given timeframe. We noted that this fluid had been checked by two people before being administered.
- Theatres kept the medicine keys in a locked cupboard but the master key was kept by administration staff. This was not in line with national guidance.
- We received information on the first day of our inspection that suggested the medication fridge checks in theatre 6 had been falsified before our visit. We took special interest in this information and purposely reviewed the check log from that theatre. The log demonstrated that checks had been completed by the

same member of staff for 21 days in a row. We obtained a copy of the staff duty rota and could see that this person had not worked 21 days in a row. We spoke to the member of staff and the theatre manager during the inspection but were unable to verify the integrity of the checklist or obtain a satisfactory explanation for the anomaly identified.

Records

- We found that notes in the clinical areas were held securely and remained confidential.
- Patients had their care needs risk assessed and recorded in all the clinical areas we visited.
- We identified variation in the quality of the filing of patient data. Some clinical areas demonstrated excellent practice in handling documentation by ensuring surgical pathway information and additional paperwork were appropriately filed and secured to ensure safety and continuity of care. However, other areas showed poor practice with loose paperwork stuffed into files in no particular order and with a large number of loose records falling out of the clinical note pack. This meant that reviews of clinical notes were problematic and carried an increased risk of loss of key information. We identified that areas with consistent administrative support maintained clinical notes to a high standard, but those who did not have such support struggled to keep the notes in an acceptable format.
- Records were transferred internally between departments and externally when required. However, administration and clinical staff across the hospital expressed concerns about the difficulties and extended delays in obtaining patient notes. Some told us that they felt no other option but to 'hold on' to notes to ensure their availability. We saw notes being retained in administrative offices during the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that Deprivation of Liberty Safeguards (DoLS) training is currently not available to most staff at the trust. We were told that this training was only available to staff at senior level. We asked if there was a formal way of disseminating the learning from senior to other staff and were told that this had currently not been addressed.
- Data supplied by the trust suggested that only 41% of staff had completed Mental Capacity Act training and no data was available for consent training.

Safeguarding

- We saw from the training data provided by the trust (relating to staff working in surgery) that two levels of adult and child safeguarding training (Levels 1 and 2) were available. The data suggested a completion rate of 43% for adult Level 1 and 36% for adult Level 2. The records indicated the completion rate for safeguarding children group 1 was 51% and safeguarding children group 2 was 24%.
- However the staff we spoke to during the inspection could describe a safeguarding alert and identify a safeguarding concern. They were also able to explain the paths they would take to report a concern.
- We found an example of good practice in one clinical area that demonstrated how a safeguarding concern had been raised and handled. The process included a multidisciplinary meeting and the process had a clear audit trail for all the actions taken by staff and members of the multidisciplinary team (MDT).

Mandatory training

- Training records were presented as a directorate and not broken down into individual clinical areas. It proved problematic to identify good practice or training shortfalls from the data submitted.
- We reviewed individual training records from clinical areas and found that some areas were better than others at monitoring and ensuring that staff attended training.
- We were told and saw evidence that the training matrix was held centrally on an electronic record. However, some staff told us that the records held by the HR department were not accurate. One clinical area had recently employed a member of staff to review the accuracy of the records and liaise with staff and HR to ensure an accurate training record was available.
- Staff told us they received adequate training to meet people's needs.
- The data submitted by the trust suggested a completion rate of only 56% for basic life support training, which was clearly of concern.
- However, we saw that 93% of staff had received infection control training.

Surgery

Use of the 'Five steps to safer surgery'

- We saw that the department had embraced and fully embedded the 'five steps to surgery' and could demonstrate an audit cycle to reflect its use and identify any shortfalls. We observed the theatre team using the checklist during the inspection.

Identification and treatment of deteriorating patients

- The staff we spoke to were able to describe their roles and identify the necessary steps to take in the event of a medical emergency. They were able to identify the location of emergency equipment and describe the steps outlined in the hospital's emergency policy.
- The national early warning score (NEWS) system was used throughout the surgical department and a clear escalation procedure was printed on the front of the observation booklet to help staff. We found patients had their observations and scores recorded regularly. However, we noted inconsistencies across the surgical wards in the recording of actions taken when a score indicated the need for a medical review. The NEWS pathway contained a section where staff should document the actions taken once an elevated score was identified. Some notes identified a very high standard of recording while others demonstrated a lack of consistency. In some cases there was nothing documented to suggest that an elevated score had been acted upon, which meant that we were unable to identify the steps consistently taken to manage deteriorating patients.

Nursing staffing

- Despite a recent increase in substantive nursing staff, the hospital employed a high number of agency staff to fill the existing staff vacancies.
- We were told that the hospital operated a recruitment day every two weeks that was attended by the matrons in an attempt to recruit more staff and that the trust had recently employed ten band 5 nurses from Spain.
- The trust used a staffing acuity tool but this was last used in July 2013 to assess staffing requirements but not all the staff we talked with were aware of this tool. We were told at the inspection that the trust intended to review the staffing levels with an acuity tool on an ongoing basis so that staffing levels throughout the hospital were continuously monitored.
- Staffing handovers were held several times a day. Some clinical areas we visited had started to use a handover sticker in patients' clinical notes as a checklist to ensure that all the important information was reviewed and discussed. This was a nurse-led incentive and we were told that it encouraged junior nurses and support staff to identify any shortfalls in the handover process. The sticker was ticked to record that all the aspects listed had been discussed. However, the notes we reviewed demonstrated a lack of consistency in the way that the staff recorded areas discussed. Observations identified at least three methods (**√, X, -**) of signing off the handover that were open to interpretation when we spoke to the staff in the area. No guidance or standardisation guidelines were in place for staff.
- We were told that staffing skill mix was a problem in the department. This was evident from the rotas we viewed. Although the trust had recently made efforts to recruit more nurses, recruitment focused mainly on band 5 junior nurses. We noted a high use of agency staff in the department. These combined factors had an impact on the skill mix. The trust had recruited a one year fixed term band 7 education nurse to support newly recruited nursing staff.t Skill mix
- We were told that agency staff completed a training induction when they came to work at the hospital. We asked to see a completed version of the induction handbook in several different clinical areas. None was available to view. We saw a selection of completed agency induction checklists but we did not see evidence that the agency staff on duty at the time of the inspection had completed a checklist or induction booklet.

Medical staffing

- Before the inspection, concerns were raised about surgical cover in the department.
- We found that the consultant group provided on-site cover between 8am and 5pm five days a week and an on-call service at weekends.
- We were told by staff that consultant ward rounds took place seven days a week. However, governance meeting minutes referred to 'relying more on the registrars and trusting them to deal with patients'. It was also stated that assurances were needed that 'each team has a robust system for communication and escalation in patient care'. This demonstrated the conflicting information given on our site visit.

Surgery

- The trust had recently recruited consultants in anaesthesia and gynaecology in an attempt to address concerns about the lack of consultant cover.
- The rotas confirmed one senior house officer (SHO) providing night-time cover for theatres, wards and A&E.
- Nursing staff and junior doctors told us that they felt there were not enough doctors to provide cover in the department.
- We observed patients waiting extended times for discharge because of delays to discharge documents being completed.
- The rotas we viewed showed three SHO vacancies that were being covered by locums.

Major incident awareness and training

- We reviewed the major incident plan in place at the trust.
- During our unannounced inspection, we saw this in action where the hospital was put on 'alert' to provide support for a major incident. We witnessed staff following procedures to ensure they could meet the needs of their inpatients as well as treating and caring for unexpected emergency patients.
- The staff we spoke with could tell us their role in managing a major incident and expressed confidence in doing so.
- We observed medical staff being deployed to clinical areas to review inpatients so that patients who were medically fit to go home could be discharged, thereby helping to ensure bed capacity for unscheduled emergency admissions.
- The trust had major incident and business continuity plans in place.
- Although the hospital's major incident status did not last long, we saw plans to postpone elective surgical activity and the development of plans to prioritise unscheduled emergency procedures.

Are surgery services effective?

Requires improvement

We found evidence that the trust was adhering to the National Institute of Health and Care Excellence (NICE) national guidance, although we were not provided with evidence of improvements to services following local or regional audits. Timely pain relief provision was not consistent due to a combination of a stretched pain team (which consisted of one specialist nurse only) and the workload of junior doctors.

Multidisciplinary working was found in pockets within the directorate but was not widespread.

Evidence-based care and treatment

- We found evidence that national guidance was being followed in the department and hospital policies were based on NICE and Royal College guidelines
- For example, care was provided in line with NICE clinical guideline 50 ('Fall prevention'), clinical guideline 83 ('Rehabilitation after critical care'), clinical guideline 92 ('VTE'), clinical guideline 29 ('Pressure area care'), clinical guideline 139 ('Infection control) and clinical guideline 124 ('Fractured neck of femur).
- In addition, clinical areas were following 'sepsis six'.
- There was evidence in the care plans and notes we reviewed to demonstrate compliance with local hospital policies.
- We saw involvement in national audit programmes. However, we noted that audit activity within the department could be improved upon. Staff reported not having enough time to engage meaningfully with audit processes.

Pain relief

- The trust employed one nurse specialist who was the sole member of the specialist pain team who provided specialist pain reviews and provided specialist knowledge, advice and support to nursing staff. The specialist nurse was supported by the outreach team and the on-call anaesthetist.
- We were told that, despite this individual's lack of resources, they provided invaluable support to patients and nurses' clinical areas, but it was not possible to deliver an effective service when the service was being delivered by just one person.
- The trust was found to be performing worse than expected in the national audit of falls for ensuring that patients received adequate pain relief within 60 minutes of hospital admittance.
- Patients who were receiving patient-controlled analgesia (PCA) or epidural infusions had a prescription

in place for anti-sickness and reversal medication as well as an intravenous bag of fluid to be used in the event of an emergency. This was in line with national guidance.
- Nursing staff told us that patients who were not on a PCA or epidural pathway often had to wait for a long time to have pain medication prescribed, due to the lack of doctors available to cover the surgical wards.
- The patients we spoke to also told us of the long waits they experienced to have their pain assessed and medication prescribed by a doctor.
- We observed patients alerting nursing staff to their increased pain levels and saw their pain addressed in a timely manner.

Nutrition and hydration

- We received information before the inspection that raised concerns about the quality of food served to patients.
- However, we spoke to patients during our inspection who told us that they were happy with the meals that they had received during their stay and staff told us that the quality of the food had greatly improved.
- Patients were given food options daily so they could choose what they wanted to eat and when patients missed the opportunity to select food in advance, they could choose from the hot food available on the day, select from a range of sandwiches or opt for tea and toast.
- The hospital offered a range of food that met patients' individual dietary needs – for example, Kosher, vegetarian, gluten free, soft and pureed food. We saw patients who needed support with eating being assisted in a kind and caring manner.
- Patients were screened using the Malnutrition Universal Screening Tool (MUST). If a risk of malnutrition was identified, a food diary was kept by the staff.
- Patients' weights were recorded on admission and monitored to identify any weight loss during their hospital stay. This was evidence of good clinical practice on the wards with most patients being weighed according to hospital policy. However, we did identify that some weights were not recorded within the expected time frame.

Patient outcomes

- CQC outliers identified a raised mortality rate with intestinal obstruction without hernia. The trust responded to the outliers' alert and an appropriate action plan has been put in place. This will need to be monitored by the trust in the forthcoming months.
- The department participated in national audit and submissions were made for all 34 audits it was eligible to take part in.
- Regular data submissions were made to the national bowel cancer audit and the trust scored better than expected. All patients (100%) were seen by a clinical nurse specialist. The national rate was 87%.
- Data was submitted to the Royal College of Physicians' audit of falls and bone health in older people. The data suggested performance tending towards worse than expected for 5/19 indicators. These 5 indicators related to adequate pain relief within 60 minutes of admission, documentation in medical notes that falls prevention information had been given to the patient, lying and standing blood pressure monitoring and completion of home hazard assessments.
- However, the trust performed better than expected for two of the indicators relating to patients being prescribed bisphosphonates (a class of drugs that prevents the loss of bone mass) or other appropriate therapy for osteoporosis.
- We reviewed minutes from a meeting referring to an emergency laparotomy audit carried out in 2011. The data analysis (based on 66 patients over six months) showed the time between admission and theatre booking (median 1.8 days; range 0.1–42.6 days), the time between booking and surgery (median 4.9 hours; range 0.8–44.0 hours) with an overall 30-day mortality of 23% (with 27% mortality in patients aged over 65). It was documented in the minutes that this audit should be carried out again in 2012. However, no data to suggest that this has been carried out was submitted.

Competent staff

- Training data supplied by the trust showed that staff training was not being delivered in a consistent manner across the department.
- We saw that some ward areas had worked hard to ensure that staff had their training needs met; others

were not sure of what had been delivered and what was outstanding. The directorate had recently employed a person to collate, review and update the staff training records.
- We saw records showing that most staff had received an appraisal in March 2014. This was an improvement on the data collected in the last NHS staff survey in 2013.
- We did not see evidence of regular supervision and staff told us that supervision sessions were not a regular occurrence.
- Nursing pin numbers were checked annually to ensure that all nursing staff had a valid registration and appeared on the national register.
- Medical staff engaged in the appropriate revalidation processes.
- Data demonstrating comparative outcomes among clinicians was not available.

Multidisciplinary working

- We could not be confident that there was a functional multidisciplinary approach to the care delivered in the surgical department. Staff felt they functioned very well in their own teams or disciplines but reported a lack of positive working beyond that.
- We received attendance registers for general and orthopaedic mortality and morbidly (M&M) meetings. We also reviewed a comprehensive urology M&M presentation for April 2014. This demonstrated M&M activity in the department. However, we did not see any notes or minutes of these meetings, which would provide an audit trail of clinical decision making or actions taken from the monthly reviews.
- We were told that communication within the surgical departments and throughout the hospital was fragmented and difficult, especially between A&E and the bed management support team
- Staff told us that they thought this was because of the high patient volume and flow, staffing problems and general pressure to deliver.
- We identified a positive approach to multidisciplinary working with the pain nurse specialist and anaesthetists, theatre team and infection control team.

Seven-day services

- We were told by the consultants that they undertook ward rounds seven days a week (on Saturday and Sunday for just the new patients) however it was raised in their own governance meetings that there was an over reliance on registrars. This meant that consultants were on site from 8am–5pm Monday to Friday and an on-call system operated out of hours and at weekends.
- Physiotherapy and occupational therapy services were provided Monday to Friday.
- We found of out-of-hours imaging and pharmacy support available.

Are surgery services caring?

Good

We judged the surgical department as having a caring rating of 'good'. We reviewed a vast amount of information and feedback about the service delivered at Medway hospital. This information was taken from a range of sources – data submitted from the trust, conversations with patients and their relatives at the time of the inspection, the listening event, online feedback, comment cards and thank you cards displayed on the wards.

We found some of the feedback was negative in tone but it was balanced by the verbal feedback from patients and their relatives during our inspection. We observed that staff interacted well and did their best to make patients comfortable given the demanding and difficult environment in which they worked. We found that staff demonstrated a caring and loyal approach to their individual staff team.

Compassionate care

- We saw staff deliver caring and compassionate care to patients.
- The patients and relatives we spoke with were complimentary about the nursing and medical teams and the care they delivered. However, they also commented on the workload and stress they witnessed staff having to endure.
- Patients and their relatives said they were treated with dignity and respect during their stay. We witnessed other patients and their loved ones being treated in this way.
- People who attended the listening events generally spoke very highly of the staff at Medway.
- The hospital performed below the England average for the inpatients NHS Friends and Family Test.

Surgery

- Patients' views and comments on NHS choices were mixed, but they praised staff for being knowledgeable, providing excellent care and promoting dignity and respect.
- Comments also highlighted waiting times, overcrowding and poor communication as concerns.

Patient understanding and involvement

- Most patients we spoke to felt they understood their care options and were given enough information about their conditions. However a few people told us that having to waiting a long time to see a doctor was a concern.

Emotional support

- The Chaplaincy service, which was available five days a week from 9am–5pm and also provide an on-call service to both patients and relatives.

Are surgery services responsive?

Inadequate

The surgical department was currently unable to cope with its routine workload and emergency service provision. We saw inappropriate areas used as escalation wards for patients who needed overnight stays. We were told that patients were being clerked in inappropriate areas such as staff offices or one preparation room that was also used to administer bowel preparation. One ward had a small area with seating for eight people; this was used to receive all GP referrals each day for patients needing a surgical review.

The recovery staff collected data on the long delays experienced in returning patients to ward areas, which had a knock-on effect on theatre productivity. We saw from the data collected over 24 days in April 2014 that delays in obtaining beds or collecting patients from wards affected 34% of patients who had surgery. We were told that patients were routinely returned to holding wards until a more appropriate bed became available. This meant that patients were admitted in one clinical area, taken to theatre, returned to a holding area and then moved to a permanent ward. This process was not indicative of a positive patient experience or conducive to continuity of care. We found patients who needed surgery were kept nil by mouth for unnecessary and extended lengths of time.

Service planning and delivery to meet the needs of local people

- Patients often experienced long delays in the recovery area after their surgery due to a lack of beds. A high dependency unit (HDU) nurse produced a booklet that told patients of the delays that might occur during their hospital stay. One surgeon distributed this booklet with clinical letters to highlight the issues patients might face. Patients experienced long waits for medical review and untimely discharges.
- Data submitted to the CQC suggested low rates of operation cancellations. However, seven days' worth of handwritten emergency lists reviewed showed a high rate of procedure cancellation with an average of seven cases a day.

Access and flow

- The Department of Health monitors the proportion of cancelled elective operations and the Medway trust scored similar to expected regarding cancelled operations when compared with other trusts. However, when we asked if elective and CEPOD theatre use was routinely measured or audited we were told it was not.
- We observed the surgical department struggling to cope with the volume of patients, which was in part due to a high number of medical patients occupying surgical beds impacting on surgical pathways.
- During the inspection, it was apparent that they were struggling to cope with patient flow, appropriate bed allocation and timely discharges.
- Patients told us that they experienced long delays in obtaining appointments and often had surgery cancelled without a future date for admission.
- We found theatres struggling to care for the number of patients who did not have an allocated ward bed. This had a knock-on effect on productivity in the department.
- The patients and staff we spoke with described lengthy delays with the discharge process. We were told that this was caused by a lack of doctors who were unable to come to the wards because they also provided cover to A&E and the theatres.
- We saw an appropriate reduction of night-time theatre activity but identified patients who became urgent cases as a result of long waits. One example was a patient who had an abscess drained at 2am in the morning because they had waited over 48 hours. Surgeons told us that they were aware of patients

needing operations for urgent peritonitis and less urgent cases, such as abscesses, that were not meeting the 'time to surgery' recommendations set out in national guidelines. We asked for data to confirm this and were told that none was available.
- The data also suggested that the trust scored similar to expected for the number of patients not treated within 28 days of last-minute cancellations for non-clinical reasons.

Meeting people's individual needs

- We saw how one surgical ward provided individual support for a patient with dementia and challenging behaviour. This ensured that this patient had their complex care needs met 24 hours a day.
- The hospital had clinical and support staff who also worked as translators and thereby offered instant access to language support. There were also agreements in place for external translators to provide support for patients if an appropriate member of staff was unavailable.
- We saw an example of dementia observation on a ward. Patients with dementia were visible from the nursing station and were all wearing sensor alarms to alert staff if they wandered out of their clinical area. We were told that staff were trying to obtain funding for an activities coordinator to provide daily stimulus for this patient group. However, there was no such person in post at the time of our inspection. We saw that all the dementia patients had a food chart in and were given assistance at meal times to ensure their dietary needs were met. Fluid intake was also monitored most of the time although we noted some inconsistencies in the quality of the recording. The trust had dementia 'champions' who were available to provide support and guidance for both patients and staff.
- The quality of patient lockers was not consistent, which meant that patients were unable to secure their valuables during their stay.
- We saw each clinical area had a number of patient information leaflets about a range of medical conditions available for patients and their relatives.

Learning from complaints and concerns

- Some patients at the listening event expressed concerns about how staff within the surgical wards communicated with them when a concern was raised informally or formally and people told us they thought formal complaints were not handled well, and some not even responded to.
- Complaint information booklets were readily available for patients.
- Staff in the surgical wards told us that the trust was now actively listening and meeting with patients, relatives and friends.
- When we asked staff what they thought the barriers to improvement were, we were told that patient flow, staffing and the lack of capacity to deal with the number of patients was the biggest obstacles to overcome.

Are surgery services well-led?

Requires improvement

We considered the surgical directorate to require improvement in order to become a well-led service. All the staff we spoke to told us that they were hopeful and excited about the leadership style of the new management team. They expressed a hope for change in the culture whereby they would feel listened to and valued by senior management. They also said they were hopeful of an open and transparent culture in which there would be an emphasis on quality patient care and improving staff welfare.

However, the persistent obstacles identified in this report suggest that the surgical department could not be said to be constantly well led at matron, directorate or trust level. Junior staff (administrative, support workers and band 5s) reported a disparity with management support within the directorate and felt they were neither listened to nor had their concerns addressed. Staff told us that "nothing changes" despite raising concerns with their immediate line mangers.

Staff within the surgical division told us that the poor performance in the staff survey reflected their own feelings – that is the high reports of experiencing harassment and bullying and feeling pressured to come to work when unwell. We were concerned by our findings that documentation had been altered to appear to show compliance, and that incident reporting was not always encouraged. This demonstrated to us that this was not a

culture of openness and transparency or one that was encouraged to learn. The division appeared to be out of touch with the national movement towards consultant led care seven days a week.

Vision and strategy for this service

- We saw that the trust had a strategic plan to improve its services. The plan identified many key areas for improvement but focused on ensuring consistency safe services, evidence-based care for every patient, patient-centred delivery and using insights from patient experience to improve service delivery and patient satisfaction.
- A capacity plan identified having the right professional of the right grade in the right place, maximising new roles and ways of working, and recruiting competent and capable individuals and teams with the right values and behaviours.
- A culture and people experience plan focused on recruiting the best people for leadership and change management, and the development of health and wellbeing policies and practice.
- Priority was being given to two areas of improvement, specifically in the surgical department. This included reviewing the surgical on-call rota and embedding improved performance metrics in the surgical assessment unit.

Governance, risk management and quality measurement

- We found significant issues with the governance structure in the department. When we addressed this with the chief nurse, we were assured that the trust was aware of the issues and in the process of assessing and improving the governance structure and quality in the trust as a whole.
- The staff we spoke to who held governance roles did not express any confidence in the current structure or processes.
- One consultant told us that in the past consultants had taken it upon themselves to review incidents of concern because of a lack of confidence in the governance structure.
- We found evidence of engagement in national mandatory data collection. However, we identified several areas where the trust could improve quality through closer monitoring of the services it delivered: in particular in the use of its theatres, delays in appropriate bed and ward allocation and the clinical outcomes for patients who experienced long surgical delays and cancellations.
- A problem with the call bell system on one ward was escalated to the governance meeting in October 2013 but was still an agenda item in February 2014, which was four months after it had appeared in the minutes. This showed that a problem was identified and escalated by staff but not resolved in four months of governance meetings.
- The trust told us they had started addressing governance issues. Some of the steps taken to date were increasing Board visibility, taking a new approach to risk and Board assurance, and recruiting eight clinicians to the Board.

Leadership of service

- There was a lack of evidence to suggest that the surgical department was being led effectively.
- We identified pockets of good clinical standards but they were not consistent throughout the department and largely due to leadership style.
- Staff at senior level told they felt supported and proud to work at Medway.
- However lower level staff reported feeling unsupported and that they struggled to deliver safe, effective holistic care to patients because of the continuous restraints and challenges identified earlier in this report.
- We reviewed data for Medway from the NHS Staff Survey 2013 and found that it scored better than expected in 'Support from managers', which was an improvement on the data collected for 2012. However, it scored a worse than expected result (in the bottom 20% of trusts nationally) for staff working extra hours, witnessing potentially harmful errors and near misses, and feeling pressure to attend work when unwell. The survey also revealed that the trust performed worse than expected for staff feeling satisfied with the quality of their work and the patient care they were able to deliver, and those who reported experiencing harassment, bullying or abuse from colleagues.

Culture within the service

- We observed a very hard-working, committed, loyal and proud staff team in the surgical department. We saw

staff deliver good-quality care despite the fatigue they were experiencing. Staff we spoke to reported feeling "worn out" but "hopeful" of the new changes driven by the chief nurse and ex-team.
- We found individual teams to be very supportive of each other.
- Senior staff told us that they had started meeting regularly with the sole intention of sharing good practice and supporting each other.
- However, there were concerns about a culture of acceptance, and familiar practice being used as a coping mechanism in response to daily pressures.

Public and staff engagement

- Public engagement was now a prime focus of the trust and strategies had been developed to improve engagement. These incentives were being led by the patient experience lead and the chief nurse to improve patient experience.
- We were told about the open drop-in sessions hosted by the new chief executive for staff to comment or raise concerns. We asked staff if they were aware of the drop-in sessions and if they had used them. Some staff told us they were not aware of the sessions; others said that they were aware but had not had an opportunity to attend. A few staff we spoke to had been to a session and reported finding it a useful experience.
- We were told that the chief nurse operated an open-door policy for staff. We asked the staff if they were aware of this and had used the facility. Most staff were aware of it and some told us that they had taken the opportunity to discuss concerns. They said that, although they were aware that things would not change instantly, they found the experience a "positive and reassuring" process that made them "feel listened to".
- Staff told us about a new approach to engagement through social media. They said that the chief nurse operated a Twitter account that was used as a forum for staff and public alike to make comments or share experiences or examples of best practice, and to obtain feedback.
- The hospital Board had committed to strengthening the patient 'voice' by listening to a patient story at the beginning of each meeting.
- As part of the transformation agenda, a patient experience group had been created with matrons, the Patient Advice and Liaison Service, governors and Healthwatch Medway all having an active role.
- Patients' affairs support and the Patient Advice and Liaison Service were available.
- These incentives meant that steps were being taken to encourage public and staff engagement, and they were recognised as positive in changing both patient and staff experience.

Innovation, improvement and sustainability

- There was a pocket guide for nurses that included a sepsis screening tool and treatment advice and a documentation guide that contained important contact numbers for escalation.
- The WOW awards enabled patients and visitors to report members of staff who had delivered excellent and outstanding care.
- The 'Transforming Medway' programme was a quality improvement programme focusing on better quality of care, improved patient and staff experience, and more value for money.
- The 'Schwartz Rounds' programme aimed to improve communication between patients and caregivers, promote compassion and empathy, enhance spiritual care, influence caregiver training, encourage the dissemination of best practices, and empower patients and families.
- An external provider had been commissioned to undertake training in root cause analysis for 50 key staff.
- A 'mortality working party' had been set up, led by the clinical audit team, to monitor and improve mortality outcomes at the trust.
- A review of the Patient Advice and Liaison Service review had been completed by Cambridge NHS Foundation Trust, and plans were being developed to address its recommendations.
- Work was underway at Medway to improve the Friends and Family Test feedback. Wards were being encouraged to take ownership of the data and be proactive with the feedback obtained.

Critical care

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

Information about the service

Critical care services are provided at Medway NHS Foundation Trust in three separate locations. The intensive care unit (ICU) has nine beds, the surgical high dependency unit (HDU) has 10 beds and the medical HDU has six beds. Patients who have a potentially life-threatening illness or injury can be admitted to an intensive care bed where they receive one-to-one nursing care (level 3 care). Patients who are too ill to be cared for on a general ward but do not need an intensive care bed can be admitted to a high dependency bed (level 2 care). Between January 2013 and December 2013, 2,185 patients were admitted to the critical care locations of this hospital.

Critical care outreach services are available 24 hours a day throughout the hospital to assist with the assessment and management of deteriorating patients.

During our inspection on 24 and 25 April 2014 and follow-up inspection on 1 May 2014, we visited all three critical care locations. We spoke with four patients, three relatives and 34 staff (nurses, doctors, managers and support staff). We looked at care and treatment as well as reviewing care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. Before and during our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Critical care followed national evidence-based care and treatment and carried out local audit activity to ensure compliance. Patients were comfortable and their nutrition and hydration adequately maintained. Patient outcomes were within expected ranges. Nurse staffing levels in critical care were in line with national standards, but there were concerns over the medical oversight within the medical HDU.

There was good multidisciplinary and multi-professional working in critical care, including allied health professional support and medical specialist input. At times, patient flow prevented timely discharge from a critical care area. There was good practice around consent and Mental Capacity Act assessments as well as the management of deteriorating patients.

Critical care staff followed the trust incident reporting system and demonstrated learning from incidents. Mortality and morbidity (M&M) meetings were held but not minuted, and staff were unable to show that learning took place. Critical care services were provided in a clean environment. However emergency equipment was not always checked in line with trust policy and not all medicines were stored in accordance with national regulations.

Many members of staff were not up to date with infection control and other mandatory training. Staff appraisals were carried out regularly. New staff

Critical care

underwent trust induction to ensure that they were competent to work in critical care, although there were no specific guidelines for newly appointed critical care consultants.

Care and treatment delivered in critical care was compassionate and based on the individual needs of each patient and those close to them were involved in the planning of care and treatment. Staff were able to demonstrate that service planning and local governance and risk management activity was taking place, with comments and complaints discussed at meetings to promote learning. Leadership within the service was strong with a mostly cohesive culture.

Are critical care services safe?

Requires improvement

Critical care staff followed the trust incident reporting system and demonstrated learning from incidents that took place there. Mortality and morbidity (M&M) meetings were held but not minuted, and staff were unable to show that learning from this activity was taking place. Critical care services were provided in a clean environment. However, not all staff were up to date with infection control and other mandatory training. Emergency equipment was not always checked in line with trust policy and not all medicines were stored in accordance with national regulations. There was good practice around consent and Mental Capacity Act assessments as well as the management of deteriorating patients. Nurse staffing levels in critical care were in line with national standards, but patients in the medical HDU (known as the Bronte Critical Care Unit) were managed by medical consultants rather than critically care trained consultants. This is not in line with the Core Standards for Intensive Care units published in 2013. Local response to major incidents followed trust policy.

Incidents

- During the period December 2012 and January 2014, there were no Never Events reported relating to patients using critical care services at this trust.
- During the period June 2012 and July 2013, there were two patient safety incidents with a rating of moderate reported to the National Reporting Learning System (NRLS) relating to patients using anaesthesia pain management and critical care services at this trust.
- Staff told us they reported incidents using the trust computer-based Datix system. Records confirmed this and showed that reported incidents were analysed and monitored. Staff said that incidents were investigated locally and that learning from incidents was shared locally as well as trust-wide when other areas of the trust were at risk of experiencing the same or similar incidents. We saw records that confirmed this. For example, minutes of the ICU senior staff nurse meeting on 5 February 2014 discussed the practice of administering intravenous medicines after a medicines error that was reported as an incident. These minutes and a separate document reminding staff of correct

procedures for administering intravenous medicines were available for all ICU staff to read in the 'update' book (a folder used to communicate written information to ICU staff).

- One member of staff told us that multidisciplinary M&M meetings were held locally in critical care every Wednesday morning. They said that both expected and unexpected deaths were discussed at these meetings and contributing factors to the deaths established. Another member of staff told us that mortality audit meetings were held in critical care on a monthly basis. They said that all critical care staff were invited to this meeting to discuss any concerns they had following the death of any critical care patient. We were told that minutes of these meetings had not been taken. However, we saw records that ICU mortality audit data had been collected and collated into calendar months, thereby showing that some analysis had taken place. Staff were not able to provide any evidence that learning from this activity had taken place.

Safety thermometer

- The NHS Safety Thermometer was used to indicate how nursing staff were performing in the critical care areas of the trust. In critical care during the period April 2013 to March 2014, local records showed there were eight incidents of hospital-acquired pressure ulcers, no incidents of hospital-acquired deep vein thrombosis (DVT) and five incidents of catheter-acquired urinary tract infections. Our intelligent monitoring found that the median result for the trust in the above incidents was below the median for England.
- Critical care also used safety performance records to indicate nursing staff performance. We saw that results were clearly visible to staff, patients and visitors in all three critical care areas. For example, compliance with safety relating to peripheral and central intravenous lines was 100% in February 2014 and was displayed in ICU. Records demonstrated that safety performance results were also discussed at staff meetings and cascaded to other staff via the 'update' book.

Cleanliness, infection control and hygiene

- All three critical care areas we visited were clean, tidy and free from unpleasant odours. We saw records that confirmed there were cleaning schedules that were followed regularly. We witnessed staff and visitors washing their hands, using hand gel and wearing appropriate personal protective equipment such as gloves and aprons.
- Isolation facilities were available in all critical care areas. For example, there were two isolation rooms in use on ICU for two patients with actual or potentially infectious conditions. We saw that these two isolation rooms shared a dedicated sluice where soiled linen and waste could be processed or disposed of safely without contaminating other patient areas.
- Infection control audit results for the period April 2013 to March 2014 were predominantly good. For example, the commode audit results showed 100% compliance with infection control for 10 out of the 12 months of audit activity. The June 2013 result was 50% compliance and 67% in December 2013. Target compliance for the commode audit was 90%.
- Intensive Care National Audit and Research Centre (ICNARC) data was only available for the period January 2013 to June 2013. This data showed that the percentage of patients admitted to critical care with C. difficile infection was zero and no critical care patients developed this infection during their stay there.
- Staff told us that input from a microbiologist to patient care took place on a daily basis in critical care areas. However, this was only by phone on some days because the microbiologist was covering services at another hospital as well as Medway Maritime Hospital.
- Staff were able to show us how they accessed the trust infection control policy on the hospital intranet. We looked at 59 critical care staff infection control training records and saw that it had been more than 12 months since eight staff last attended annual mandatory update training in infection control.

Environment and equipment

- We looked at the resuscitation equipment available in all three critical care areas. Resuscitation equipment was stored on resuscitation trolleys, which we noted were configured differently and not standardised. This was not in line with the current national standards issued by the Resuscitation Council (UK). It meant that there was a risk that the hospital resuscitation teams might find it difficult to locate and retrieve resuscitation equipment quickly in an emergency because of the differing design, layout and contents of each trolley. We saw records that confirmed an action plan was in place

to standardise resuscitation trolleys and their contents in the hospital including the critical care areas. However, the records did not indicate a time frame by which the resuscitation trolleys were to be standardised. Records also showed that resuscitation equipment was not being checked daily in all critical care areas in line with trust policy. Staff told us that local audit of this activity took place but was not recorded. The trust resuscitation policy (which was out of date) stated that 'Resuscitation officers will check (audit) the ward/department level record of resuscitation equipment checking'. We saw the last such audit carried out in 2013 did not include ICU or the medical HDU.

- Staff told us that ICU had recently undergone a refit and scheduled deep clean. We saw that each bed space was identically furnished with standardised equipment to monitor and care for critically ill patients. Staff told us that all patient bed spaces in all critical care areas conformed to current NHS Estates guidance. Records showed that workplace inspections of the critical care areas were carried out every three months. When deficiencies were identified, they were repaired in a timely manner. For example, we saw that one inspection identified damage to a bathroom floor in the surgical HDU and this had since been repaired.
- Staff we spoke with felt they had sufficient equipment that functioned and was maintained for use in the care of critically ill patients. We saw records that showed that critical care lacked MRI-scanner compatible equipment, which meant that patients on multiple infusions of medication could not easily undergo MRI scans. However, staff told us that a bid for funding had been made to purchase MRI-scanner compatible equipment. During our inspection, we saw records that confirmed funds to purchase this equipment were to be released by the trust finance department on 25 April 2014.
- We saw that critical care equipment was maintained and regular checks carried out as appropriate. For example, the arterial blood gas analyser carried out self-checks automatically, which were monitored remotely by the point of care testing department. Staff told us that electronic records of such checks were stored electronically and automatically by the controlling computer system.
- We saw that a fire exit in the medical HDU was partially obstructed by equipment and trolleys so that in the event of a fire it would not be possible to evacuate patients on beds through the fire exit without first moving the partial obstruction. Staff told us that there was insufficient room to store equipment in the medical HDU, which was why it was stored partially obstructing the fire exit.

Medicines

- Medicines were stored securely in cupboards with coded key locks in critical care areas. Refrigerators used to store medicines were secured with locks operated by a key. In ICU, there was a wall-mounted key store where keys, including the refrigerator lock key, were stored. On all three days of our inspection, we saw that this key store was unlocked and left open. Patients, staff and visitors could access keys from the key store, which meant that gaining access to medications by people not authorised to do so was possible. Staff told us that the key store was left open so that anyone could access keys to obtain drugs in an emergency or urgent situation.
- We looked at the emergency and other medicines stored on the resuscitation trolleys and they were all in date and fit for use.
- We found that the controlled drugs cupboard in Bronte was not compliant with the misuse of drugs safe custody regulations 1973.

Records

- Staff told us that patient records were in electronic and paper form. Electronic records were stored securely and individual passwords were required in order for staff to gain access to them. Staff said that, when they had finished with the electronic patient records, they ended their session on the computer before leaving the screen so that no unauthorised access could take place. They told us that in the event that they forgot to end their session on the computer when they left, an automatic log off or screen saver to protect the records was not yet in place. We saw that paper records were stored in closed drawers and that only records that staff were constantly using were left out at patients' bedsides – for example, charts used to record patients' vital signs such as heart rate and blood pressure. However, access to records was controlled because staff were always present.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that verbal or written consent to care and treatment was obtained from patients. We saw records that confirmed this. If a patient was unable to give

verbal or written consent to care and treatment, because they lacked mental capacity or were unconscious, staff said that best interest decisions were made when administering care and treatment to critical care patients. They said that best interest decisions were made in consultation with patients' next of kin whenever possible.

- Records showed that Mental Capacity Act assessments were carried out for critical care patients when there was any question as to their mental capacity.
- Few staff were trained to carry out Deprivation of Liberties Safeguarding (DoLS) assessments in critical care, and not all patients needing a assessment received one. New legislation resulted in there being an increased demand and staff told us that the trust legal department had advised that these assessments were required. As a consequence of the new legislation and advice from the legal department, the trust was currently formulating an action plan to address the shortage of staff trained to carry out these assessments.

Mandatory training

- Critical care had a system in place to monitor and record the mandatory update training attended by the staff working there. Staff told us that they were up to date with some of their mandatory training such as training in safeguarding vulnerable adults. However, they said they were not up to date with all mandatory training. We looked at their training records and saw that only one member of staff had not received safeguarding vulnerable adults training. However, the records showed that not all staff were up to date with other mandatory training. For example, 31 members of critical care staff were in need of update training in resuscitation.

Management of deteriorating patients

- Staff told us that the national early warning score (NEWS) system used to identify patients at risk of deterioration was not used in critical care areas of the trust. We were told that staff working there received specific training in the identification and management of critically ill patients that negated the need for the use of NEWS there. However, staff told us, and records showed, that not all critical care staff were up to date with this training.
- When patients were identified as being well enough to be discharged from critical care, we saw that staff used ward-based documentation to record their vital signs and that they used NEWS. Staff told us this was to help keep patients safe by giving ward staff a baseline early warning score record of patients' vital signs with which to compare other scores calculated when the patients left critical care. We looked at records that confirmed this.

Nursing staffing

- The core standards for intensive care units 2013 were used to establish the nursing staffing requirements in critical care. During our inspection, all critical care beds in the trust were occupied and all critical care areas were fully staffed, enabling the necessary care to be delivered to patients. Critical care staff told us that any shortfall in nursing staff was filled by the use of their own staff through the trust's internal flexibank. This ensured that critically ill patients were cared for by qualified staff with appropriate skills and experience of working in the trust's critical care areas. Staff in the medical HDU told us that they were often short of nursing staff due to staff sickness, but this was not reflected in the nursing duty roster that we saw.
- We observed nursing handovers and saw that they were comprehensive, including information relevant to ensuring staff coming on duty were aware of each individual patient's plan of care and treatment – for example, past medical history, diagnosis, test results, planned investigations and resuscitation status.

Medical staffing

- The ICU and the surgical HDU had a dedicated team of critical care or anaesthetic trained doctors available 24 hours a day. A consultant led the doctors on site during the day and was contactable by telephone overnight. If required, the consultant could be called in overnight to join the team of doctors caring for patients in these critical care areas.
- According to the Bronte Critical Care Unit standard operating procedure (which was due to be updated in 2011 and had not been) the responsibility for the medical HDU (which would also accept non-ventilated Level 3 patients under specific circumstances), the consultants overseeing these patients were within the medical directorate and therefore did not always have specific critical care training. We were provided with evidence that daily ward rounds occurred by a medical consultant within hours, but out of hours patients were managed by the on-call medical registrar.

Critical care

Major incident awareness and training

- Critical care staff were aware of their responsibilities and the action they should take in the event that a major incident was declared in the hospital. Staff were able to show us how they accessed the major incident plan document on the trust intranet. They told us that this plan had been followed when a major incident had been declared in 2013 and that it had worked well to create capacity in ICU and the surgical HDU in the event that patients from the incident required care there. During our follow-up inspection visit on 1 May 2014, a major incident was declared and we saw staff follow the major incident plan. The major incident was 'stood down' after approximately 30 minutes, which negated the need for patients to be transferred out of critical care areas. However, we saw that suitable patients had been identified and preparations were under way to transfer them out of critical care if required.

Are critical care services effective?

Good

Critical care followed national evidence-based care and treatment and carried out local audit activity to ensure compliance. Patients were comfortable and their nutrition and hydration adequately maintained. Patient outcomes were within expected ranges when compared with other similar critical care services. Staff appraisals were carried out regularly. All new staff underwent trust induction to help ensure they were competent to work in critical care although there were no further specific guidelines for newly appointed critical care consultants. There was good multidisciplinary and multi-professional working in critical care and allied health professional support was available 24 hours a day.

Evidence-based care and treatment

- Critical care staff used a combination of NICE, Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided.
- We saw that critical care staff carried out local audit activity to ensure that national standards and trust policy were being followed. For example, we saw records that showed monthly observation audits on every patient on every ward were carried out. These were spot check audits to ensure that staff were following national guidelines and trust policy in the use of the NEWS system (used to identify patients at risk of deterioration). Results demonstrated that in 2013 compliance was 97.23%.

Pain relief

- We saw that patients' pain was regularly assessed and documented. Records showed that pain relief was administered promptly and patients' pain reassessed after administration to ensure that their pain was adequately controlled at all times. Patients we spoke with told us that their pain was under control and they felt comfortable

Nutrition and hydration

- Records demonstrated good assessment of patients' nutrition and hydration requirements. We saw that nutritional assessments were carried out on admission to critical care and reassessed at regular intervals. We saw records to show that referrals were made to dietitian services to ensure that balanced nutrition and hydration were provided on an individual basis to each patient. Pharmacy services were also involved in the provision of nutritional supplements and artificial feeding for patients who were unable to eat normally – for example, patients being fed intravenously.

Patient outcomes

- Critical care staff contributed to the ICNARC database. Results from ICNARC showed that patient outcomes and mortality for the period January 2013 to June 2013 were within expected ranges when compared with other similar services' data.
- Records showed that there were six unplanned readmissions within 48 hours of discharge from ICU during the period April 2013 to March 2014.
- Staff told us that the trust participated in the national cardiac arrest audit (NCAA). The NCAA report for the period April 2013 to September 2013 indicated that outcomes from cardiac arrest at Medway Maritime Hospital were slightly better than expected when compared with similar hospitals' activity. For example, survival to discharge following an in-hospital cardiac arrest was 28 compared with the expected 27.4. The trust resuscitation policy indicated that audit activity to ensure compliance with national standards in clinical resuscitation would be carried out by the resuscitation officers in the trust. It also indicated that audit activity to ensure that national standards and trust policy on

withholding resuscitation were adhered to by trust staff would be carried out by the resuscitation officers. Staff told us that the system of standardised recording of resuscitation events in the trust was not always followed and that audit activity to ensure national standards in clinical resuscitation was not taking place. They also told us that the last audit of adherence to trust policy on withholding resuscitation was carried out in between January and March 2013 by a member of staff who was not a resuscitation officer. The audit made several recommendations: for example, "Rational (for the decision to withhold resuscitation) should be more clearly recorded." However, staff told us that there was no action plan available to show how the trust planned to implement the recommendations of the audit, and no further audit had taken place.

Competent staff

- Staff we spoke with in critical care told us that they received appraisals at least annually. We saw records that confirmed this. We witnessed physical supervision and support of newly appointed staff working in critical care.
- Critical care had a monitoring system that ensured staff maintained professional registration with their relevant professional body: for example, the Nursing and Midwifery Council.
- Other than standard and local induction training undertaken by all new staff, we were told that there were no specific guidelines for newly appointed critical care consultants.

Multidisciplinary working

- During our inspection, we saw multidisciplinary team working between specialties and with allied health professionals. For example, we saw physiotherapists working with ICU staff to deliver care to critical care patients. Staff we spoke with told us that they felt there was a good working relationship between specialties, such as obstetricians and surgeons, intensivists and the rest of the critical care staff. We witnessed good communication between these groups of staff during multidisciplinary ward rounds that took place during our inspection.
- Patients discharged from critical care were followed up by critical care outreach staff until assessments showed that they were was sufficiently stable and no longer in need of critical care input. Staff told us that the critical care consultant nurse routinely followed up patients six weeks after they were discharged from critical care.
- The critical care outreach services were available 24 hours a day throughout the hospital to assist with the assessment and management of deteriorating patients. We saw records that confirmed the availability of at least one critical care outreach nurse in the trust at all times.

Seven-day services

- Allied health professional support was available to critical care staff 24 hours a day if needed. Staff told us that they were able to obtain mobile imaging services in the critical care area at any time day or night. They also said that it was possible to obtain help out of hours from an on-call physiotherapist. The trust had access to an out-of-hours supply of most medicines from an emergency cupboard, and was able to obtain help from an on-call pharmacist if required.

Are critical care services caring?

Good

Care and treatment delivered in critical care was compassionate and based on the individual needs of each patient. Patients and those close to them were involved in the planning of care and treatment and were able to make individual choices on the care they wished to receive. Emotional support was available to patients and those close to them during and after admission to a critical care area.

Compassionate care

- We saw that the latest NHS Friends and Family Test results for March 2014 were displayed in each critical care area. ICU and medical HDU results were 100% positive and surgical HDU results were 95% positive.
- During one nursing handover, we witnessed genuine compassion from the nurses coming on duty when they were informed of the death of a patient they had cared for recently. We also witnessed staff breaking bad news to those close to one of the critical care patients. This was carried out in an appropriate environment, without interruptions, in a considered manner. We saw that sufficient time was allowed for those present to ask questions. Those close to one of the critical care

patients confirmed that they had understood what they had been told during this discussion, its implications for their loved one, and that they would receive continuous support and be able to ask further questions at any time.

- Staff entered into open discussions with patients and/or those close to them when they were dissatisfied with any aspect of the care or treatment provided. When issues could not be resolved locally, they were directed to relevant services in the trust: for example, the Patient Advice and Liaison Service.

Patient understanding and involvement

- We observed doctors, nurses and physiotherapists interacting with patients in all three areas of critical care. Their interaction was compassionate and took into consideration each patient's individual situation. For example, we observed staff telling a ventilated patient that they were about to give them some medication intravenously despite the patient apparently being unconscious. We also observed ward rounds where patients' options of care and treatment were reviewed. We saw that the opinions of patients, and at times those close to them, were involved in the decision about the care and treatment that was to be provided. Records showed that one patient's resuscitation status had been discussed with them and their spouse and the patient had decided that they did not wish to receive cardiopulmonary resuscitation in the event that their heart stopped or they stopped breathing. Staff had then completed relevant documentation upholding the patient's decision.

Emotional support

- During our inspection, we saw the trust's clinical nurse specialist in organ donation working with a patient and those close to them when life-sustaining treatment was being withdrawn. Staff told us that other clinical nurse specialists were involved in the care of patients in critical care: for example, a tissue viability nurse specialist.
- There was good awareness among of critical care staff of the delirium that could be induced in patients as a result of their treatment. The staff tried to prevent this by moving patients away from the two beds in ICU that were in a room with no windows and therefore no natural light. Staff told us that they made every attempt to reduce lighting and noise overnight to simulate as near normal an environment for patients as possible.

Patients were followed up after discharge from the critical care units by the critical care consultant nurse, thereby meeting the NICE clinical guideline 83 for critical care follow-up and rehabilitation.

- Although staff told us that there were no formal bereavement counselling services available in the trust, we saw that critical care staff were able to offer bereavement support in a variety of ways. Each critical care area had a bereavement link-nurse and access to the trust end of life care matron during normal working hours. We saw a range of information leaflets available to help staff support bereaved relatives: for example, 'What to do following a death – information for bereaved relatives and friends' and a guide for teenagers, 'Saying goodbye to Dad'. We also saw some responses from relatives who had completed a Medway end of life care survey, and these indicated that bereavement care was good in the surgical HDU.

Are critical care services responsive?

Good

Critical care staff were able to demonstrate service planning and delivery met the needs of their critical care patients. At times, patient flow prevented timely discharge from a critical care area, although this did not prevent patients receiving the care and treatment they required. Specialist input to meet the individual needs of critical care patients was available from specialists in the trust, although there was no formal translation service provided for those patients whose first language was not English. Comments and complaints were managed in accordance with trust policy and discussed at staff meetings to enable learning to take place.

Service planning and delivery to meet the needs of local people

- Staff told us that recently an increase in critical care outreach activity had been predicted. We saw that the outreach staffing levels were increased during to cope with the anticipated additional demand.

Access and flow

- Staff reported that patient flow in the trust was poor and there were sometimes delays in admitting patients to a critical care bed. They said that this was due to the fact that there were often delays in transferring to a ward

patients who no longer needed critical care services. They said that the hospital lacked capacity to deliver care to patients in an environment relevant to their needs. During our inspection visit on 1 May 2014, there was one patient in the surgical HDU and one patient in the medical HDU who no longer required critical care. Staff told us that they were unable to discharge them from critical care because there were no ward beds available for them in the trust at that time.

- Local records showed that bed occupancy for the period April 2013 to March 2014 was 88.4% in ICU, 91.1% in the surgical HDU and 87.5% in the medical HDU.
- Admissions criteria and process were set out in each critical care area's operational policy.
- Only 2% of patients needing a critical care bed were not admitted within four hours of being referred to the service. They said that this was due to patient flow issues in the rest of the hospital preventing the creation of an available bed in critical care.
- Records we looked at showed that during the period September 2013 to March 2014 there were 188 out-of-hours discharges from critical care. Forty-eight were from ICU, 85 from the surgical HDU and 55 from the medical HDU. Staff told us that this was mainly due to patient flow issues in the rest of the hospital preventing discharge of patients from critical care areas during normal working hours. They said that each out-of-hours discharge was logged as an incident using the trust Datix system.
- Records we saw showed that there was only one non-clinical transfer out of critical care during the period April 2013 to March 2014.
- Local records showed that there were six cancelled planned admissions due to the lack of a critical care bed during the period April 2013 to March 2014.

Meeting people's individual needs

- Staff told us that members of staff who spoke languages other than English were contacted via the hospital switchboard when a translator was required in the trust. They said that patients' relatives who spoke English were used if a member of staff was not available to offer translation between staff and patients who did not speak English. The trust did not provide a formal translation service in the event that a member of staff or family members of patients were not available.
- Staff in all critical care areas told us that, when patients with learning disabilities or diagnosed with dementia were admitted, a referral was made to the trust's learning disabilities or dementia nurse specialist who then became involved in their care. During our inspection, there were no such patients in the critical care areas.

Learning from complaints and concerns

- Posters displaying information for patients and visitors on how to raise concerns or complaints, make comments or give compliments were clearly visible in all three critical care areas. Details of the names of trust staff to contact, as well as contact telephone numbers and an email address, were also given on these posters.
- Staff told us that complaints were managed in accordance with trust policy. We saw records that confirmed this and that complaints received were discussed at staff meetings.

Are critical care services well-led?

Good

Critical care staff were aware of the philosophy, objectives and local plans for the service. Local governance and risk management activity was taking place and was communicated to staff within the service. There were communication challenges to critical care from trust management. Leadership within the service was strong with a mostly cohesive culture. There was evidence of public and staff engagement as well as innovation within the service.

However, the medical HDU was sited in a separate directorate, and as such was not seen as part of the critical care unit despite that it offered Level 2 (and potentially Level 3) care to patients. The standard operating procedure was out of date, and the input from doctors trained in anaesthesia or critical care was not in line with current best practice or national standards. This needs to be addressed.

Vision and strategy for this service

- Staff were aware of the plans to relocate the medical HDU closer to the other two critical care areas. The nursing philosophy was displayed in the staff room of the surgical HDU so that all staff were reminded of its

content. Each member of ICU nursing staff had received a copy and were aware of the 2014–2015 objectives and ground rules, and we saw that team objectives were discussed at staff meetings.

Governance, risk management and quality measurement

- Operational monthly meetings were held and we saw that they were well attended by multidisciplinary critical care staff as well as staff from other areas of the trust, such as the pharmacy.
- Staff demonstrated good governance and risk management awareness and action. For example, they were trying to resolve the ongoing situation of critical care patients being discharged out of hours by reporting each out-of-hours discharge as a clinical incident. They had actively engaged with trust governance to establish an action plan. However, they told us that trust governance had acknowledged their concerns but not shared any action plan with them.
- We saw records to demonstrate that appropriate risk assessments were being carried out in critical care. For example, we saw a display screen equipment risk assessment dated 12 February 2014 and a risk analysis form for new and expectant mothers at work dated 28 March 2014.

Leadership of service

- However, the medical HDU was sited in a separate directorate, and as such was not seen as part of the critical care unit despite that it offered Level 2 (and potentially Level 3) care to patients. The standard operating procedure was out of date, and the input from doctors trained in anaesthesia or critical care was not in line with current best practice or national standards. This needs to be addressed.
- With effect from 1 May 2014, critical care services sat in the trust management structure with surgery and anaesthetics, and reporting to an interim director of operations. In the organisation quality governance structure, the services sat with acute and emergency medicine, reporting to two clinical directors and one head of nursing. There was a designated clinical lead consultant and an identified matron as well as a consultant nurse. We saw that there was strong leadership within critical care. There were multidisciplinary meetings to analyse issues and ensure that staff were kept informed and received feedback. However, staff told us that feedback to critical care staff from outside the service was poor: for example, feedback from the venous thromboembolism committee to critical care staff.

Culture within the service

- We saw there was a calm and friendly environment in all critical care areas. There was cohesive working between the nursing teams in each individual critical care area as well as between ICU and the surgical HDU. The medical HDU was located some way away and cohesive working between nursing staff there and the other two areas was not apparent. Staff we spoke with were open with the information they shared with us and proud of the high standard of care they felt they were able to deliver to patients in need of critical care. They expressed frustration at the poor flow of patients that delayed discharges from critical care and what they felt was poor communication from others outside their service.

Public and staff engagement

- Staff told us that they had been involved in the planning of the temporary move of ICU patients during the recent refit and deep clean. We saw that staff were kept informed of activities in relation to the newly refurbished unit, such as the reintroduction of disposable curtains.
- We observed that an information leaflet called 'While you are waiting' had been introduced in the surgical HDU as a result of comments received from patients' relatives. The comments had been the lack of information available to them about delays in their relatives returning from the operating theatre. Staff told us that the information in the leaflet addressed this issue.

Innovation, improvement and sustainability

- The surgical HDU had developed a system called 'ward watcher' that constantly monitored patient dependency levels. All three areas of critical care used 'ward watcher'. This enabled all staff working there to be aware of the likely care requirements of their patients as well as making it easier for them to identify patients who were suitable for discharge to a general ward.

Maternity and family planning

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

Information about the service

Medway Maritime Hospital maternity services delivered 5,911 babies between October 2012 and November 2013. The maternity service consists of a fetal medicine unit, antenatal clinic, day assessment unit, triage department and a large community midwifery service of four teams each covering a specific geographical area within Medway and Swale.

The delivery suite consists of 10 delivery rooms, four beds allocated for women requiring an induction of labour and a double obstetric theatre. One delivery room is equipped with a birthing pool. In addition, the maternity service has a five-bed, midwifery-led service called the Birth Place. The Birth Place has two rooms equipped with birthing pools, four postnatal beds and a low-risk triage assessment area.

The 23-bed postnatal ward (Kent Ward) provides care to women who have had uncomplicated deliveries, either vaginally or by elective or emergency caesarean sections. Women are cared for by a range of staff ranging from midwives, nurses and maternity care workers.

In addition to Kent Ward, the maternity service has a 23-bed antenatal and postnatal ward (Pearl Ward), which cares for women who are expected to stay for over 24 hours. Women who have been considered as high risk following the birth of their baby or babies are routinely cared for on Pearl Ward. There is also a six-bed transitional care unit for babies who need close observation but not intensive medical input.

We inspected the maternity service in August 2013 because we had identified an increase in the numbers of notifications of incidents that related to the care of both antenatal and postnatal women. We took enforcement action against Medway Maritime Hospital to ensure that the health, safety and welfare of women who used the service were protected.

We talked with 14 women, their partners and 22 staff, including care assistants, midwives (including the consultant midwife), nurses, junior doctors, consultants (including the clinical director) and the general manager for the service. We observed care and treatment and looked at five care records in order to track the women's journey from admission to after delivery. We received comments from our listening event, and from people who had contacted us to tell us about their experiences. We also considered information provided by the trust and external agencies such as the Royal College of Obstetricians and Gynaecologists.

Maternity and family planning

Summary of findings

Since our inspection of the maternity service in August 2013, we found there had been significant improvements in the overall care provided and there was a feeling of optimism and enhanced morale among the range of healthcare professionals working within the maternity service. However, because of the relative short time span between our previous inspection and this recent review, the overall changes to the service were still being embedded and it was evident that some improvement initiatives were still in their infancy with concerns about their long-term sustainability. The inspection team were impressed with the obvious improvements that had been made, and felt that the trajectory of the unit was very positive.

Care and treatment delivered to women throughout their pregnancy were compassionate and based on the individual needs of each woman. Women and those close to them were involved in the planning of their birth and were able to make individual choices on the care they wished to receive.

We found that not all clinical guidelines had been updated. The rates of caesarean sections and third and fourth degree perineal tears were higher than expected. There was a positive staff culture in reporting clinical incidents. However, there had been changes to how incidents were reviewed and managed and there was some confusion among staff about the overall ownership of incidents. There was good multidisciplinary and multi-professional working between the maternity service, community midwifery service and the neonatal intensive care team.

The number of midwives to births was in line with national recommendations with an overall ratio of 1:29 being achieved during January, February and March 2014. We found that the availability of a consultant obstetrician on the delivery suite was not always consistent with the recorded 98 hours per week reported by the trust due to consultants being expected to cover the emergency gynaecology theatre.

Are maternity and family planning services safe?

Requires improvement

There was a process in place for staff to report clinical incidents and they spoke positively about learning from incidents. However, there were some inconsistencies in the number of reports that were submitted monthly. Clinical audits showed that the maternity service were providing 'harm-free' care. However, we were concerned about the process for ensuring that women were re-evaluated for the risk of venous thromboembolisms (VTEs) when their clinical conditions changed.

The management of care records, including compliance with information governance and completion of blood labels, required improvement to ensure that women and babies were protected from the risk of harm.

The number of midwives to births was in line with national recommendations with an overall ratio of 1:29 being achieved during January, February and March 2014.

We found that the availability of a consultant obstetrician on the delivery suite was not always consistent with the recorded 98 hours per week, as reported by the trust due to consultants being expected to cover the emergency gynaecology theatre.

Incidents

- The Strategic Executive Information System (STEIS) records Serious Incidents and Never Events. Serious Incidents are those that require an investigation. There were 15 Serious Incidents reported at Medway Maritime Hospital associated with the maternity service between December 2012 and January 2014. These included:
- Never Events ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented); there is a nationally defined list of 28 incidents that are classified as Never Events. There were no reported Never Events for Maternity services at Medway Maritime Hospital during the previous 12 months.

- There was a 'datix' system in place to report adverse events, accidents or near misses and staff across various grading and job roles understood the system in use when we spoke with them.
- We reviewed the maternity service dashboard, which indicated that there had been 946 Datix reports submitted between March 2013 and February 2014.
- There was a significant variance between the numbers of Datix reports submitted on a monthly basis. For example, there were 36 Datix reports received in March 2013, 59 in April 2013 and 67 in February 2014. This compared with higher levels of reporting for October 2013 (118), November 2013 (127) and December 2013 (117). The expected level of monthly reporting for Datix incidents for maternity services was set by the trust as more than 70 reports (reporting a high number of incidents can reflect a good safety culture).
- There was no direct correlation between the numbers of births against the number of Datix incidents that were reported. For example, there were 453 births in July 2013 with 70 Datix reports submitted versus 458 births in October 2013 with 118 reports submitted.
- Overall, staff told us that they considered there to be a positive attitude to incidence reporting and that lessons learned were disseminated. We saw evidence that outcomes of investigations had been placed in ward-based folders that were referred to as 'Better care folders'.

Safety thermometer

- The maternity service participated in submitting information to the patient NHS Safety Thermometer and the service achieved 100% in the delivery of harm-free care between March 2013 and March 2014 with the exception of December 2013 when one patient was identified as receiving treatment for a urinary tract infection while catheterised.
- 'Saving lives' audit data submitted by the trust indicated that the delivery suite had attained a 0% compliance rate in relation to the management of a urinary catheter device.
- There was no data for October 2013, although we noted that one patient had sustained a superficial injury after suffering a fall on 3 October.
- Only one patient was reviewed as part of the January 2014 'Saving lives' review and so we did not consider the outcomes for that month to provide an accurate reflection of the overall service.
- The maternity service had attained 100% compliance in the completion of a VTE risk assessment between March 2013 and March 2014.
- A review of four case notes during the inspection confirmed that VTE risk assessments had been carried out. Each woman had been scored initially as 1 because they were pregnant, or had given birth in the preceding six weeks. However, there was no robust system for ensuring that women were re-evaluated for the risk of VTE if their clinical condition changed. We identified one woman who, on admission to the maternity unit, was evaluated as low risk. After delivery of her baby, her condition had changed and her risk of VTE had increased. She had not been re-assessed, nor had she received any VTE management to reduce the associated risks. This was discussed with a manager for women's health who confirmed that, while initial assessments took place, there was no process for ensuring the quality and accuracy of the information, and that this was an area that required improvement.
- A Datix report referred to an incident whereby a woman had not been assessed for the risk of VTE. However, a subsequent review identified that the woman was an intermediate risk and required pharmacological prophylaxis to reduce the likelihood of her developing a VTE.
- A second Datix incident report revealed that a woman had been incorrectly assessed (and scored as a 2). A review was carried out and it was identified that the woman should have been scored as a 4, which, according to the local trust policy, would have meant she should have received some form of intervention to reduce the risks associated with VTE.

Cleanliness, infection control and hygiene

- During our inspection, we found the maternity service to be clean and well maintained. Women using the service told us they often noticed domestic staff cleaning the ward areas and side rooms.
- Overall, the trust scored as well as other trusts for cleanliness in the Survey of Women's Experiences of Birth, CQC, 2013.
- We noted that medical equipment such as patient observation monitors and treatment trolleys had been de-contaminated, and these were marked with a sticker indicating the date they had been cleaned.
- Audit data provided by the trust indicated that the maternity service routinely attained 100% with the

'Saving lives' programme between September 2013 and February 2014. However, it was observed that compliance with peripheral venous cannula management for January 2014 fell to an average of 93% across the delivery suite and Kent and Pearl Wards.

- Hand hygiene audits were seen to be carried out on a monthly basis across all areas of the maternity service. Compliance with hand hygiene practice was consistently high with routine compliance rates of 100%.
- It was noted that hand hygiene compliance for Pearl Ward fell to 95% and 90% for October and November 2013 respectively. The subsequent three months' data demonstrated an improvement in hand hygiene practices, with an overall compliance rate of 100% for Pearl Ward.
- Our observations during the inspection staff routinely used PPE such as gloves and aprons. We saw staff routinely decontaminating their hands before and after contact with women.
- There was evidence that cleaning of the birthing pools in the Birth Centre and the delivery suite were appropriately decontaminated between each use.
- Data provided by the trust demonstrated that there was 100% compliance with the routine screening of women for MRSA in September, October, and November 2013. There was no data available for December 2013. No women were noted to have acquired MRSA during their stay on Kent or Pearl Wards between April 2013 and February 2014.
- There were no cases of C. difficile reported for the maternity services between April 2013 and February 2014.
- Seventy-seven per cent of staff within the women's health directorate had undertaken training in infection control. This was highlighted in red on the trust's training matrix, indicating that insufficient numbers of staff had received training in this area.

Environment and equipment

- There was a sufficient amount of cardiotocography (CTG) monitoring equipment. CTG monitoring is used to monitor the foetal heartbeat and uterine contractions during pregnancy and active labour. Staff told us that a CTG monitor was available in each of the 10 delivery suites and additional monitors were available on the ward.
- Neonatal resuscitaires were readily available and we saw that these had been checked on a daily basis to ensure they were functioning correctly and were fully equipped.
- An entry in the women's health risk register on 30 December 2013 indicated that a number of resuscitaires had become obsolete and so they would need to be replaced in the future.
- The Birth Centre was opened in 2012; it was found to be bright, clean and well equipped. Women who used the service spoke positively about the environment and the facilities available.

Medicines

- During our previous inspection, we raised concerns with the hospital regarding their unsafe management of medications. A number of improvements had since been made.
- The maternity service had regular access to a pharmacist and the discharge process had therefore improved because there had been a reduction in the waiting times for discharge medication.
- Staff were routinely monitoring the temperature of medication fridges. However, we found that over a two-week period there were occasions when the temperature exceeded the recommended 8°C. Staff we spoke with were unaware of the hospital policy in relation to the safe storage of fridge medications. We were told that the temperature should be between 5°C and 7°C. However, this was not consistent with the hospital policy. Furthermore, we noted that the fridge with fluctuating temperatures stored Anti D, which was used in the management of rhesus positive newborns. Because of the increased temperatures, which exposed the Anti D to temperatures outside the manufacturer's recommended storage range, the staff could not be certain that the medication remained viable.
- Controlled drug stock levels were checked twice daily to ensure that all controlled drugs were accounted for.
- The service often used FP10 prescription pads. There was a robust governance system in place for ensuring the appropriate use of these FP10 pads.

Records

- Each woman who elected to have her baby at Medway Maritime Hospital was issued with a set of care notes that were commonly referred to as 'hand-held notes'.
- In addition to hand-held maternity notes, the details of each woman choosing to deliver at the hospital were

manually entered into two separate electronic databases: Euroking Maternity Information System and Viewpoint. Staff told us that there was a high level of data-entry duplication, which in their opinion increased the risk of data-entry errors.

- We reviewed the Datix incident forms dating from September 2013 to February 2014. There were seven incidents that were associated with incorrect data entry. The most common example of was the incorrect sex of a newborn.
- We were told of an incident that had occurred in September 2013 whereby confidential patient information was sent to an incorrect address; this had been recorded as a Datix incident that we subsequently reviewed. Concerns regarding compliance with information governance had been logged on the women's health risk register on 28 January 2013. Despite the service being aware of the risks associated with poor compliance with information governance, actions to address the matter were slow to be implemented.
- There were 10 Datix incident reports dating from September 2013 to February 2014 that related to poor information governance compliance; these included mis-filed records.
- Information provided by the trust indicated that 95% of staff within the women's health directorate had completed training in information governance.
- There were 16 Datix incident reports dating from September 2013 to February 2014 in which blood samples had been mis-labeled. As a result, the samples had been rejected by the laboratory. Consequently, 10 babies needed to be re-bled to ensure an appropriately labelled sample was sent to the laboratory so that an appropriate medical care plan could be implemented.
- The hospital routinely issued newborn babies with a Personal Child Health Record, or 'red book'. Women told us they had spoken with a midwife regarding the use of the red book.
- There were eight incidents in which clinical information such as hepatitis B status was missing from the red book.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Eighty-six per cent of staff had received training in the Mental Capacity Act.
- Eighty-eight per cent of staff had received training in obtaining informed consent.

Safeguarding

- According to data sent to us by the trust, 81% of staff within the women's health directorate had undertaken level 2 training in safeguarding children, and 93% of staff had undertaken training in safeguarding adults.
- 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.
- Monthly perinatal meetings took place that were seen to be well attended by members of the obstetric and neonatal teams. It was apparent that discussions regarding women and babies at risk of abuse, or who were subject to engagement with social services, were held before the women presenting to the hospital to deliver their baby. Staff we spoke with on both the delivery suite and the NICU were able to tell us of any 'at-risk' births that were scheduled for the near future. There were care management plans in place for each of these at-risk births. These included contact details for nominated social care case managers. Staff were also able to describe the antenatal and postnatal mental health referral process, which was consistent with the trust's perinatal mental health guideline that had been ratified in September 2013.

Midwives we spoke with were aware of the guidance and multi-agency policy regarding female genital mutilation (FGM), which we were told was readily accessible on the trust intranet. We were shown a copy of this policy

Mandatory training

- Staff we spoke with talked positively about the training opportunities available to them. A review of the women's health directorate mandatory training database demonstrated that the average completion rate of all mandatory training modules was currently 86%.
- Data regarding the completion of mandatory training for medical staff in the maternity service was not available for us to review on the inspection. However, post inspection data showed compliance rates for 6 of the 13 areas at 100% and the remaining 7 areas showed compliance rates between 64% and 82%.

Maternity and family planning

Management of deteriorating patients

- The maternity service used an early warning tool called the Modified Maternity Early Warning System (MMEOWS) to help staff promptly recognise acute illness and/or rapid deterioration.
- There was a policy underpinning the use of MMEOWS. However, it was noted that the review date for the policy was May 2011. Looking at six MMEOWS charts showed that staff were following the requirements of the MMEOWS policy in regard to the frequency of physical observations.
- We were provided with audit data that demonstrated a consistently high compliance rate in regard to the completion of MMEOWS charts for the delivery suite and Pearl and Kent Wards for those charts reviewed between January and March 2014. When a woman had triggered MMEOWS, which according to the MMEOWS policy required escalation, the audit data demonstrated that 100% of cases had been appropriately escalated.
- There were policies and procedures in place to help staff to manage emergencies such as obstetric haemorrhages, severe pre-eclampsia and eclampsia management. Staff we spoke with were able to signpost us to the relevant clinical guidelines and polices, and they also demonstrated a working knowledge of them.
- Staff reported the lack of a high dependency unit on the delivery suite as being something that needed to be resolved, because women were currently transferred to the intensive therapy unit (ITU). Having high dependency facilities on site would improve the continuity of care for women and their families. We were told by staff that ways to develop this were being actively explored. One consultant had been identified as developing a business case to determine the feasibility and suitability of incorporating a high dependency unit within the delivery suite. This was recorded as an action in the Women's Health Labour Ward Forum dated 4 February 2014.

Midwifery staffing

- In each of the areas that we visited, there always appeared to be sufficient numbers of staff working. Women told us that staff were responsive to their needs and agreed that there were enough staff to meet their needs.
- The maternity dashboard used by the trust showed us that the workforce was monitored in relation to staffing ratios; for example, the ratio of midwives in contracted posts compared with the number of anticipated or 'benchmarked' births for the year. The benchmark was set for 1:29; we found that the ratio of midwives to births for December 2013, January, February and March 2014 had been achieved according to the dashboard.
- The dashboard demonstrated that there had been an increase in the number of midwives employed by the trust. The ratio of 1:29 was a significant improvement on previous months when the service had achieved 1:36 in March 2013, 1:34 in May, June and July 2013, 1:32 in August and September 2013 and 1:30 in October and November 2013. The trust used 'Birthrate plus' as a means of determining the midwife ratio depending on the acuity and needs of the women who elected to use the maternity services at Medway Maritime Hospital.
- Information provided by the trust indicated that the establishment for the hospital maternity service was 135 whole time equivalent (WTE) staff and 46.7 for the community service.
- There was a vacancy rate of 11.8 WTE in March 2014 for the hospital service and 1.96 WTE for the community maternity service.
- From the data given to us by the trust, we could not determine the specific number of different professionals such as midwives, nurses and maternity support workers who were employed.
- Bank and agency staff were used to cover vacancies, short-term sickness, annual leave and planned training. The total usage of bank and agency staff equated to 21 WTE for the month of March 2014, bringing the total available workforce to 189 WTE. The total number of staff required to provide a ratio of 1:29 for a benchmarked delivery population of 5,100 was 175.8 WTE.
- Maternity services used a number of varying grades of staff to meet women's needs. We were told that all women were supported by a qualified midwife during labour. A midwife was also allocated to support women during the elective caesarean section operating lists that took place three days a week. Women receiving care on the postnatal ward were supported by midwives, surgical nurses and maternity support workers.
- Staff told us that since our previous inspection, which had taken place in August 2013, there had been a "vast improvement" in the number of midwives employed by the service, and this had meant that the number of shifts experiencing staffing shortages had reduced.

Maternity and family planning

- We reviewed the Datix incident reports between September 2013 and February 2014. There were 55 reports associated with staff shortages across the maternity service. There were 15 occasions in September 2013, 12 in October, 7 in November, 11 in December, 9 in January and 1 in February 2014 when an incident form had been completed stating that there had been insufficient numbers of staff to meet the needs of the service.
- Between September and December 2013, the Birth Place had closed on a total of 12 occasions because midwives had been required to support the delivery suite or to work on Pearl and/or Kent Wards because of staff shortages. The closure of the Birth Place meant that women who had chosen to use that service were transferred to the postnatal ward until they were discharged.
- The frequency with which the Birth Place had been required to close because of insufficient numbers of staff had greatly improved. The lead for the Birth Place told us that there had been only two occasions in 2014 when it had closed, with no reported closures for the whole of March 2014.
- There were 11 reported incidents in which women experienced delays in treatment such as inductions of labour because of insufficient numbers of staff available to meet their needs. However, we noted that the frequency of delays in such treatments had reduced during January and February 2014.
- We found that a midwifery acuity assessment tool had been introduced into the service in April 2014. The head of midwifery told us that the compliance rate for completion of the acuity tool was only 53% and therefore any data extrapolated from the tool would not be a true reflection of the actual acuity of the unit.
- The use of agency midwives was limited to a small number of individuals who had been interviewed by the head of midwifery. We found that the maternity servicer had developed a local resource folder that contained information such as the skills of agency midwives who were frequently booked to work in the department.

Medical staffing

- There were 12 WTE consultants supporting the women's health directorate. The maternity dashboard indicated that the labour ward had 98 hours of consultant cover each week, providing input between 8.30am and 10.30pm seven days per week. In addition, there was a consultant on-call rota to cover out-of-hour emergencies. During our inspection we witnessed the on call consultant for the labour ward being called to cover the emergency theatre for gynaecology, which meant that their time on the labour ward was not protected.
- Of note, the benchmarked number of deliveries, according to the maternity dashboard, was set at 5,100 births (425 births monthly). The Royal College of Obstetricians and Gynaecologists Safer Childbirth 2007 report suggests that, when units expect to deliver between 5,000 and 6,000 babies annually, the level of consultant obstetrician presence should be 168 hours each week. This requirement was also identified in the trust's policy entitled 'Staffing levels – obstetrician guideline', which was ratified in June 2013. Section 9 of the policy states 'At Medway NHS Foundation Trust we have provided 98 hours consultant presence on the delivery suite since January 2010. 168-hour cover can be considered after integration with Dartford and Gravesham NHS Trust.' The proposed integration of Medway NHS Foundation Trust with Dartford and Gravesham NHS Trust was officially terminated in October 2013. A review of the obstetric business plan may be necessary to ensure the service meets the future increase in the number of women accessing the service.'
- With the exception of the foetal medicine consultant who only covered the obstetric rota, all other consultant obstetricians covered both the obstetrics and gynaecology rota.
- We spoke with a number of doctors and found that specialist trainee and staff grade clinicians were routinely allocated to cover the elective caesarean list. We were told that they were not routinely supervised by a consultant while carrying out the procedure, but considered that they could access a consultant should they experience any surgical complications. We reviewed the consultant rota for a period of seven weeks, during which there were 21 elective caesarean lists. However, there were only three occasions when a named consultant had been allocated protected theatre time to be able to attend the surgery.
- Three ward rounds occurred each day at 8.30am, 1pm and 8.30pm. A further round was scheduled for 5pm if it was considered necessary, but it was dependent on the acuity of the service. Two ward rounds occurred at the weekend.

Maternity and family planning

- The labour ward staffing guideline set out the objectives of the ward round. These included a handover of all women who were currently on the delivery suite, as well as reviewing the planned work for the day, which included inductions of labour, augmentations and caesarean sections.
- There was an entry in the women's health directorate risk register dated 24 February 2014 that had identified a risk of delays in women being transferred to the delivery suite after induction of labour because there may have been earlier delays in consultants reviewing them. The risk had been escalated to the clinical director and increased surveillance was taking place by the reviewing of Datix incident reports by the general manager. We spoke with two women who had been admitted for induction of labour. They both said they had not been seen by the consultant but had spoken with a junior doctor. There was a plan of care documented for each woman.
- We observed a morning handover on 25 April 2014. We noted that this was chaotic with people arriving and leaving at different times. Staff that we spoke with later were not able to tell us the actual start time of the handover, with some people assuming it started at 8.30am while others believed it started at 9am. We reviewed the labour ward staffing guideline, which stated that the morning handover should commence at 8.30am and be conducted by the consultant responsible for the labour ward.
- There were no records to show who had attended ward rounds.
- The service was supported by a range of clinicians ranging from specialist trainees (6 posts) through to staff grade doctors (10 posts). A small number (2) of foundation year doctors were allocated to the service on a rotational basis. Trainee doctors we spoke with were positive about the support and learning opportunities they received while working in the maternity service.

Major incident awareness and training

- The maternity service reported two unit closures on 12 November 2013 and again on 20 January 2014. We reviewed the investigation report into the unit closure of 12 November 2013. The actions taken by the staff were considered to be consistent with the trust policy entitled 'Trust escalation of emergency closure of the maternity unit'.
- There was a 'Maternity and gynaecology patient management business continuity plan', which was ratified in November 2013. Senior midwifery staff we spoke with were aware of this plan and were able to signpost us to the document.

Are maternity and family planning services effective?

Requires improvement

The maternity service at Medway Maritime Hospital used a range of evidence-based practice that was consistent with national standards in a number of areas including, but not limited to, the provision of antenatal and postnatal care. However, a number of policies and procedures were found to be out of date and were in need of review to ensure that they were consistent with national evidence-based guidance.

The number of emergency caesarean sections performed by the service was higher than expected, as was the number of women sustaining a third or fourth degree perineal tear during labour, when compared with national outcomes.

There was good multidisciplinary and multi-professional working between the maternity service, community midwifery service and the neonatal intensive care team. Women were supported by a dedicated physiotherapy service Monday to Friday. There was provision for access to a physiotherapist for emergency situations outside normal working hours.

Evidence-based care and treatment

- Departmental policies were easily accessible on the shared drive that staff were aware of and reported they used. The policies were divided into sub-categories, namely: Maternity; Maternity–antenatal; Maternity–gynaecology; Maternity–intrapartum; and Maternity–postnatal.
- Policies routinely made reference to guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and the National Institute for Health and Care Excellence (NICE). There were a number of policies that were out of date such as 'Sepsis in pregnancy', which had expired in December 2011 and was no longer consistent with best practice or evidence-based

guidance. Guidance on the management of sepsis in pregnancy was reviewed by RCOG in 2012. While most of the trust's local policy referred to the best practice highlighted by the RCOG 2012 guidance, there was no reference made to the use of intravenous immunoglobulins in the management of severe sepsis, for example.

- During 2011/2012, the trust exceeded the national target of ensuring that at least 90% of women booked into the antenatal clinic were screened for infectious diseases including hepatitis B, HIV, syphilis and rubella.
- As part of the inspection, we reviewed the provision of antenatal care at Medway Maritime Hospital. The number of women booked into the antenatal pathway before 12 (+6 days) complete weeks had declined in the preceding three months. A review of bookings was scheduled to take place to determine any geographical trends that may have explained the reasons behind this.
- Women were routinely offered advice during the antenatal period, which included smoking cessation, foetal anomaly screening and external cephalic version (ECV). We also found that the service routinely offered all women a foetal scan at 36 weeks; this fell outside the scope of the NICE quality standard 22 for antenatal care.
- There was a policy entitled 'Clinical risk assessment (antenatal)', which was ratified in May 2013. The policy contents were consistent with the requirements of the NICE quality standard 22 for antenatal care. Additional trust policies and guidance were available to staff, such as the 'Obesity in pregnancy' guideline and 'Screening tests – pregnancy related' guidance. Staff were aware of these policies. A review of six sets of hand-held notes demonstrated that women were routinely being provided the appropriate levels of antenatal care that were consistent with the quality standard.
- The maternity service provided a range of specialist antenatal clinics that were supported by consultant obstetricians. These clinics ranged from, but were not limited to, antenatal diabetes management, maternal medicine, obesity, vaginal birth after caesarean sections and foetal abnormality clinics.
- The maternity dashboard indicated that the number of women who successfully opted for a vaginal birth following caesarean section (VBAC) ranged from between 50% and 81% over a 13-month period. The service achieved their key performance indicator (KPI) of VBAC, which was set at 75% on three occasions (November 2013, January and February 2014).
- There was a range of policies in place to help support staff to provide care that was consistent with the NICE quality standard 32 for caesarean sections. We saw that staff routinely provided care that was in line with the quality standard. For example, we found that staff used foetal blood sampling as one means of determining whether a caesarean section should be considered because of abnormal foetal heart rate patterns. Two women who had undergone elective caesarean sections both told us that they had been given a number of options and offered choices as to how they could deliver their babies. This included a documented discussion with one mother who had previously had a caesarean section and for whom a vaginal birth was now an option.
- The maternity dashboard indicated that the maternity service was not meeting quality statement 5 of the NICE quality standard 37 for postnatal care, which is specifically related to ensuring that women receive breastfeeding support through an evaluated and structured programme. This was because the maternity service was failing to ensure that at least 85% of women were supported when beginning breastfeeding. Breastfeeding initiation rates consistently fell below the trust's red flag KPI of 70% over a 13-month period. Action was being taken by the service to address this area by appointing to a vacant infant feeding midwife post and by reinitiating the local trust breastfeeding strategy. Staff told us that the maternity support workers on the postnatal ward were currently responsible for supporting women with breastfeeding.

Pain relief

- Pain relief such as entonox was routinely available on the delivery suite and in the Birth Place.
- There was a policy in place to support staff in the management of remifentanil patient-controlled analgesia. In addition to staff guidance, the service had produced a patient information leaflet that was given to women to help them understand the benefits and risks of using remifentanil patient-controlled analgesia during labour.
- Women we talked with postnatally, or who had been admitted for induction of labour, spoke positively about their pain management.
- The maternity service had recently reviewed its guidance on the management of women with epidural

anaesthesia (April 2014). The revised guidance had been developed by a multidisciplinary team including midwives, consultant obstetricians and consultant anaesthetists.
- Information regarding the benefits and risks of epidural anaesthesia was readily available in a number of different languages to women who used the service.
- The maternity service had 24-hour anaesthetic support that was provided by clinicians ranging from consultant anaesthetists to specialist trainees. Consultant anaesthetic cover was provided on the delivery suite 50 hours a week from 8am to 6pm Monday to Friday.
- An antenatal anaesthetic clinic was supported by a consultant anaesthetist and operated weekly.

Nutrition and hydration

- The maternity service operated a number of antenatal clinics to support obese and bariatric women, as well as those with gestational and chronic diabetes.
- We spoke with three women who provided mixed reviews on the overall quality of the food that was provided by the hospital.

Patient outcomes

- According to the data we collected before our inspection, the trust had a similar profile of delivery methods compared with national counterparts. However, this data was from 2011/2012 and intelligence we gained from our external stakeholders, as well as information provided by the trust, showed that the trust currently performed a higher number of caesarean sections. The maternity dashboard for the trust indicated a caesarean section rate of 26% (March 2014) against a KPI of 23.5%.
- Additional data from external stakeholders indicated that the total number of emergency caesarean sections carried out between October 2012 and November 2013 was 946 versus an expected number of 819. Elective caesarean sections for the same period totalled 614 versus an expected number of 560.
- The service consistently breached their 'red flag' KPI of 14% for emergency caesarean sections with eight out of 13 months being higher than 14%. This high level reflected what we were being told by staff.
- The high caesarean section incidence rate had been identified by the service and an audit entitled 'A review of intra-partum care and decision making for emergency caesarean sections at Medway Maritime Hospital between 2 December 2013 and 23 February 2014' was conducted by a consultant obstetrician and consultant midwife. As a result of the audit, 33 of a possible 115 emergency caesarean sections were considered to have been 'potentially modifiable'. As a result of the audit, recommendations were made to reduce the emergency caesarean section rate. These included improved CTG training as well as the reintroduction of STAN monitoring. STAN is a method of checking on the progress of a baby during labour. The audit data was scheduled to be presented to the audit meeting in May 2014, at which time an action plan would be agreed to implement the audit's recommendations.
- The maternity dashboard also indicated a high prevalence of third and fourth degree perineal tears. The red flag KPI for the department was set as more than 10 third or fourth degree tears per month. The service breached this red flag KPI on three consecutive months between November 2013 and January 2014. Again, the high incidence rate had triggered an internal review. A total of seven recommendations were made as a result of the review. An action plan had not been fully devised because the report was also scheduled to be presented at the May 2014 audit meeting.
- The total number of deliveries categorised as 'other forceps delivery' totalled 313. This was statistically higher when compared nationally.
- The total number of normal (spontaneous) deliveries was 3,642. This was statistically higher when compared with normal (spontaneous) deliveries nationally.
- The maternity service submitted information to RCOG relating to the intrapartum outcomes for women who used the maternity service during 2011 and 2012. Because of poor data quality, information provided by the service for 4 of the 11 maternity indicators was not considered by the RCOG for inclusion in the final national report.
- There were 108 women re-admitted to the maternity service following discharge. This was in comparison to an expected number of 111. Each readmission was recorded on the Datix incident reporting system and we found that each case was reviewed to determine the reason behind the re-admission and whether it had potentially been preventable.
- The total number of neonates re-admitted to the service was significantly lower than expected for the time period of October 2012 to September 2013. The number was 148 versus an expected 238.

- The average length of stay was recorded as two days; this was comparable nationally.
- The trust had agreed to participate in a national diabetes audit: 'Pregnancy services for women with pre-gestational diabetes during 2014 and 2015'.

Competent staff

- Appraisals of medical, midwifery, nursing and ancillary support staff was being undertaken and staff spoke positively about the process.
- Figures given to us by the trust indicated that as at January 2014 83% of consultants employed by the women's health directorate had received an appraisal. The shortfall was due to one consultant being off on long term sick and another newly appointed.
- All 'Non-training doctors' (100%) and 83.97% of non-medical staff such as midwives, nursing staff and maternity care assistants were seen to have recently received an appraisal.
- Data from the 'UK National Screening Committee – Antenatal and newborn screening education audit for 2011/2012' showed that the trust had a designated person who was responsible for the audit, coordination and education of relevant staff regarding the national antenatal screening programme.

Multidisciplinary working

- There was evidence that multidisciplinary working was taking place between the maternity service and the neonatal team. Examples of this included the joint management of a six-cot transitional care unit that was located on Pearl Ward. There was a guideline in place that clearly explained the roles and responsibilities of both the neonatal and midwifery care staff. We spoke with staff from both the Oliver Fisher NICU and Pearl Ward. Both staff groups were complimentary about the working arrangements of transitional care and they considered that the service worked well.
- We spoke with two mothers who were using the transitional care service at the time of our inspection. They both told us that there was good communication with both the neonatal and midwifery service and that both services involved the mothers in the management of their babies.
- Minutes from the monthly perinatal meetings gave evidence that there was good attendance from both the obstetric and neonatal teams.
- Although the handover we observed on 25 April 2014 was considered to be chaotic, there was good attendance from a range of multidisciplinary professionals including midwives, consultants, junior doctors and maternity care assistants. In addition, the maternity service was now supported by a clinical pharmacist to ensure that there were safe and effective systems in place to manage medications.
- Medway Maritime Hospital operated a community maternity team that consisted of approximately 44 WTE midwives. Staff with talked positively about the relationship that had developed between the community midwifery service and the health visiting team that was operated by Medway Community Healthcare.
- There were four Datix incident reports, dating from between September 2013 and February 2014, in which the community midwifery team had not been informed of a woman's discharge. This meant a delay in women being reviewed by a community midwife after discharge from hospital. However, it was noted that there was a positive relationship between the community- and hospital- based services, especially in relation to facilitating the re-admission of babies and/or their mothers.
- There were policies in place to support the external transfer of both neonates and mothers. The policy gave information to staff on how to access external specialist beds, such as intensive care beds; this could be done via the national Emergency Bed Service.
- In the unlikely event that the delivery suite had to close, there was a process for escalating the closure to external agencies such as the South East Coast Ambulance Service. We reviewed the investigation into the closure of the unit in November 2013. There was evidence of staff using the closure escalation policy appropriately and of clear communication taking place with a local NHS hospital that had agreed to accept any woman who had previously been booked to deliver at Medway Maritime Hospital.

Seven-day services

- The maternity unit, labour ward had 98 hours of consultant cover each week, providing input between 8.30am and 10.30pm seven days per week. In addition, there was a consultant on-call rota to cover out-of-hour emergencies.

Maternity and family planning

Are maternity and family planning services caring?

Good

Care and treatment delivered to women throughout their pregnancy was compassionate and based on the individual needs of each woman. Women and those close to them were involved in the planning of their birth and were able to make individual choices on the care they wished to receive.

The women we talked with spoke positively about the emotional support they had received from the maternity service, especially during their labour. However, there was no formal bereavement service available to women; at the time of our inspection, this service was provided informally by the midwifery team.

Compassionate care

- We observed staff interactions with patients as being friendly and engaging.
- The women we spoke with were complimentary about the care and support they had received from a range of healthcare professionals including midwives, doctors, maternity support workers and administrative staff.
- The trust scored 'about the same' as other trusts in England on all aspects of the maternity survey and in the Survey of Women's Experiences of Birth, CQC, 2013.
- The Friends and Family Test for maternity services is divided into four separate categories: antenatal care, care during labour, care received on the postnatal ward and community-based postnatal care. The NHS uses a 'net promoter score' (NPS) to demonstrate the overall likelihood of someone recommending a particular service.
- In March 2014, the overall NPS for those people using the antenatal care service at Medway was 74. This was a reduction on the previous month's score of 83 but higher than in January 2014 when the service scored 62.
- In March 2014, the overall NPS for those people who were likely to recommend the labour ward or birthing unit was 66. This again was an improvement on the previous month when the score was 62 and a significant improvement on November 2013 when the score was 32.
- In March 2013, the overall NPS for those women who were likely to recommend the postnatal ward to friends or family was 68. This was a slight reduction on the previous month of 74 but again a significant improvement on the overall score in November, when the service scored 43.
- In March 2014, the overall NPS for those women who were likely to recommend the postnatal community service to friends of family was 72. There had been a sustained increase in this area since November 2013. We found that the trust had increased the number of community midwives since our last inspection in August 2013 and staff reported improved working conditions and reduced workload when we spoke with them during this inspection. This meant that the community midwifery service was able to spend more time with each woman during their postnatal visits.
- There were 13 comments on the NHS Choices website specifically related to the maternity service at Medway Maritime Hospital. Six people rated the maternity service as being '5 star', with three ratings relating specifically to the Birth Place. Comments included "They (the midwifery team) tended to our every need and ensured that all procedures were fully explained and that myself and my husband were happy with what they were doing" and "The midwives were so caring, knowledgeable and supportive; they helped get us all through a longer than expected stay, with a smile."
- Six people raised concerns relating to different experiences of their pregnancy pathway, ranging from restricted access to the antenatal booking clinic, through to poor facilities and poor staff communication. When people had raised issues, a senior member of the maternity team had responded on the public website requesting the individual person to contact them directly so that they could address their concerns.

Patient understanding and involvement

- We spoke with 14 women during our inspection. Most were satisfied with the information and advice they had been given leading up to and during labour, and following the birth of their baby.
- Women using the service told us that the midwifery team were caring and that the care provided depended on the wishes of the mother. One woman said, "They follow the lead of the mum. They will give you all the support and advice you need."

Maternity and family planning

- We were told by the women using the service that, overall, they were kept well informed and were provided with sufficient information with regard to any clinical interventions that were necessary.
- The women using the service told us they had been informed of the discharge process and provided with sufficient information.
- Comments included "Although the unit is busy, staff appear calm. We were delighted by the whole experience and would happily use the service again."
- Another woman told us that she had been required to wait approximately 4 hours before her induction of labour could start. She said that she had not been offered any "real explanation" as to why the delay had occurred.

Emotional support

- Staff showed us the facilities they used for women needing higher levels of emotional support after the birth of a stillborn baby, for example.
- At the time of our inspection, there was no substantive bereavement midwife in post although this had been identified as an area of risk on the women's health risk register in July 2013. After an internal review, funding was secured for a bereavement midwife to undertake a nine-month secondment into the role. This was confirmed as starting in May 2014 after the successful appointment of an internal candidate.
- There was information available to people such as contact details for the local Kent Stillbirth and Neonatal Death Charity (SANDS).
- There was a robust process in place for supporting women with mental health concerns; referrals were made to antenatal clinics, facilitated by consultant obstetricians.

Are maternity and family planning services responsive?

Good

The maternity service was able to demonstrate that service planning and delivery met the needs of the local population.

Historically, the midwifery-led unit, the Birth Place, had been closed on a frequent basis because of insufficient staff levels across the maternity service. This led to women who used the service complaining of a poor experience. Changes to the service took place between January and March 2014, which led to improved staffing ratios and the relocation of the antenatal triage service, away from the delivery suite. These improvements led to a noticeable reduction in the frequency with which the Birth Place was required to close.

Comments and complaints were managed in accordance with trust policy and discussed at staff meetings to enable learning to take place.

Service planning and delivery to meet the needs of local people

- The senior midwifery staff acknowledged that the demand on the maternity service had increased in recent years and, after a review by an external consultancy in response to a proposed merger with Dartford and Gravesham NHS Trust, a number of specialist posts were dissolved. A review of the number of deliveries each quarter at the trust between April 2010 and September 2013 demonstrated a gradual increase in the overall number of deliveries taking place at Medway Maritime Hospital. This resulted in a persistently high workload for the service.
- We raised concerns with the trust in August 2013 and, to ensure that it achieved a midwife to birth ratio of 1:29, the trust undertook a period of active recruitment to appoint to vacant posts. One of the most common themes arising from discussions with staff across all professions was overall sustainability of the 1:29 midwife ratio.
- Women using the service described the overall activity as "busy but calm".
- Between September and December 2013, the Birth Place had closed on 12 occasions because due to staff shortages. However the frequency with which the Birth Place had been required to close due to insufficient numbers of staff had greatly reduced. The lead for the Birth Place told us that there had been only two occasions in 2014 when the Birth Place had closed, with no reported closures for the whole of March 2014.
- Women told us that they had been offered a number of choices throughout their pregnancy. When women had been assessed as suitable for delivering their baby in the Birth Place, they had been offered this choice. Three women who had recently been admitted for an induction of labour were able to explain their care and treatment pathway; two women we spoke with were

able to explain the risks involved with their specific treatment pathway and both had confirmed that they had been given sufficient information to make an informed decision about the care and treatment they were planned to receive.

Access and flow

- The maternity service reported two unit closures on 12 November 2013 and again on 20 January 2014.
- After our inspection in August 2013, the triage suite had been relocated to the foetal medicine/ante-natal day unit, which was located on level 2. The triage service operated a 'Call the midwife' advice service between the hours of 8am and 5.30pm; a log of all calls was made and the necessary paperwork was then sent to the delivery suite as well as being transcribed into the respective woman's care record.
- The triage service was operated by a core team of midwives. A consultant midwife was available to carry out external cephalic version (ECV). ECV is a manoeuvre that attempts to reposition the baby into a head-down position.
- The department had also started an outpatient induction of labour programme, which was being audited by the department. This was considered to be an innovative practice in terms of assisting the service to meet the needs of the local people, and helping reduce the number of admissions to the antenatal ward.
- Women had a choice about delivering their baby in the Birth Place, rather than in the main labour ward or at home. Access to this service was decided during the antenatal period and was determined according to whether women met the admission criteria that were mapped against risk assessments.

Meeting people's individual needs

- After our inspection in August 2013, the maternity service engaged with external stakeholders to carry out a regional Joint Strategic Needs Assessment. This assessment included a review of the local population demographic profile. One example of how this assessment benefited the local population was the re-introduction of a specialist teenage pregnancy midwifery post.
- The trust further commissioned a specialist breastfeeding advisor to help support women in beginning and maintaining breastfeeding. This role complemented the Medway CCG Integrated Commissioning plan for 2013–2015, which included an increase in the initiation of breastfeeding in hospital by 2015. At the time of the inspection, there was no substantive post-holder for this position, although we were advised it had been recruited to.
- Medway and Swale had a relatively large Eastern European migratory population. There were interpreter services available and patient information leaflets, such as those relating to the use of epidurals, were available in different languages.

Facilities for mothers and relatives

- We spoke with the birthing partners of two women who had recently given birth. They spoke positively about the care their partners and newborn babies had received but were disappointed with the facilities for birthing partners. One person said they had had to sleep on the floor while another had spent two nights sleeping in a non-reclining chair.
- During our previous inspection, we raised concerns with the trust that the bereavement suite was not fit for purpose. A number of women who had given birth to stillborn babies complained that they could hear crying babies and women in labour, which caused them additional emotional distress. The bereavement suite had since been refurbished; this included sound-proofing of the room so that external noise from the delivery suite was reduced. However, it was not yet fully operational because a number of small repairs and adjustments were required.
- We had also found previously that private and confidential conversations could be overheard. There were limited facilities available for medical and midwifery staff to hold sensitive conversations with women and their birth partners. A new side room had since been refurbished on the delivery suite that allowed such conversations to take place

Learning from complaints and concerns

- A review of claims, complaints and serious incidents within the women's health directorate was undertaken by the head of midwifery; this analysis was presented to the Trust Quality Committee on 17 February 2014. The review included an analysis of trends, with the resulting findings associated with poor staff attitude, poor communication and information sharing, CTG interpretation, unit closures, patient experience, delays with the induction of labour pathway and concerns with

the bereavement pathway. There were recorded actions against each of the outcomes to enhance service provision and to ensure overall quality of care was improved.

Are maternity and family planning services well-led?

Requires improvement

There was a noticeable change after our previous inspection in August 2013 when we found the service to be heavily under-invested and staff felt undervalued and unsupported. At this most recent review, there was a consistent feeling of optimism and enhanced morale among the range of healthcare professionals working within the maternity service. Staff told us that internal communication within the directorate had improved. The internal re-structuring at matron and sister level was seen to have a positive effect on the way the directorate operated on a daily basis.

Changes to the directorate's risk management structure was convoluted and there lacked an overall sense of ownership with regard to the management of risk within the maternity services. There were delays in investigations into serious incidents being completed, which ultimately led to delays in the service learning from incidents and accidents. The team were impressed with the improvements effected by the department in response to previous concerns raised.

Vision and strategy for this service

- During our discussions with the senior clinical team, the main priority for the service was to address the higher than normal caesarean section rate and to reduce the number of third and fourth degree perineal tears.
- We were told that before the appointment of an interim general manager, the 'Service delivery plan for women's health' had not been reviewed or updated since 2008. A review of the service plan has since been carried out and was seen to be based on the Joint Strategic Needs Assessment. The plan included the re-introduction of a teenage pregnancy advisor post and also the establishment of a multi-agency antenatal access group to review the processes for women accessing antenatal care at Medway Maritime Hospital.

Governance, risk management and quality measurement

- There was a maternity risk management strategy that was ratified by the clinical and executive group committee as well as being approved by the women's health policy and procedure committee and the women's health directorate governance group. It was acknowledged by the general manager that the risk management strategy was in need of a review after recent changes to the governance structure.
- We were told by staff that the overall governance structure of the maternity service had improved since we last inspected in August 2013. However, we found, from speaking with staff, that since changes to the risk management structure had taken place there had been an increase in the number of individuals involved in the overall process; this meant that staff were not always sure who was assuming overall responsibility for risk management because it was thought that "someone else would pick it up", and that there were consequently delays in incidents being concluded in a timely manner.
- There was a specialist midwife for risk who was employed to work 30 hours a week. Their role was to lead and advise on risk identification, analysis and management, as well as developing knowledge and skills in relation to good practice and addressing areas of concern that were likely to have an impact on the quality of care provided by both qualified and unqualified staff.
- A monthly governance safety meeting took place within the women's health directorate. We reviewed the minutes for the meetings held between September 2013 and February 2014. There was a process for reviewing serious incidents and for following up any outstanding actions. However, we noted a number of actions that had remained outstanding between meetings.
- A weekly quality forum took place, which was attended by members of the multidisciplinary team. All Datix incidents were reviewed and decisions made as to whether incidents should be progressed to serious incident investigations or required root cause analysis. Some staff raised concerns that, because all preliminary Datix reviews were only carried out by one person, who then presented their recommendations to the forum, this solo review was open to subjective interpretation with little challenge being offered.
- Staff were concerned that there were sometimes delays in serious incident investigations being completed in a

timely fashion, which resulted in delays in action plans and the dissemination of lessons learned. An entry in the women's health risk register on 18 December 2013 identified that a lack of clerical and administrative support had led to delays and a "significant backlog of governance related typing for [serious incidents] and complaints".

- An investigation into the closure of the maternity service on 12 November 2013 was carried out and a report of the findings finalised on 10 February 2014. While there were no lessons learned recorded against the unit closure, two recommendations were made as a result of the review. There was a period of four weeks between the finalisation of the report and the development of a two-point action plan. We found that the implementation of a 'Birthrate Plus' acuity tool had been introduced in April 2014 but a review of the 'escalation to emergency closure of the maternity unit' policy had not taken place to reflect this implementation. Therefore, although a change to practice had been introduced, there had been a delay in the updating of the supporting policies and protocols that were necessary to help support staff.
- Sixteen Datix incident reports dating from September to December 2013 were still under review.
- Two Datix incidents dated 15 November 2013 and 17 December 2013 were still marked as 'In holding area, awaiting review'.
- The maternity dashboard indicated that the ratio of supervisor of midwives to substantively employed midwives was 1:18. The head of midwifery told us that the actual ratio was nearer to 1:13 or 1:14, although we were not given any evidence by the trust to support this.
- The Local Supervising Authority annual report to the Nursing and Midwifery Council for 2012/2013 reported that Medway NHS Foundation Trust had a supervisor of midwives to midwives ratio of 1:12.
- The above report also indicated that the percentage of midwives who had undergone a supervisory annual review during 2012/2013 was 70%.

Leadership of service

- Oversight of the maternity service was by way of three individuals: a general manager, head of midwifery and a clinical director.
- There was evidence that, historically, the head of midwifery had not been fully supported in their role as a leader. They told us that they now felt well supported and had recently been assigned a mentor. The head of midwifery was seen to be liaising with the chief nurse on a frequent basis and it was apparent that they were happy to seek help and support from external stakeholders such as the regional heads of midwifery group and the Local Supervising Authority.
- We were informed by the executive team that the structure of the whole organisation had been reviewed. There was a plan to reduce the overall number of clinical directorates from eight to four; this change had been instigated by the previous executive team. While senior members of the clinical team within the maternity service were well informed of the proposed changes, there was some confusion among the more junior staff members.
- We were told that communication between the midwifery and medical teams had "greatly improved" since CQC had last inspected in August 2013. Minutes from weekly directorate core team meetings demonstrated that there was good engagement from both the midwifery and medical teams in terms of the overall management and leadership of the service.
- There was a range of evidence to demonstrate that the delivery suite coordinator engaged frequently with the allocated supervisor of midwives when there were operational concerns that might have an impact on the quality of care being provided to women using the service.

Culture within the service

- We found that since our inspection in August 2013 there had been a significant improvement in the maternity service. Staff morale was noted to be better and this was clearly attributed to improved working conditions.
- The 22 staff that we spoke with over the two days were all extremely passionate and motivated to move the maternity service forward. Staff were clearly committed to ensuring that mothers-to-be and their birthing partners received care that was of the highest quality.
- The concept of delivering good care was supported by an increase in the number of training days staff had been allocated annually, rising from 4 to 5 full days. Staff spoke positively of the training opportunities available to them.

Public and staff engagement

- The maternity service and NICU were awarded a regional award by UK Mum Awards for 'Maternity Department Miracles' in November 2012.

Maternity and family planning

Innovation, improvement and sustainability

- The standardisation of the maternity dashboard allowed the maternity management team to identify areas of the service that may require improvement.
- The use of a staffing acuity tool was introduced in April 2014. Overall compliance with staff completing the tool was 53% and so the results provided would not have been an accurate reflection on the actual acuity of the department. The general manager had already acknowledged this as an area for improvement.
- The quality of CTG analysis had been identified as an area that required improvement. A revised training package was introduced. We saw that staff accessing the training were continuing to be monitored to ensure they were competent and that there was a consistent approach across the service in relation to the interpretation of CTGs.
- The results from an audit in relation to the higher than expected caesarean section rate recommended the re-introduction of STAN monitoring. There was concern from some senior members of the management team that the introduction of new initiatives may not always be evidence based or offer value for money. We were told that two consultant obstetricians had recently joined the service from a London maternity service that had also experienced a high caesarean section rate; the reduction in caesarean section rates at the London unit was attributed to the introduction of STAN monitoring.
- There was a general concern that the overall financial sustainability of the foetal medicine department was in question. This was corroborated by an entry on the women's health risk register that stated that "The foetal medicine service will be decommissioned if not recognised and fully remunerated." The foetal medicine unit was undertaking an audit at the time of the inspection to determine whether the service offered value for money, and whether practices in the department were evidence based. For example, all women were offered scans at 36 weeks' gestation.
- However, it was clear that, owing to the reasonably short time since we last inspected the maternity service, improvements were not fully embedded and there were concerns regarding the overall long-term sustainability of the service. This was fully acknowledged by the senior clinical team within the directorate.
- We were told by one member of staff that the newly appointed chief executive had recently visited the maternity service and was "fully committed" to maintaining the 1:29 midwife to birth ratio.

Services for children and young people

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

Information about the service

Children's services at Medway Maritime Hospital allowed for elective, emergency and ambulatory admissions. Within the children's department there was an ambulatory assessment unit (Penguin Ward), a 32 bed children's ward which comprised of a two bed high dependency unit and a separate, four bed adolescent bay. Children were admitted for a range of medical and surgical conditions including, but not limited to, general surgery, ear, nose and throat (ENT) surgery and orthopaedics. The children's service also provided "Shared Care" services for children receiving oncology treatments from tertiary services such as the Royal Marsden Hospital and Great Ormond Street Hospital.

Medway Maritime Hospital had a neonatal ward which was categorised as a Neonatal Intensive Care Unit. The level of care provided within this unit allowed for all categories of neonatal admissions aging from 23weeks gestation, and could provide complex and/or long term intensive care support. The neonatal intensive care unit supported a eight cot transitional care unit which was located on the post-natal ward, as well as supporting the regional Neonatal Emergency Transport Service (NTS) for Kent.

The trust had a community children's nursing team which was based on the main site which was supported by a team of nurses. The trust also operated Woodlands Special Needs Nursery which was located in Rainham, Kent. We did not visit Woodlands as part of this service review.

We talked with three children and the parents of six other children who were using the service at the time of the inspection and 18 staff, including care assistants, clerical support staff, nurses, junior doctors, consultants (including the clinical director) and the general manager for the service. We observed care and treatment and looked at six care records in order to track the patient's journey from admission to discharge. We received comments from our listening event, and from people who had contacted us to tell us about their experiences. We also considered information provided by the trust and external agencies.

Services for children and young people

Summary of findings

Care and treatment delivered across children's services was compassionate and based on the individual needs of each child. Children and those close to them such as their parents or carers were involved in the planning of care and treatment and were able to make individual choices on the care they wished to receive. Leadership within the service was strong with a mostly cohesive culture. There was evidence of public and staff engagement as well as innovation within the service.

Services for children and young people followed the trust incident reporting system and demonstrated learning from incidents that took place there. Mortality and morbidity (M&M) meetings were held and staff were able to demonstrate that learning from this meeting was taking place.

The children and young person's service was provided in a clean environment. Emergency equipment was not always checked in line with trust policy and was readily accessible and available. There was good practice around consent and the management of deteriorating patients. Nurse staffing levels in the NICU and on the children's ward were in line with national standards but there were medical staffing challenges due to changes in the provision of training posts.

Children's services followed national evidence-based care and treatment and carried out local audit activity to ensure compliance. The Oliver Fisher Neonatal Unit was recognised as a positive outlier in three of four performance areas in the 2012 National Neonatal Audit Programme. There was good multidisciplinary and multi-professional working.

Are services for children and young people safe?

Good

The directorate responsible for providing services to Children and Young People followed the trust incident reporting system and demonstrated learning from incidents that took place there. M&M meetings were held on a monthly basis in addition to regular quality governance meetings.

Children and neonates were cared for in a clean and safe environment. Where equipment was obsolete, contingency plans were in place to ensure that any emergency situation could be appropriately managed. Age appropriate emergency equipment was accessible and there was evidence that this was checked on a routine basis. There was good practice around obtaining consent from those individuals with parental responsibility, or from those children who had been considered competent to consent to their own treatment.

There were systems in place to recognise and then manage deteriorating patients. Nurse staffing levels in neonatal intensive care and on the children's ward was in line with national standards but there were medical staffing challenges in the NICU due to fluctuations in the provision of medical teaching posts provided by the local deanery.

Incidents

- Staff told us that there was a positive culture towards incident reporting and the subsequent management and investigation of incidents. Staff considered that there were changes to practice following incidents.
- According to the Children's Service Balanced Scorecard for January 2014, there were three serious incidents reported between April 2013 and January 2014.
- There were no reported never-events for children's services between April 2013 and January 2014.
- The trust reported 19 incidents to the National Reporting and Learning Centre between 01 January 2014 and 21 April 2014 which were specifically related to the Neonatal Intensive Care Unit (NICU).
- 5 incidents were specifically related to the mis-calculation or incorrect programming of infusions or infusion devices respectively.

- In response to the increase in infusion rate errors, changes were made to the way nursing staff handed-over their patients between each shift. This included the re-calculation of infusion rates and the review of infusion pump devices to ensure they had been accurately programmed.
- The trust provided us with the incident listing reports from September to February 2014 for children's services. In total, 199 incidents were reported. 1 of these described a death and 7 "Moderate harm – requiring intervention or prolonged hospitalisation".
- 49 incidents specifically related to the management of medications. It was evident from talking with staff and from reviewing the incidents that there was a very positive culture for reporting medication errors.
- The service identified an increase in errors associated with the prescribing and on-going administration of gentamicin. During 2012/2013 the NICU reported 10 incidents attributed to gentamicin in neonates. The trust Quality account for 2012/2013 reported that the target of gentamicin associated areas for the following year (2013/2014) was to be zero.
- Four gentamicin associated incidents were identified during September 2013 and reported as Datix incidents. The service implemented a gentamicin care bundle and has also introduced gentamicin prescription stickers to help reduce the risks of prescribing errors. There were no further reported incidents associated with the use of gentamicin between October 2013 and February 2014.
- We saw evidence of incidence reporting and learning being displayed in staff areas.
- Monthly mortality and morbidity meetings were seen to be taking place. The agenda was structured and there was evidence of multi-disciplinary engagement and discussions taking place.
- It was noted that a senior midwife did not always attend the perinatal morbidity and mortality meeting.

Safety thermometer

- Children's services utilised a "Children Balance Scorecard" to monitor the overall quality and performance of the service. There were key performance indicators for a range of areas including the percentage of patients experiencing harm free care. The target for harm free care within the children's service was set at 97%. The actual percentage as of January 2014 was 99.1%.
- The overall performance for harm free care had been reported as 100% up until December 2013. A neonate had been noted to have sustained a small nasal septum pressure ulcer in January 2014 which had resulted in the reduction of harm free care year to date.

Cleanliness, infection control and hygiene

- The trust reported 2 cases of Methicillin Sensitive Staphylococcus aureus (MSSA) bacteraemia and 2 cases of MSSA positive skin swabs between October 2013 and January 2014. Each of the 4 MSSA cases were identified as having the same strain of MSSA. A clinical microbiology specialist from the Staphylococcal Reference Laboratory at Public Health England suggested that the MSSA strain was not common and that there may well have been a single source for the outbreak.
- We were provided with the root cause analysis (RCA) for the incident which resulted in the death of premature neonate, with a contributing factor being related to the MSSA bacteraemia. The RCA identified that the manipulation of central venous lines may have been a contributing factor to the outbreak. The unit responded by providing medical and nursing staff with revised guidance, education and training in relation to the placement and management of central lines.
- The RCA identified that data from the local "Saving Lives", hand hygiene and environmental audits were all "Very good". This was consistent with the audit data provided to us by the trust.
- A second MSSA outbreak occurred in February 2014 which resulted in the colonisation of 4 neonates, but this time with a different strain of MSSA.
- All staff members were screened to determine whether they were colonised with MSSA; three staff were identified and treated accordingly.
- There have been no further reports of MSSA since the implementation of the new guidance and changes to practice.
- The number of catheter associated blood stream infections (CABSI), based on the total number of cases versus the total number of catheter days was 7.1 for 2013 which was an improvement against the previous year of 9.5 CABSI per 1000 catheter days.
- There were no reported cases of MRSA or C. difficile for the service between April 2013 and January 2014 according to the Children's Balanced Scorecard.

- During our observations of the immediate environment in which children and neonates received treatment and care, we found all areas to be suitably clean.
- Where cleaning took place, domestic staff were using colour-coded equipment items for different parts of the ward.
- We saw that both domestic and clinical staff had readily available access to personal protective equipment including gloves and aprons.
- Hand wash facilities were easily accessible however we noted that there were only three hand-wash basins within the neonatal intensive care unit.
- We observed staff to routinely be decontaminating their hands both before and after patient contacts within the NICU.
- Staff and visitors were observed to be washing their hands before they entered the NICU or special care baby unit.
- Infection control audit data provided to us by the trust demonstrated that in August 2013, the NICU achieved an overall infection control compliance rate of 88%.
- The hand hygiene and PPE component of the NICU audit demonstrated an overall compliance rate of 90%.
- "Saving lives" audit data demonstrated that NICU consistently attained an overall compliance of 100% for the completion of care bundles associated with peripheral venous lines and central line catheters.
- The children's ward were seen to attain compliance of at least 93% between September 2013 and March 2014, with the exception of January 2014 (83%), for the completion of care bundles associates with peripheral venous lines.
- "I'm clean" stickers were seen on medical equipment throughout children's services which indicated that medical devices had been recently cleaned.
- There was documented evidence that clinical equipment such as incubators and cots were deep-cleaned between patient use and a numbered tracking system was in place to allow staff to identify which incubators a specific baby may have been cared for in. This was as a result of the recent MSSA outbreak.
- The domestic staff that we spoke with were knowledgeable and well informed about their role and responsibility.
- An entry on the Children's Directorate risk register, dated 22 October 2013 alluded to the fact that air handling ducts on the Oliver Fisher Neonatal Intensive Care Unit had not undergone routine maintenance and therefore compromised patient safety in the event of the system failing. We were provided with an update during the inspection that the necessary works to maintain the system had been identified, a specialist company had been commissioned and that an action plan would be devised to service each of the three clinical rooms (NICU, HDU and SCBU) at different times so as to allow for business continuity. This work had been agreed as part of a business case to have the neonatal HDU gantry replaced.
- A second entry was made on the Children's Directorate risk register, dated 05 August 2010 whereby sewers located beneath the children's ward on level 2 were regularly overflowing resulting in raw sewage contaminating communal areas of the ward.
- There were two Datix incidents reporting that sewage had leaked from the drains. We were also told by ward staff that the drains had leaked the day prior to our inspection. It was noted from the risk register that the issue had been discussed on multiple occasions at various panels including the local governance committee and health and safety committee. Sensors had been installed to alert staff to any imminent blockage so that the maintenance team could attend to resolve the issue. However, staff reported that to resolve any blockage, the sewer access panels located along the ward corridors were required to be lifted which resulted in the ward being contaminated with the smell of sewage.
- We found that there were systems in place for the corridors to be appropriately cleaned following any leakage and staff told us that they had a good relationship with the domestic staff which ensured that the areas could be cleaned in a timely and effective manner.
- We were told that the children's ward was scheduled to be relocated to another floor in September 2014 and so it was unlikely that any immediate action would be taken to resolve the issue long-term.
- Infection control procedural guidance was available to staff on the intranet and we saw that staff followed guidance with regard to waste disposal, management of bed linen and disposal of sharp items, such as needles and the handling of specimens.

Environment and equipment

- An entry on the Children's Directorate Risk Register dated 27 August 2013 indicated that the manufacturer

of the gantry in the neonatal high dependency unit (NHDU) had issued a "Condemned Notice" in 2007 and therefore would no longer be able to replace any faulty components. The gantry is equipped with medical gases such as oxygen and medical air, as well as providing ports for medical suction. During our inspection we were informed by the clinical director that funding for a business case had been agreed by the executive team on 22 April 2014 which would allow the gantry system and medical monitoring equipment to be replaced.

- We asked staff to explain the contingency plan should the gantry system fail. We were told that the occupation of the NICU rarely exceeded 85% and therefore any baby or neonate requiring continual oxygen therapy would be relocated to the NICU.
- Portable suction and oxygen was also available as an additional contingency in the event of a total failure of the gantry system.
- We were told that each gantry worked in isolation so the risk of an overall failure to the gantry system would be extremely rare and so the overall risk was mitigated. The actions described by the staff we spoke with were consistent with the control measures that had been recorded on the departments risk register.
- We found the Neonatal unit to be equipped with essential items required to support the care and treatment of infants. This included an open-top resuscitaire which was used to provide care and warmth to babies just after birth.
- A bio-medical technician was allocated to the neonatal intensive care unit to oversee and maintain vital equipment such as ventilators.
- We discussed the availability of equipment for supporting a child in the event that they needed ventilation support. The staff member told us that there was a transport ventilator available and if need be a ventilator from the neonatal unit would be used for a baby, prior to transferring to a Paediatric Intensive Care Unit. Staff said that these arrangements worked well.
- There was age appropriate resuscitation equipment available on the NICU and the children's wards. This equipment was seen to be routinely checked. We also found that where children were seen in the out-patients department, appropriate resuscitation equipment was available.

Medicines

- We saw that medicines in each of the clinical areas were stored safely and in accordance with effective medicines management.
- We reviewed six drug charts; medicines were found to be prescribed by registered medical practitioners. However, it was observed that while the drug charts requested the unique General Medical Council licence number for the prescribing doctor to be recorded, this was not seen to be done.
- The drug charts used on the children's ward were considered by staff to contain many pages and could be confusing if a child was admitted for long periods of time.
- We spoke with the pharmacist and matron responsible for the area. We were told that a multi-disciplinary working group had been established to review the current drug chart and that this was a "Work in progress".
- The six charts we reviewed were considered to be clear and concise.
- Staff had access to national formularies such as the Paediatric British National Formulary.
- There were policies and guidelines in place to support staff when prescribing medication such as those used during the intubation of a neonate.
- The NICU was supported by a pharmacist who attended a weekly "Grand round". Staff that we spoke with, including the paediatric safety lead for the NICU considered that greater input from the pharmacy team would ultimately improve patient outcomes.

Records

- Care bundles such as visual infusion phlebitis scores were routinely being used and we saw evidence of this during the inspection.
- The care notes that we reviewed were considered to be well maintained. Notes were filed in clear, chronological order.
- Treatment plans were clearly recorded, and where discussions had been held with parents or those with parental responsibility, these had been documented.
- Nursing notes were seen to be structured and factual and were free from subjective opinions.
- The use of "Five Steps to Safer Surgery" were seen to be routinely used for children undergoing surgical procedures.

Services for children and young people

- There were three reported incidents between September 2013 and February 2014 where incorrect patient details had been entered onto blood samples; these omissions resulted in the child or baby having to undergo further blood tests.
- There were four incidents for the same time period where incorrect patient details had been shared with external stakeholders.

Consent

- Surgical consent forms were seen to be completed to a satisfactory level, with the necessary risks associated with surgery clearly documented.
- The staff that we spoke with demonstrated a clear understanding of consent and parental responsibility. Staff told us that they had access to policies and procedures which could be used to support them when trying to determine whether an individual had parental responsibility for a child.
- The "Looked After Children Health Team" had devised an easy-to-follow flow chart to support staff in relation to Consent and Parental Responsibility for Looked after Children.
- A policy entitled "Restraint Policy for Children and Young People" was available on the trust intranet. The policy was scheduled for review in July 2012.

Safeguarding

- There were discrepancies between the data supplied to us by the trust and of those records held locally by ward managers regarding number of staff who had received training in relation to the safeguarding of vulnerable children.
- The number of staff reported to have undertaken safeguarding children at level 1, within the children's directorate was 69.5% and 49.5% for level 3 safeguarding children training. The trust policy "Safeguarding and Protecting Children Training Strategy" indicates that all staff employed by the trust should undertake level 1 training and that "All paediatric nurses" should undertake level 2 training. The data provided by the trust recorded "N/A" against level 2 training for the Children's directorate.
- Staff had access to the Kent and Medway Safeguarding Children Procedures which was dated from 2007. This multi-agency policy was updated and a more recent version was made available to the public in February 2014. As such, some of the content such as contact details for social services had changed from those listed in the 2007 document.
- Surgical consent forms were seen to be completed to a satisfactory level, with the necessary risks associated with surgery clearly documented.
- There were named safeguarding consultants who were each responsible for covering different geographical areas.
- The trust employed a lead nurse for safeguarding vulnerable children.
- There were two "Safeguarding Children Coordinators" based within the trust. The role of the coordinator was to organise medical reviews for 'at-risk' children, to organise for consultants to attend strategy meetings and case conferences which involve children where-by those children have had direct engagement with the trust by way of clinical treatments, outpatient appointments or visits to the A&E department.
- The number of case conferences involving children had increased from 220 between January and April 2013 to 313 for the same period in 2014.
- Due to the increased work-load, there were 29 children who were subject to an initial child protection plan, for whom hospital staff had not been informed because of delays in the administration process of ensuring those plans had been filed in the relevant medical notes.

Mandatory training

- According to the Children's Balanced Dashboard for January 2014, the overall mandatory training compliance rate for the department was 70% versus an expected key performance indicator of 90%.
- The total number of consultants working within the division who had received a recent appraisal was 94% versus an expected key performance indicator of 90%.
- The total number of non-medical staff, such as nurses and health care assistants who had received a recent appraisal was 71% versus an expected key performance indicator of 90%.
- The number of clinical staff who had undertaken an appropriate manual handling course was flagged red, with an overall compliance rate of 31.8%.

- An entry in the Children's Directorate Risk register dated 13 September 2013 confirmed that there was a dis-parity between the data held locally by the directorate and that held centrally by the Human Resources Team.
- There was a general consensus amongst the staff that we spoke with that accessing the mandatory training modules was often "Difficult" and was "Unreliable". Some staff raised concerns that the actual mandatory training requirements were "Confusing" as they were often being changed at a corporate level.

Management of deteriorating patients

- The trust used a paediatric early warning score system (PEWS) to ensure the safety and well-being of children. This 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.
- We spoke with staff on the children's ward who told us that the care of children was well managed. They said there was good communication between ward-based staff. Data from the Children's Balanced Scorecard indicated that year to date, there had been no incidents whereby the clinical condition of a child had deteriorated to stage which would have been categorised as a serious incident.
- Approximately 70% of staff had received training in paediatric basic life support and 82% of staff had received neonatal basic life support.
- Although the children's ward provided high dependency care, we were told that there were no nursing staff who had undertaken any formal High Dependency Training although this was an area that was being reviewed. Staff were able to access training which was provided annually by the South Thames Retrieval Service (STRS); this helped staff to have an awareness of how to manage and stabilise an acutely unwell child while the regional retrieval team made their way to the hospital.
- We were told that the overall number of children who required retrieval by STRS had reduced in 2013/2014 despite there being an increase in the number of children requiring high dependency care. We were not provided with any evidence to help us corroborate this. The annual STRS report no longer provides a hospital specific break-down on the number of retrievals they carry out and the trust do not collect this data.

Nursing staffing

- Information provided by the trust indicated that as of January 2014, the establishment for the children's directorate was 344.85 Whole Time Equivalents (WTE). This included staff employed to work at the Woodlands Special Needs Nursery and Community Health services.
- The total number of vacancies was 21.48 WTE or 6.23% of the directorates budgeted workforce.
- The number of staff allocated to work on the children's ward is 6 registered nurses during the day. Rotas demonstrated that this was mostly achieved on a regular basis. Where vacancies existed, these were covered by bank staff and on rare occasions, agency staff were seen to be used and it was noted that the same agency staff were booked demonstrating a degree of consistency.
- The NICU had appointed a number of newly-qualified registered nurses. The matron told us they had initially been sceptical of this because of the lack of experience the newly qualified nurses had. However, the NICU education facilitator had devised a support programme which entailed competency based clinical assessments, observed practice and a period of supernumery time to allow staff to embed into the unit.
- All bank and agency staff had received a local induction prior to starting their shift. Evidence of this was seen at the time of our inspection.
- The NICU was allocated a nurse-in-charge each shift who remained supernumery. This meant they could provide managerial and clinical support across NICU, HDU, SCBU and transitional care.
- The number of staff working in the NICU with a relevant, nationally recognised post-graduate qualification in Neonatal Intensive Care was 63 out of a workforce of 86 people (73%) and a further 6 staff were currently studying towards it.
- The nurse staffing ratio for the NICU was seen to be consistent with the recommendation from the British Association of Perinatal Medicine, The Royal College of Nursing and as described in the Toolkit for High Quality Neonatal Services.

Medical staffing

- There NICU was supported by 6 whole time equivalent consultants and eight middle grade, trainee doctors.

Services for children and young people

- Consultant cover was provided to the NICU and SCBU 24 hours a day, seven days a week. The consultant on call also covered the Neonatal Emergency Transport Service.
- The general paediatric service was supported by 7 WTE consultants, eight middle grade, trainee doctors and two foundation year doctors.
- A number of consultants were found to be qualified in paediatric echo-cardiology. However a specialist cardiac service level agreement also existed between Medway Maritime Hospital and Great Ormond Street Hospital who provide foetal cardiac anomaly screening services.
- The service is supported by one full time paediatric surgeon, and two joint appointed (with another provider) consultant surgeons.
- Three consultant anaesthetists were employed by the trust who had experience of paediatric anaesthesia.
- Ward rounds on both the NICU and the children's ward were consultant lead. Ward rounds occurred each day and were structured to allow for multi-disciplinary engagement.
- Prior to our inspection, we had received information from an anonymous source that the culture within the NICU could be construed as "Hostile". We spoke with a range of staff who told us that due to the frailty of some of the more premature neonates, experienced nursing staff would challenge the clinical decisions of the more inexperienced junior doctors. The nursing staff were considered to be highly experienced individuals with whom there was a strong professional relationship with the consultant body. The clinical director and unit matron spoke positively about the ability of the nursing team to challenge clinical decisions, as they considered this approach allowed for a multi-disciplinary care model as compared to a unit which operated a purely medically led approach.

Major incident awareness and training

- There was a Paediatric Major Incident Protocol in-place which had been ratified in September 2013. Consultation of the protocol had included key members of the trust included representatives from the Emergency Department (ED), Adult Medicine, and Paediatric Consultants.
- Senior staff that we spoke with were aware of the Major Incident Protocol and were able to sign-post us to the document on the trust intranet page.
- It was not clear from our discussions with staff that any major incident training had taken place so that staff could rehearse the major incident protocol to allow them to become proficient with its use

Are services for children and young people effective?

Good

Policies and procedures were seen to be evidence based and reflective of nationally recognised best practices. The Oliver Fisher Neonatal Intensive Care Unit operated a donor breast-milk bank which was registered with the United Kingdom Association for Milk Banking.

Both the children's ward and the Neonatal Intensive Care Unit were seen to have positive indicators in relation to patient outcomes. This indicated that patients consistently received effective care. There was evidence of strong multi-disciplinary team working within the various in-patient and community based children's services and neonatal intensive care unit. The Neonatal Intensive Care Unit were also found to have strong working relationships with the Maternity service where examples of good practice were seen such as the shared transitional care service located on the post-natal ward.

Evidence-based care and treatment

- Staff told us and we saw that they had access to a range of policies and procedures on the hospital intranet. Policies were written with reference to relevant evidence based guidance such as that provided by the National Institute for Health and Care Excellence.
- There were detailed policies which were based on guidance from professional bodies. For example, the neonatal resuscitation policy had been reviewed in October 2012 and was consistent with guidance from the Resuscitation Council (UK) 2010 guidance.
- We looked at some examples of the policies available to guide staff and found up to date policies on 'Safeguarding' (with the exception of the out-of-date multi-agency document relating to the safeguarding of vulnerable children), and, 'Modification of the Paediatric Surgical Pathway'.

- However, some policies had not been updated, including the policy titled, 'Consent in Paediatric and Neonatal Care', which was due to be updated in December 2013.
- There was a detailed policy entitled "Paediatric Guidelines" which had been consistently updated to reflect changes in practice. The document provided guidance to all grades of staff but was specifically directed towards consultants. The document included information in relation to the management of children who had sustained burns which enabled staff to provide treatment in line with regional practices. In addition, the guidance had been updated to reflect changes to the way children were managed in cases of bacterial meningitis so that practice was consistent with the recommendations of the National Institute for Health and Care Excellence (NICE).
- We saw from governance minutes that both the medical and nursing teams were engaged in the review and development of clinical policies so that they remained consistent with the latest guidance and recommendations available.

Pain relief

- There was a process in place for ensuring that neonates received oral sucrose as a means of reducing their pain response during procedures such as heel prick blood screening and lumbar punctures. This process was supported by a further guideline for the administration of analgesia and sedation in the neonate.
- Staff that we spoke with demonstrated a good understanding of both pharmaceutical and non-pharmaceutical pain management strategies in the neonate. Their knowledge was consistent with the local policy on pain management.
- Children admitted to Dolphin or Penguin ward underwent an age appropriate pain assessment. We reviewed six sets of case notes which demonstrated that staff were routinely assessing children's pain levels.
- One teenager that we spoke with said "They have managed my pain very well following surgery".
- While the trust had a policy for the pain management of adults, there was no separate guideline for children and adolescents although it was noted in the Acute Pain Management Policy for Adult patients that age specific guidance was being developed.

Nutrition and hydration

- The trust did not directly employ dieticians; this service was provided by Medway Community Healthcare. However, the clinical staff that we spoke with told us that there was a process for referring patients to the service.
- A Diabetes Clinical Nurse Specialist was employed by the trust to support children and young people with managing their diabetes.
- The children that we spoke with described the food as "Okay" and "There seems to be enough of a choice".
- We saw that the neonatal intensive care unit implemented Total Parental Nutrition to those neonates admitted to the unit within the first twenty four hours if their clinical condition was such that they were too unstable for enteral feeds.
- The Oliver Fisher Neonatal Unit operated one of only 15 donor breast-milk banks in the country. The milk bank was a member of the United Kingdom Association for Milk Banking. There was a process in place for the receiving and screening of donor breast milk. This process was supported by a Donor Expressed Milk protocol which we were shown during the inspection.
- There was a local policy available to staff regarding the management or naso-gastric feeding tubes. This guidance had been reviewed in 2014 and was consistent with the best practice guidance issued by the National Patient Safety Agency in 2011.
- Staff on the neonatal intensive care unit were supported with a range of guidance and support regarding the management of nutrition and hydration. Where neonates were born with physical defects such as a cleft lip or palate there was guidance, which had been reviewed in April 2014 which helped support staff to successfully implement oral feeding including support for breast feeding mothers.
- During 2011/2012 (the latest data available), the proportion of babies born at less than 33 weeks gestation who were receiving any of their own mothers milk at final discharge from the neonatal unit was 50% compared with a population average of 58%. This shortfall had been identified by the service and we saw that efforts were being made to improve in this area.

Patient outcomes

- Perinatal mortality, including any stillbirths was reported as 32 versus an expected number of 38.3 for the time period of October 2012 – November 2013.

- The survival rate for neonates who, having been born at 23 weeks gestation and admitted to the NICU was 100% for 2013.
- The total number of days whereby a neonate required ventilator support via a endotracheal tube was reduced from 979 days in 2012 to 829 in 2013.
- The total number of neonatal readmissions was reported as 148 versus an expected number of 238.7 for the time period of October 2012 – November 2013.
- The number of children readmitted to the ward within 30 days following an elective admission was 3.9% versus a KPI of 9.0%
- The number of children readmitted to the ward within 30 days following an emergency admission was 11.9% versus a KPI of 13.8%.
- Children's services submitted a range of data to national audit programmes. This included the National neonatal audit programme, Paediatric Asthma Audit, Childhood epilepsy, National Paediatric Diabetes Audit and the College of Emergency Medicine Audit on Paediatric Fever.
- Data from the 2012 National Neonatal Audit Programme identified Medway Maritime NICU as a positive high outlier in three out of four areas assessed. That is, 92% of mothers who delivered their babies between 24 and 34+6 weeks gestation received a dose of antenatal steroids; 100% of babies who born weighing less than 1,501grams or born at less than 32 weeks gestation, and who remained as an inpatient, underwent ROP screening as per the current national recommendations; finally, there was a documented record that 95% of parents or carers were seen by a senior member of the neonatal team within 24 hours of their babies admission to the NICU.
- The latest available data from the National Paediatric Diabetes Audit demonstrated that Medway Maritime Hospital had seen a reduction in the number of patients admitted into hospital with a diagnosis of Diabetic Ketoacidosis when compared to the previous year.
- The DKA incidence rate for 2011/2012 was 4464.3 per 100,000 children and young people with diabetes versus an upper threshold of 8,297/100,000 and a lower threshold of 2,402/100,000. This meant the trust was performing within the expected range.
- The total number children and young people with diabetes experiencing an episode of hypoglycaemia and who required an admission to hospital was also within the expected range.
- Information available from the Trust Quality Account for 2012/2013 indicated that there had been additional investment in the diabetes service at the trust, with the appointment of an additional paediatric diabetes specialist nurse, increased paediatric dietetic time and additional outpatient clinic slots.
- Data from the Quality Account for 2011/2012 indicated that the trust performance was comparable to national outcomes in relation to the management of children with asthma. It was noted that approximately 75% of children and young people admitted, remained in hospital for less than 24 hours, and none needed intensive care of intravenous therapy to manage their symptoms.

Multidisciplinary working

- There was evidence that multidisciplinary working took place between the maternity service and the Neonatal team. Examples of this included the joint management of a eight cot transitional care unit which was located on Pearl ward. There was a guideline in place which clearly explained the roles and responsibilities of both the neonatal and midwifery care staff. We spoke with staff from both the Oliver Fisher Neonatal Intensive Care Unit and Pearl ward. Both staff groups were complimentary about the working arrangements of transitional care and they considered that the service worked well.
- We spoke with two mothers who were using the transitional care service at the time of our inspection. They both told us that there was good communication with both the neonatal and midwifery service and that both services involved the mothers in the management of their babies.
- Minutes from the monthly perinatal meetings evidenced that there was good attendance from both the Obstetric and Neonatal Teams. The meeting allowed for discussions to take place regarding any imminent high risk pregnancies which would potentially impact on both the neonatal and obstetric service.
- Staff reported a positive relationship with the pharmacy and physiotherapy team. Of note, the physiotherapy team were held in high regard and were described as being "Excellent".
- Some staff raised concerns about the limited of availability of a pharmacist to support the NICU. They considered that increased pharmacy presence on the NICU would help to improve patient outcomes and patient safety.

Services for children and young people

- The trust did not directly employ dieticians; this service was provided by Medway Community Healthcare. However, the clinical staff that we spoke with told us that there was a process for referring patients to the service.
- A review of the diabetic transition clinic was carried out in 2013. Adolescent diabetes clinics are currently held to support people aged from 16 years through to 25 years of age. The clinic is supported by both a paediatrician and adult physician. Transition to adult services
- There was a consistent theme that access to child and adolescent mental health services (CAMHS) was often difficult due to a poor provision across the region. CAMHS services were commissioned to a third party organisation.
- There were mixed responses regarding the relationship between the children's ward and the children's emergency department. The medical team spoke positively about the relationship they had with the ED, with one paediatrician acting as the lead.
- The nursing staff we spoke with on the children's ward were less positive about the relationship they had with the ED, with some members of the nursing staff stating that they would not want to work in the ED and that they "Preferred for acutely unwell children to be fast-tracked to the HDU on Dolphin ward" because the ED was not an appropriate environment.

Seven-day services

- Dolphin ward is an acute paediatric inpatient ward that has 28 beds inclusive of seven side rooms and two high dependency beds. The service operates twenty-four hours a day, seven days a week and is fully supported by a multi-professional team. Consultant Paediatricians are available out of hours by way of an on-call rota system. Consultant lead ward rounds are run each day.
- Dolphin ward is supported by the Penguin Assessment Unit. This unit is also open 24 hours a day and offers a service whereby children can be assessed by a paediatrician after having been referred from external health care professionals. Children under shared-care support agreements are also able to attend Penguin unit.
- The physiotherapy department offer a full service Monday to Friday to the Women and Children's Directorate. Outside of normal working hours, the department offers an emergency respiratory service to the paediatric department although it was acknowledged that not all physiotherapists who covered the emergency on-call service were specialists in paediatric physiotherapy.
- The provision of paediatric surgical care could only be provided during working hours Monday to Friday on a predominantly elective basis, with limited capacity for non-elective surgical procedures. Surgical cases admitted to the children's ward out-of-hours were routinely referred to the adult specialities such as orthopaedics and the general surgical team for management. The directorate acknowledged that expansion of the paediatric surgical service would be necessary in future years.

Are services for children and young people caring?

Good

Patients and family members spoke positively about the care and treatment they received. The Children's service was not subscribed to Friends and Family Test but the service sought feedback from patients by other means such as comment books.

We observed staff engaging in a positive way with children and their family members or carers. Children told us that they felt involved in the care they received, and they told us that where applicable, they were able to consent to their own treatment and care. Although there was no formal bereavement service available to family members, staff were seen to adopt this pivotal role in order that they could provide the necessary emotional support to families during difficult times such as palliative care. The service would benefit from a more formalised bereavement service in order that they can provide a more consistent service in the future.

Compassionate care

- There were five comments made on NHS Choices regarding the Children's and Adolescent Service at Medway Maritime Hospital.
- Each awarded the Children's and adolescent unit "Five stars" with the exception of one person who awarded the service "Four stars" due to a poor experience in the ED.

Services for children and young people

- Comments included “They [the staff] could not have been more caring and professional”, “The staff treated me with the upmost respect and the play leaders always made sure my son had toys to play with” and “The staff are compassionate and caring”.
- During our observations we saw staff interacting with children in an age appropriate manner and communicating with parents in a caring and compassionate way. Information was given in response to questions and staff took time to engage with both children and adults during the course of their duties.

Patient understanding and involvement

- We talked with three children and the parents of six other children during our inspection. The mother of one child said “We were admitted via the Penguin Assessment Unit. We have received excellent care so far. The staff have been very good when communicating with us. We know exactly what is happening and why they are happening”.
- Another parent said “The doctors and nurses have been very supportive. We were involved in the ward round so we know what the treatment plan for today will be”.
- One teenager that we spoke with said that “The surgeon did not inspire me with confidence. However, the rest of the team have been great. They have managed my pain very well.” We were told by the teenager and their parent that they had been fully involved in their care and treatment.
- The parents and children that we spoke with were able to identify who their named nurse was for the day but one parent said “They are all happy to help so even if I can’t find my nurse, I know I can ask anyone”.
- Treatment plans were clearly recorded, and where discussions had been held with children and/or their parents or those with parental responsibility, these had been documented.

Emotional support

- There was no formal bereavement resource available within the directorate to support parents, families and staff.
- There was information available to people such as contact details for the local Kent Stillbirth and Neonatal Death Charity (SANDS).
- Children requiring palliative care would be referred to a local children’s hospice to plan end-of-life care. Some children would continue to be supported at home by COaST if the child and family chose not to engage with external agencies.
- Chaplaincy services were offered by the hospital.
- Ward based staff told us they could access clinical nurse specialists for advice and support. It was further acknowledged that the role of the CNS was to support children and their families.
- The safeguarding team informed us that the number of children requiring CAMHS input had increased, and continued to increase on an annual basis. The provision for CAMHS was reported to be poor in the area.

Are services for children and young people responsive?

Good

The service was found to be responsive to the needs of the local community. Despite a significant increase in the number of neonates receiving care and treatment in the Oliver Fisher Neonatal Intensive Care Unit over the last ten years, appropriate planning and unit design had enabled the NICU to absorb the increase with a degree of flexibility to accept additional cases in the future. However, it was evident that the directorate were aware that the local population was likely to increase in the future, and as such were responding to this increase by considering the future design and functionality of the NICU.

There were many positive examples of how, as an integrated service, children’s services were able to meet the ever increasing and more complex needs of children in the local community. Such services were seen to have a positive impact on the local population, with reductions in the number of children with co-morbidities and complex needs being admitted into the hospital.

Service planning and delivery to meet the needs of local people

- Both Dolphin and Penguin wards were staffed to a minimum ratio. This meant that the service could operate to full capacity at any time without the need to source additional staff. Where the needs of children increased, we found that additional staff could be sourced to meet the needs of children using the service.

Services for children and young people

- We reviewed the Datix incident reports for the Children's Directorate to determine whether any of the children's unit were required to close as a result to them being at full capacity or because or staff shortages. We found that two women were required to be re-diverted to another hospital because the special care baby unit was at full capacity and had been forced to close for a short period of time to allow for discharges to take place and to create additional capacity.
- There were no unit closures reported as a result of staffing concerns. Furthermore, there were no staff related incidents for the Children's Health Directorate between September 2013 and February 2014.

Access and flow

- Bed occupancy across children's services was reported as 66% year to date against an expected annual target of 90%.
- The overall occupancy for the Oliver Fisher Neonatal Unit was 83% for 2012/2013; Intensive care was operating with an occupancy rate of 83%, High Dependency Unit 108%, Special Care at 82% and transitional care 72%.
- The total number of babies admitted to the Oliver Fisher Neonatal Unit for 2012/2013 was 951; this was a reduction of 26 babies on the previous year.
- The average length of stay for elective patients fluctuated between 1.00 and 2.43 days between September and December 2013, with an overall average year to date figure of 2.54 days.
- The average length of staff for non-elective (emergency) admissions fluctuated between 0.66 and 1.64 days between September and December 2013, with an overall average year-to-date figure of 1.02 days.
- The percentage of admitted patients who received treatment within 18 weeks of being initially referred was 99.6% against a target of 90%.
- The percentage of non-admitted patients who received treatment within 18 weeks of being initially referred was 99.61% against a target of 95%.
- The number of patients who were booked for elective day-case paediatric surgery but who subsequently were required to remain overnight totalled 9 between April and December 2013.

Meeting people's individual needs

- The trust operated a community nursing team specifically to support children and young people with learning disabilities.
- The trust also operated a Children's Outreach and Specialist Team (COaST). COaST consisted of a team of nurses, carers and a specialist social worker whose role it was to provide an outreach service to children with life threatening and life limiting illnesses, aiming to keep children out of hospital as much as possible. The COaST comprised of but was not limited to a Clinical Nurse Specialists for Diabetes, Oncology and Respiratory. The outreach service was only supported by one Band 6 sister and so the service could not be operated seven days per week.
- Ward staff spoke positively about their engagement with both of the community based teams. Examples were given of how the community team had helped to reduce the number of admissions some patients had historically experienced as they could be supported in their own homes as compared to being admitted to the hospital ward.
- The consultant team also informed us that they could refer children to the Attention Deficit Hyperactivity Disorder (ADHD) Nursing service whose role it was to support newly diagnosed and existing children and their families.
- Over 5% of the local population were from diverse ethnic groups. We found that information leaflets were not readily available in other languages or formats and this was reiterated by the staff that we spoke with. However, staff spoke positively about the availability of interpreter services with contingency plans in place to utilise telephone interpreting services if a face-to-face interpreter could not be sourced.
- There was an adolescent games room attached to Dolphin ward; this was seen to be equipped with age appropriate equipment such as a pool table. This area offered older children and adolescents a place to go while they were receiving in-patient care or treatment.

Learning from complaints and concerns

- Children's services had received a total of 25 complaints year to date (April 2013 – January 2014). It was noted that there had been a peak in the number of complaints received during January 2014 with a total of 7 complaints being recorded.
- Complaints were discussed at the monthly Children's Governance Meetings where trends were considered to resolve areas of concern.

Services for children and young people

Are services for children and young people well-led?

Good

There was a strong clinical and nursing leadership structure within the directorate. Staff spoke positively about working at Medway Maritime Hospital. Improved recruitment within the Neonatal Intensive Care Unit had a positive impact on the working conditions of staff within the unit.

Senior staff who were allocated lead roles spoke passionately about the importance of such roles, and it was apparent that the staff were committed to improving the level of care they provided to the local population.

Both the NICU and Children's services were seen to actively participate in national and local research in order that long-term standards of care for children could be improved.

Vision and strategy for this service

- Each of the staff that we spoke with were passionate about enhancing children's services. There was a consistent theme that the provision of a formal bereavement service and a palliative/end-of-life care service were fundamental to the future of children's services.
- While there were local provisions for seeking feedback from patients and families, children's services were not subscribed to the Friends and Family Test. Both senior and junior members of the children's team were positive about the wish to receive feedback from people using the services they provided. This had been noted within the Children's Directorate Governance meeting in February 2014.
- There were concerns that the provision for community based child health services were under-funded due to being over-subscribed. A joint strategic review of the community service was required to ensure the service remained sustainable in the long term.
- The Neonatal Intensive Care Unit continued to be involved in national research projects and was continuing to perform well according to the data from the National Neonatal Audit Programme. We noted from the quality report for 2012/2013, and having spoken to the clinical director and matron for the service that the NICU were "not resting on their laurels" and were keen to lead in the innovation and overall improvement of the provision of neonatal intensive care services.

Governance, risk management and quality measurement

- There were monthly departmental governance meetings which were structured in line with the five domains; safety, effectiveness, caring, responsive and well led.
- These meetings were well attended by a range of health care professionals from both the neonatal intensive care service and the general paediatric team. Representation was also made by the Community Paediatric Team.
- There were two consultant paediatricians who were assigned as the governance leads for general paediatrics and community child health respectively.
- Risks that appeared on the children's directorate risk register were seen to be reviewed at the monthly governance meeting. Where actions were required, key staff were identified to take owner-ship of the action although it was not clear from the minutes provided to us whether appropriate time-scales were set against each action point.
- There was a process in place for ensuring that where new guidance had been issued by external organisations such as the National Institute for Health and Care Excellence, these were discussed at the governance meeting and actions recorded if amendments to policies were required.
- We saw that the Children's service responded effectively to serious incidents and learnt lessons from those events. For example, the recent MSSA outbreak within the NICU triggered a range of changes in practice from the screening process through to the review of central line insertion and subsequent management.
- The Quality Report for both 2011/2012 and 2012/2013 demonstrated that the lead nurse for children's services presented key performance data to members of the board. Where service improvement was required, it was evident that the necessary action plans had been developed to support any relevant business case.

Services for children and young people

Leadership of service

- Each of the three internal divisions of children's services (NICU, General Paediatrics and Community Child Health) were well led. Staff had clearly defined roles and responsibilities which demonstrated good leadership across the division.
- Staff considered that while there was good leadership from within the children's directorate, there was little understanding of paediatric services within other hospital departments and at executive level. Staff consistently referred to children's services as working "In a silo" from the rest of the trust due to the poor understanding of the service.
- The consultants that we spoke with raised concerns regarding the constant changes that occurred at executive level and that the changes meant it was harder to achieve overall stability for the organisation. There was some frustration that the changes in the executive team had led to delays in a number of key business cases being approved.
- It was noted that due to the changes in the organisational structure of the trust, the women and children's health directorate would be assigned one clinical director, who was a consultant obstetrician. The role of the current clinical director for children's services was due to be dissolved in May 2014 although a clinical lead role would remain. There was some concern that these changes would further result in children's services being isolated from the rest of the trust as there was to be no voice for children on the trust board.

Culture within the service

- Staff at all levels, were positive about the support they received from consultants on the wards and senior managers.
- There were monthly ward meetings, team briefs and online information to ensure staff were kept informed of developments in the trust.

Public and staff engagement

- Local arrangements were in place to seek feedback from children and their families. These arrangements included a local comments book and also the introduction of a six-monthly patient feedback survey.

Innovation, improvement and sustainability

- The neonatal intensive care unit were participating in five national research programmes at the time of our inspection. They had provided data to a further three completed research studies in 2013 ranging from The Preterm Prebiotic (PIPS) Study to the "Amino Acids regimen and intravenous lipid composition in preterm parenteral nutrition: a trial of nutritional evaluation and optimisation in neonates (NEON) study.
- The NICU had completed 6 audits during 2013 and 9 other audits were still in progress.
- The NICU actively used hypothermic therapy in the management of neonates presenting with Hypoxic Ischaemic Encephalopathy (HIE). 15 neonates were actively cooled in 2013. 20 babies born with HIE were discharged from the Neonatal Intensive Care Unit, with 19 babies on oral feeds and one discharged on naso-gastric feeds.
- The neonatal and paediatric outreach community team operated a seasonal RSV clinic; the total number of children benefiting from this clinic had increased from 11 ex-premature babies in 2011 to 21 in 2013 with an additional 7 children being vaccinated due to being on long-term ventilation or at the discretion of a consultant.
- The neonatal intensive care unit operated an outreach service. The purpose of this service was to enhance the discharge pathway for a range of neonates who were admitted to the NICU. We found that some neonates could be discharged earlier than anticipated because parents were supported by the outreach service. The service carried out 244 home visits in 2013. 10 babies, who had been discharged from the Oliver Fisher Neonatal Unit in 2012, having been oxygen dependent, were subsequently weaned off oxygen by the outreach service during 2013.

End of life care

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

Information about the service

Medway Foundation Trust employ an End of Life (EOL) Clinical Nurse Specialist(CNS).The hospital have access to the Hospital Palliative Care Team(HPCT), which is provided by Medway Community Healthcare that provide services to all clinical areas across the hospital, working in an integrated manner with the EOL CNS. The EOL care CNS is supported by the HPCT which consists of Palliative Care Consultant, four Palliative Care Clinical nurse specialists and secretary/multi-disciplinary team (MDT) coordinator.

The EOL care CNS was available four days per week and the HPCT were available Monday to Friday 9 to 5pm. Out of hours the Wisdom hospice provided advice and support regarding palliative care. The palliative care consultant was onsite at four sessions per week and outside of these hours EOL care was provided by junior doctors within the hospital.

We visited a variety of Wards across the trust including Milton, Tennyson, Gundolf, Lawrence, Dickens, Will Adams and Ocelot Wards, Intensive Therapy Unit (ITU), Accident and Emergency (A&E) ,the patient affairs office, Mortuary and hospital chapel. We reviewed the medical records of six patients at the end of life (EOL) and observed the care provided by medical and nursing staff on the wards. We spoke with four patients receiving end of life care and their relatives, received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed other performance information held about the trust.

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

End of life care

Summary of findings

The EOL care CNS demonstrated a high level of evidenced based specialist knowledge and worked effectively in conjunction with the HPCT. 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. In 2013/2014 a total of 804 referrals were made to the EOL CNS and HPCT. We saw evidence that urgent referrals were seen on the same day and medicines were provided in line with guidelines. They held a comprehensive weekly multi-disciplinary team (MDT) meeting. They had a fast track discharge process to meet the wishes and preferences of patients on EOL care.

DNACPR forms were not consistently completed and processes for completing mental capacity assessments were not clear or robust. The DNACPR decision were not consistently discussed with patients or families.

We observed the EOL care CNS and the HPCT support and provide advice to other staff and they were highly regarded across the trust. They had development and end of life care plan and package providing a holistic approach to patients receiving palliative or EOL care. Patients and families told us staff were caring and compassionate and treated patients with dignity and respect.

Are end of life care services safe?

Requires Improvement

Medicines were prescribed and given appropriately, and incidents related to EOLC had been learnt from and practice changed. The mortuary area was clean, and staff there were up to date with their mandatory training.

The Hospital had guidance in place around the completion of the 'do not attempt cardio- pulmonary resuscitation' (DNA CPR) forms. However, our findings showed that DNA CPR forms were not consistently meeting with this guidance across the hospital and Mental Capacity Act adherence and processes were disjointed and seemingly poorly understood. In addition there was a disparity between what was reported to be available in terms of EOLC training by the EOLC team and by what was perceived by the frontline ward staff. Few staff we spoke to stated that they had received specific training outside of their induction.

Cleanliness, Infection control and hygiene

- The mortuary viewing area we visited was clean. We were told by the mortuary manager that the mortuary staff cleaned the areas twice a week and this was confirmed in the cleaning rotas we saw.
- We saw that ward and departmental staff caring for patients on EOL care pathway were bare below the elbow and that personal protective equipment (PPE) was available for use by staff
- We observed on Tennyson and Milton Wards staff sanitised their hands between patient contacts and wore aprons and gloves when they delivered personal care to patients.

Staffing

- Medway Maritime Hospital employed a Clinical Nurse Specialist (CNS) with a specific remit for EOL care. The CNS worked full-time hours over 4 days per week.
- The EOL care CNS is supported by the HPTC, which is a team provided by another provider not inspected during this inspection. The HPTC team consisted of a Palliative Care Consultant (who works 4 sessions per week in the hospital but is contactable at the Wisdom Hospice at other times), four palliative care CNS's and 1 secretary.
- 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 EOL care pathway and if staff numbers were increased to support patients with a high level of need. They stated that a recent workforce review had been undertaken to increase qualified nurses on the wards.
- On the Medical Assessment Unit (MAU) we found the ward was very busy and regularly provided care for patients requiring EOL care patients with support from the HPCT and the EOL CNS. Staff told us that it was 'difficult to manage patients at times'. Staffing levels had improved lately but 'they were still not ideal'.

Medical Staffing
- Medway Community Health provided a Palliative Care Consultant (shared with Wisdom Hospice) in the hospital 4 sessions per week but was contactable at the hospice during the rest of the week and during times of absence the palliative care consultant at the hospice would cover this post.

Incidents
- The mortuary manager was able to describe the reporting process when an incident occurred which included reporting on the Datix system and an example of where practice had changed as a result of incident reporting. They described the steps taken to prevent further similar incidents occurring, which included the retraining of staff and more checks being performed on the wards.
- This had resulted in no similar incidents occurring since January 2014. We were told the trust medical director was now monitoring mortuary related incidents quarterly.

Medicines
- Within the EOL care plan the medication for patients was comprehensively set out covering the symptom management of patients that received EOL care. The guidance was clearly set out and presented in an easy to follow manner .We spoke with medical and nursing staff that were able to show us the guidance.
- We were told by the ward managers on Tennyson and Milton Wards that medication for EOL care was available on the wards and was easily accessible.
- The Ward manager on Tennyson Ward was confident in the ability of the nursing staff to care well for EOL patients with syringe drivers with support from the EOL care CNS.
- On Tennyson Ward we were told that the EOL CNS and HPCT team would advise on the medication for syringe drivers. We observed the ward manager and RN dispense the prescribed drugs for the syringe driver along with the appropriate checks for an EOL care patient on the ward.
- Staff were knowledgeable about the need to review medication during EOL care.
- As the result of two medication errors across the hospital in the past, Midazolam was no longer available on the Wards for EOL care patients. From the root cause analysis undertaken following the incidents, recommendations were made which resulted in all Midazolam being removed from the wards.
- All patients on an end of life care pathway were discharged from hospital with a 'crisis medication pack' and advice sheet. This ensured that patients on EOL care had all their medication prescribed and available to them on their discharge from hospital which ensured streamlined care was maintained.

Records
- On visiting the Patient Affairs Officer (PAO) we saw that systems were in place to process Death, Burial and Cremation certificates. We were talked through the process by the PAO who showed us what the role involved.
- We reviewed one set of medical records and found the necessary information the PAO required to support the process. We found the medical records were fragmented and difficult to follow. Finding information to complete the documentation took time as there was no evidence of summary sheets for easy access. We noted loose paperwork which could be easily lost.
- Across the wards we visited we found evidence that the EOL CNS entered daily reviews in the patients' medical records. This gave information around changes in the patients care needs and medicines management. Frontline staff on the wards would implement the changes as required such as placing syringe drivers in place.
- Patients receiving care from the EOL CNS had their documentation kept in the patient red folder in which the EOL care documentation was kept along with other documentation. This was updated daily when the patient was reviewed by the EOL CNS.
- The Hospital had guidance in place around the completion of the 'do not attempt cardio-pulmonary

resuscitation' (DNA CPR) 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.

- While visiting the ward areas, we checked 12 medical records containing DNA CPR forms. We saw that all decisions were recorded on a standard form at the front of the notes.
- However, there were variations in the completeness of the forms across the hospital; we found that two forms had been signed by the Senior House Officer several weeks ago, which had not been countersigned / reviewed by a senior or consultant.
- On Tennyson Ward we found conflicting information on which patients had a DNA CPR in place. Out of date handover sheets were being used and different handover sheets were used by doctors and nurses; the nurse's handover sheet said beds 1, 2 and 3 had DNA CPR and the doctors handover sheet stated beds 4, 5 and 6 had DNA CPR in place.
- We saw evidence in two patient's medical records of completed DNA CPR forms which had come in with the patients and were kept with the patients. No review date was evident in either form.

Mandatory Training

- We were shown the adult and safeguarding training, which the porters received. This consisted of two sheets of written information. No practical class room lessons were given. The porters were asked to sign the training form to confirm the training had been undertaken.
- Mortuary staff told us that mandatory training was up to date except for two outstanding training courses by two members of staff. This was confirmed on the training matrix. We were told that one member of staff had the opportunity to visit another hospital to develop further skills in paediatrics.
- We saw evidence that mortuary staff had appraisals performed yearly with Personal Development Plans. We were told that objectives were set and we saw two members of staff were on management courses and one staff member was on an anatomical technology course.
- 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 to 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 we spoke with told us that their mandatory training was up to date. Mandatory training included adult and child safeguarding, fire, infection control, manual handling and mortuary training. We were unable to confirm that all the training had been undertaken during the inspection.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- There were no consistent systems or processes evident around completing MCA assessments. Staff could not tell us the correct procedure. We asked 2 junior doctors, no one was able to provide evidence, and no documentation was evident in the patient's medical records. This meant that the correct procedures had not been followed to protect vulnerable people.
- On Tennyson Ward we found that procedure had not been followed and saw that a DNACPR had been made without the patient's knowledge. We were told that no MCA assessment had been performed. We saw that consent had been received from the patient so an invasive procedure could be performed. Conflicting information was therefore in place surrounding whether the patient had or had not capacity. At no point had a MCA assessment been performed during the patients stay.
- We observed a best interests decision being made by the specialist palliative care and the medicine medical team where a patient that lacked capacity required medication to manage symptoms effectively and no relatives were present .The syringe driver was attached to manage the patient's symptoms and provide as much comfort as possible to the patient. We were told by the ward manager that the relatives were expected in in the afternoon where they would be informed of the decision.
- On Milton Ward we were told that there are two levels Mental Capacity Assessments. The first type can be completed by the nursing staff and are used around delivering basic care. The second type covers complex needs and is completed by medical staff. While on the

ward we saw one MCA assessment completed for basic nursing care but we saw no evidence of MCA completed by the medical staff around complex decisions such as DNACPR forms.
- Two of the twelve DNA CPR forms we looked at stated that patients did not have capacity to make this decision. However there was no evidence of a formal capacity act undertaken.

Are end of life care services effective?

Requires Improvement

We saw evidence across all the wards and departments we visited that the EOL CNS and the HPC team supported and provided evidence-based advice to other health and social care professionals. Alternative end of life care guidance had been developed in response to the national withdrawal of the Liverpool Care Pathway. This was currently being piloted on several wards prior to widespread use.

We were concerned about the apparent lack of EOLC training that had been undertaken for frontline staff. We saw that the EOL CNS, with support from St Christopher's Hospice, had reproduced a competency framework to support health and social care staff to assess their own skills in EOL care. The competencies covered level one to level four. However during our inspection we did not find any members of staff who had undertaken the competencies.

Use of National Guidelines

- The National End of life Care Strategy (2008) published by the Department of Health, set out the key stages of 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 end of life care should look like for adults diagnosed with life limiting conditions. The hospital had implemented NICE Quality Standards for Improving Supportive and Palliative Care for adults with the introduction of an EOL CNS and the HPCT.
- We saw evidence across all the wards and departments we visited that the EOL CNS and the HPC team supported and provided evidence-based advice when caring for patients reaching the end of life (for example, on complex symptom control).
- The EOL CNS and the HPCT had introduced systems that enhanced the quality of life for people with long-term conditions, with the introduction of the EOL care pack which encompassed the NICE Quality Standards 13. The pack included anticipatory medication algorithms to help prescribing most appropriate medication for patients who are dying, Mental Capacity Act Assessments, patient feedback form, patient information leaflet, concession parking form, cedar room information and Spiritual and a pastoral support leaflet.

Care Plans and Pathway

- The EOL CNS told us that the new end of life care plan had be developed and approved by the End of life Steering Group been and was being piloted on seven wards across the hospital. We saw evidence of the care plan in use on Tennyson and Milton Ward.
- The Department of Health (October, 2013) expects hospitals to phase out the Liverpool Care Pathway (LCP) by July 2014. In response the hospital had developed an end of life care pathway and updated the "End of life Care Policy" which gave guidance to staff and ensured that care was delivered in line with the NICE Quality Standard 13.
- Within the policy one of the aims was 'to ensure that care of the dying person is informed and supported by an individual end of life plan.' We were told that prior to patients being placed onto EOL care plan, a consultant would discuss it with the patient/family and multidisciplinary team (MDT). The discussion would be documented in the care plan a communication sheet requires the consultant to document the discussion with the patient and or family along with a register of signatures of all the healthcare professionals that provided care. There was evidence that this was being completed by the medical staff on the wards visited.
- Following referral to the EOL CNS, patients on the EOL care plan were reassessed daily to ensure the EOL care plan remained appropriate to the patients care needs.
- On Tennyson Ward, we spoke to RN who told us that they had one patient on EOL care. Patients would be offered a side room if they preferred and the EOL care plan would be commenced after discussions with the MDT, patients and relatives.
- We were told by ward staff on the pilot wards that they were familiar with the EOL care plan and felt 'well supported by the EOL CNS.'

End of life care

- We were told by the EOL CNS that there is no involvement in maternity services but the hospital had just employed a midwife to provide support. In paediatrics, systems were in place to support EOL care but there was no coordinated approach across the hospital.
- On visiting the Intensive Care Unit (ICU) we saw comprehensive systems and processes were in place to support patients requiring EOL care which included, 'the withdraw of treatment protocol.' We were told that clinicians were confident to make decisions about withdrawing treatment, initiating DNACPRs and EOL treatments and that this happened promptly.
- We were shown and told that the withdrawal of treatment form, which was used to document decisions about withdrawing treatment, included information such as an assessment of mental capacity, discussions with family and organ donation. The form specifies the treatment to be withdrawn. We checked one set of medical records where we found a form that was filled in and well recorded.
- We were told that the withdrawal of treatment form is used if the patient is expected to die within 24 hours otherwise ICU use their own adaptation of the LCP. We did not see evidence of their adaption of the LCP during our visit.
- The Mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger type book that contained the required information. We observed that the book was completed.

Training in EOLC

- We saw the objectives set for the HPCT 2013/2014 was to 'organise and provide education to qualified staff at Medway Foundation Trust' The training records identified that palliative and EOL care training was delivered to student nurses, a new CNS to the trust, allied health professionals, senior sisters and clinical support workers. The training covered areas of palliative and EOL care including teaching of symptom management, patient reviews, and communications, recognising dying and basic nursing care. However training records showed no evidence of frontline RN on the wards receiving training. This was backed up by staff we spoke too in all the wards we visited. The largest professional group that had received training were student nurses.
- In A&E an RN told us that they were aware of the palliative care team 'but had received no training and not much else'. Another RN told us that they had received no training on EOL care and 'had no idea about bereavement and how to support relatives so would just gave the leaflet '.
- We spoke to the ward manager on Tennyson Ward who told us that the EOL CNS does informal training to meet needs on the ward when requested.
- On Milton Ward we found a palliative care link nurse who had undertaken a 6 week training course around palliative and EOL care. We found no evidence in other wards of palliative care link nurses during our inspection.
- We found no evidence across the wards we visited that staff received training in communication, bereavement, spiritual issues of patients and culturally specific issues around death.
- We saw evidence across all the wards and departments we visited that the EOL CNS and the HPC team supported and provided evidence-based advice by undertaking training. Training records confirmed that in January 2014, clinical support workers were trained in recognising dying, basic nursing care, recognising symptoms and communication.

Multidisciplinary working

- The HPCT and the EOL CNS are involved in a multidisciplinary team (MDT) meeting every Wednesday morning. The MDT coordinator arranged the meeting to ensure that all patients under the HPCT and the EOL CNS were discussed along with patients that had passed away during the week. This ensured that a multidisciplinary approach to care was received by all patients.

Are end of life care services caring?

Good

On most wards we observed compassionate and caring staff that were doing their best in sometimes difficult circumstances to provide caring and dignified EOLC.

Patients and relatives were mostly complimentary about the care that they had received.

End of life care

A Children's Bereavement Service had been set up in the ICU for the children of patients who die on ICU to help them with their bereavement. The team had also developed a local Bereavement Survey to access the care received during the relative's time in hospital. The survey was based on the National Bereavement Survey and had been through the appropriate governance process in the hospital before being implemented.

Compassionate care

- Staff said end of life care was sensitive and caring. We were able to talk to families of patients receiving end of life care and feedback was positive.
- During the Inspection we observed a patient and relative having a consultation with the HPCT nurse. We observed that the nurse spoke in a professional, sensitive, caring manner giving advice on the discharge process, medication, information regarding the hospice and signs and symptoms to expect. The HPCT nurse gave reassurance and told the relative what would happen next. The consultation was conducted in a caring and sensitive manner.
- The relative thanked the HPCT nurse for the 'brilliant hard work' undertaken to get a rapid discharge in place.
- On visiting the Intensive Care Unit (ICU) we spoke to a family about the EOL care their relatives was receiving. The family told us the staff were "attentive and compassionate" and that their relative had received '5 star treatment."
- The family on ICU told us they gave the team caring for their relative who was on EOL care pathway, a 'glowing tribute and feel that the family have been looked after fantastically'. Communication is 'fantastic.'
- We were told by staff on MAU that they tried to their best to ensure dignity and respect was maintained at all times but it was often difficult as they only had one side room that could be used for patients on an EOL care pathway.

Patient understanding and involvement

- The EOL CNS had developed a local bereavement Survey to assess the care received during the relative's time in hospital. The survey was based on the National Bereavement Survey and had been through the appropriate governance process in the hospital before being implemented.
- The Bereavement survey was given to relatives when the death certificate is issued by the Patient Affairs Officer (PAO). The EOL CNS analyses the results which are sent to the specific ward areas. Any areas of concern will be highlighted to the ward manager who will take the Lead in resolving any issues. The survey results are reported quarterly to the trust Quality Committee.

Are end of life care services responsive?

Requires Improvement

The trust provided face to face care for patients at the end of their life between the hours of 9-5pm Monday to Friday only. Outside of these hours, the local hospice could be contacted by the on call teams for telephone advice and support.

Systems were in place to facilitate the rapid discharge of patients to their preferred place of care. We were shown examples of how staff had ensured that they had adhered to a patient's wishes at the end of their lives.

Access

- All patients within the trust, requiring palliative or EOL care had access to the HPC team, 5 days a week, Monday to Friday, 9am to 5 pm, outside hour's frontline nursing and medical staff could contact the Wisdom Hospice for support and advice.
- The EOL CNS was available 4 days a week. When not available the EOL CNS is covered by the HPCT. This ensured that patients received consistent care from the Specialist Palliative Care team while in hospital.
- We were told by the EOL CNS and HPCT they received on average 100 referrals per month.
- We were told by a staff member in the Emergency Department that they knew how to access the EOL CNS and HPCT if required and would actively involve them in EOL care patients.
- We reviewed two sets of medical records of patients on EOL care pathway on the MAU. The patients had only been admitted on that morning so no EOL care assessment had been made. However we observed the EOL care CNS come to the ward to undertake an assessment during our visit which meant the CNS had responded to the referral within a 2 hour window.
- On Tennyson Ward we saw that the EOL CNS had pro-actively identified a lady who was receiving EOL care using the flag system on the bed management system. We reviewed the patients' medical records and found that the patient had been reviewed the previous

day twice and the EOL CNS was back on the ward to review the patient on the day of our inspection. The EOL CNS told us that the patient had deteriorated and required input from the Palliative Care Consultant. The Palliative Care consultant was on the ward within 10 minutes to review the patient.

- The EOL care CNS and HPCT aimed to review the patients within 24 hours. This was confirmed by staff on Tennyson Ward who reiterated to us the availability and effectiveness of the HPC team and the EOL care CNS.
- The patients not referred to the EOL CNS and HPCT are those patients that deteriorated rapidly throughout the evening and night, those cared for on the ITU.
- A Palliative care medical consultants post is shared with the Wisdom hospice. We were told that this role supports patients on the ward with complex symptoms and supports all doctors across the hospital with specialist advice when caring for EOL care patients.
- The Patient Affairs Office issues Death, burial and cremation certificates. The office is opened daily Monday to Friday 9-4pm.

Support following bereavement

- No support is offered to families within the hospital after the death of their adult relative. After the death of their relative, an information booklet is given signposting families to support organisations outside the hospital and what to do next.
- We visited the mortuary viewing suite where families could come and spend time with their relatives. One hour appointments were organised through PAO between 9 and 3.30pm Monday to Friday. The mortuary manager told us that viewing times could be extended as no one is ever rushed. If this occurred the family for the next viewing would use the facilities in the Cedar Room.
- We saw a comment made by an undertaker that access to the mortuary was difficult at times. On visiting the mortuary we spoke to the mortuary manager who ran through the opening times of the mortuary and showed us a questionnaire that was sent out to undertakers to gain feedback on the service the mortuary team provide.
- A Children's Bereavement Service had been set up in the ICU for the children of patients who die on ICU to help them with their bereavement. Initiatives included a hand print of their relative, the child received a friendship bracelet with their relative and they are offered a lock of hair

Equipment

- We were told by staff that syringe drivers and other end of life equipment is kept in the hospital equipment library and not on the ward. This could lead to delays out of hours in accessing equipment. We were told by staff that EOL patients can wait up to an hour which means patients have to wait for pain/symptom control through the syringe driver.

Discharge arrangements

- Systems were in place to facilitate the rapid discharge of patients to their preferred place of care. The EOL CNS and HPCT explained that a multi professional approach is in place, which included an occupational therapist, to secure rapid discharges to the preferred place of care.
- We observed the rapid discharge of a patient from Milton ward by the HPCT. After the decision was made by the patient and family to go home, an assessment was made and the discharge was organised by the HPCT within 30 minutes of leaving the patient's bedside.
- The EOL CNS told us that the time to discharge varies on whether patients require care packages, local authority involved in the discharge and whether equipment is required to support the discharge.
- We were told by the EOL CNS and HPCT that issues could arise around delayed decision making and discharge planning. This resulted in patients being delayed and the preferred place of care (PPC) or preferred place of death (PPD) not always being achieved.
- We were told that during the discharge the ward doctors would send an electronic discharge letter to the GP and a copy to the hospice. We were unable to establish the percentage of GP's that receive discharge letters within 24 hours of a patients discharge.
- On visiting the ICU, we were given two examples where patients had received rapid discharges to their preferred place of care. In the first example we were told that an EOL care patient was discharged home to attend his daughter's wedding which we saw photographs. In this case we were told that ICU received a 'wow' award from the hospice.
- In the second example the family wished the relative to die at home. A hospital bed and ventilator was set up at

home. An ICU nurse went to the home to turn off the ventilator so they could die with their family. These examples demonstrate that the wishes and preferences of patients are being met in the last days of life.

Meeting the needs of all people

- While visiting the Emergency Department we were told by staff that patients can receive EOL care on the observation ward if the hospital is busy. Staff recognised this was not an ideal place to receive EOL care and relatives found this difficult.
- 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.
- Many staff raised concerns about the lack of bereavement service within the hospital.
- On the MEU we were shown the bereavement box. This contained the leaflets given to relatives after a death; a checklist was completed by staff to ensure proper procedures were followed.
- The EOL CNS has developed information leaflets for families whose relatives are receiving EOL care. The information available included 'End of life Care Information for relatives and carers', Spiritual and pastoral support and the chaplaincy team and information on the 'Cedar room'. On speaking to relatives we were told they had received the information which they found helpful.
- On the ICU and A&E we were told that the EOL CNS is available to support families whose relatives are in ICU and are receiving EOL care and relatives of patients who die in A& E. Both ICU and A&E pro actively referred to the EOL CNS to ensure that patients and relatives received the appropriate care.
- Patients had the option to be registered on the 'My wishes' register (Adastra) which sets out the wishes and preferences of the patient. This register can be accessed by GP, A&E and Medocc and ensured that the wishes of the patient were adhered to and that no treatments were delivered against the patient's wishes.
- The Chaplaincy service was available 5 days a week 9-5pm as well as providing an on call service to both patients and relatives. Information regarding the chaplaincy services, which included counselling, ward visits and performing funerals, was given to relatives as part of the EOL care package put together by the EOL CNS.

Relatives Facilities

- We observed across the wards, we visited, that staff supported relatives to stay with EOL care patients.
- We visited the 'Cedar Room' we found a visitors book where families had made comments which included 'standard of suite was fantastic, great comfort to our family and great peaceful room.' Other comments included 'needs blankets and pillows and an internal telephone.'
- The Emergency Department had relative facilities. However we found that the area allocated for relatives was not clean or welcoming. The viewing room had a hoist stored in it, which we were told it would be removed if a family wished to view a relative.
- The mortuary had a viewing suite where families could come to visit their relatives.
- We were told by the mortuary manager that relatives were supported by staff who would ensure that relatives knew what to expect before viewing their relative.
- Relatives visiting the Patient Affairs Office or coming to view their relative would be escorted by the PAO to the mortuary viewing room and they would stay with the relatives in the waiting area of the mortuary during the viewing.

Are end of life care services well-led?

Requires Improvement

Although we found that at a local level the EOLC CNS and HPCT worked hard (and conducively together) to provide good end of life care, there was little evidence of divisional (EOLC currently does not sit in a division at present) or consistent board input. Although the Chief Nurse contributes to the End of Life Care steering group, there was confusion as to whether they had jurisdiction over the HPCT. In addition, we were told that EOL care cannot access their risk assurance framework and lacked access to the service business planning.

End of life 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 so staff's skills were not being developed. We found little evidence that staff had received EOL training.

Vision and strategy for this service

- The EOL care CNS and the HPCT had a clear vision to provide a strengthened service and enhance the overall support provided by the EOL CNS at ward level; to maintain end of life educational sessions across the hospital and introduce the EOL competency framework and to maintain collaborative partnerships with services in the community to ensure timely streamline care.

Governance, risk management and quality measurement

- We found that the EOL service has significant governance issues as it was unclear what the governance was around the HCPT and whether the Chief Nurse was responsible for the care they provided.
- 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 EOL and HPCT. This was evident speaking with the team who were all professional, focussed and worked together for the good of the patients in their care
- At the time of the inspection the EOL care was not sitting in any directorate. We were told it would soon be part of the support services in the new corporate structure. It was not clear how this would interact with the HCPT provided by Medway Community Healthcare.
- The development of the End of Life Steering Group led by the Chief Nurse has facilitated a multi-disciplinary approach to EOL care and developed the new End of life plan which encompasses the recommendations made in the NICE QS 13.

Culture within the service

- All the staff we spoke to spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility. This was very evident that the EOL care 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 so staff's skills were not being developed.
- Across the wards we visited we saw that the EOL CNS and HPC team worked well together with nursing and medical staff and there was obvious respect between not only the specialities but across disciplines.

Innovation, learning and improvement

- The EOL care CNS gave examples of practice that the team were proud of which included the establishment of the End of Life Steering Group, the development of the end of life care plan and package, providing a holistic approach to patients receiving palliative or EOL care, comprehensive weekly MDT meeting and the streamline fast track discharge process to meet the wishes and preferences of patients on EOL care.

Outpatients

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

Information about the service

Outpatient services (OPD) at Medway NHS Foundation Trust is located across the hospital site with seven main outpatient areas. Areas one to five share a reception desk and areas six and seven have their own reception desk.

The Medway NHS Foundation Trust offers clinics in Cardiology, Colorectal Surgery, Ear Nose and Throat (ENT), Elderly Medicine, Gastroenterology, General Medicine, General Surgery, Gynaecology, Haematology, Nuclear, Medicine, Paediatrics, Paediatric Surgery, Pain Management, Radiology, Trauma & Orthopaedics, Urology, and Vascular Surgery.

During our inspection we spoke with fifteen patients, one relative and 22 members of staff. Staff we spoke with included reception and booking staff, clerical and secretarial staff, cleaning and housekeeping staff, nurses of all grades, doctors, and consultants.

We observed care and treatment. We received comments from our listening events, and we reviewed performance information about the department and the trust.

Summary of findings

All the patients we spoke with told us they felt they had been treated with dignity, and that they had found staff in the outpatients department (OPD) polite and caring. However, many patients complained to us about the waiting times in OPD clinics.

Staff were reporting incidents and feedback and learning from incidents was discussed at fortnightly OPD meetings. There were systems in place to reduce the risk and spread of infection. Medicines were stored and administered safely. The department held its own training records which were up to date and demonstrated that most staff were up to date with their mandatory training.

We found that booking templates did not always reflect the needs of the clinic and OPD staff were collecting data on waiting times and overbooked clinics, but they felt unable to make improvements to this area of the service. The trust was unable to provide a clear strategy for dealing with this issue. The electronic systems in place did not allow staff to tailor outpatient appointment letters that were fit for purpose. The trust was bringing in new systems to improve this.

The trust had mostly met national targets for the two week wait target for patients with a suspected cancer. The 18 week targets had also mostly been met.

Outpatients

Are outpatients services safe?

Good

Staff were reporting incidents and feedback and learning from incidents was discussed at fortnightly OPD meetings.

There were systems in place to reduce the risk and spread of infection. Medicines were stored and administered safely.

The department held its own training records which were up to date and demonstrated that most staff had been trained and were up to date with their mandatory training.

Incidents

- Staff in the Outpatients department (OPD) used an online reporting tool (DATIX) to record any accidents, incidents or near misses that occurred. We were told that some staff had not received the trust's training on this system, and were therefore unable to access and use the tool. We were told that staff who were unable to use the system were supported by trained staff to report incidents. The manager was unable to confirm who had received training on the DATIX tool as records had not been kept.
- We saw that staff had used the reporting system for a variety of incidents which included misfiled patient records, late starting clinics, and patient falls.
- The OPD manager told us that the fed back any learning from incidents and accidents to staff during department meetings. We saw the minutes of these meetings which confirmed that learning from incidents was discussed.
- The manager told us that once they had submitted a DATIX the person investigating sent an email outlining their investigation outcomes. However, staff said that they did not consistently receive this feedback.

Cleanliness, infection control and hygiene

- There were systems in place to reduce the risk and spread of infection and patients we spoke with all told us that they felt the department was cleaned to a good standard.
- We observed that most of the areas within the outpatients areas were clean and free from unnecessary clutter. However, in some areas we found the department was not cleaned to the required standard. For example, we found dust and debris in the weighing area in outpatient's waiting room in OPD 1, and low and high dusting in one toilet facility was not meeting the required standard.
- Cleaning staff were responsible for cleaning public areas, clinic rooms, and toilets in the OPD. The cleaning staff worked from 6 am until 9am and from 6pm to 9pm. The toilets were checked twice daily outside of these scheduled cleaning hours. There was also an emergency cleaning team that could be contacted through the house keeping office. A book in the housekeeping department contained all requests for emergency cleaning, the time that the request came in, and any action taken.
- OPD staff signed off the cleaning checklists which the housekeepers completed. The housekeeping department audited the cleaning standards against the national standards for cleanliness within the NHS. The OPD was assessed by the trust as a significant risk cleaning area which meant that they would be expected to achieve 85% in cleaning audits. The audit scores for the OPD were consistently around 90%. This meant that they were meeting with the required standards of cleanliness.
- Clinical staff had completed checklists to show that treatment couches and equipment were cleaned between patients. We saw that these checklists were comprehensive and had been completed correctly by staff.
- The OPD audited clinical cleaning checklists and hand gel audits to monitor compliance with the cleaning of clinical equipment. As a response to audits which had raised issues, the OPD sisters had allocated cleaning tasks to specific members of staff. We were shown that audits following this demonstrated that clinical cleaning standards within the department had improved.
- Minutes of staff meetings showed that the results of clinical cleaning audits were discussed with staff.
- The OPD had scored 100% on their hand hygiene audits from April 2013 to date.
- Mandatory training records held in the department showed that 100% of staff had received infection control training within the past two years and staff that we spoke with understood their role in the prevention of the spread of infectious disease.

Outpatients

Environment and equipment

- Building maintenance was managed by the estates department for the hospital. We were told that where issues were found that these were reported to the estates department who logged the requirements and issue and the department with a job number. The OPD kept a log of the work that they reported to estates and kept track of when and how issues were resolved. The departments log book showed that staff were reporting and tracking maintenance issues.
- When equipment failed staff followed guidance for decontamination and arranged for The Electronics and Medical Engineering Department (EME) to collect, repair and return the item. We were told by the manager that when this happened they borrowed equipment from the hospitals equipment library to replace equipment until it was repaired.
- The manager told us that when they required more equipment they asked the division that the equipment was required to supply this. They also said that the Hospitals League Of Friends were always supportive where the department had asked for funding for equipment. The OPD had recently been funded by The Medway League of Friends for forty new electronic treatment couches.

Medicines

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

Records

- The manager told us that an ongoing safety issue in the OPD had been the misfiling of patient records. This meant that patient records on occasions contained the wrong patient information. This could lead to unsafe or inappropriate treatment. In March 2014 five cases of misfiled patient records had been reported through the DATIX system in OPD.
- The manager told us that each time notes were misfiled these were recorded and investigated through the DATIX system. They told us that any learning from misfiled notes was shared in monthly staff meetings. The sister told us that they had raised awareness of this issue with staff to ensure that DATIX forms were being completed.
- We spoke with staff from medical records management who told us that they were sometimes carried out these investigations. They said that although it was not always possible to trace where the notes had been misfiled. Where they were able to establish a cause this was passed onto the department's manager for action.
- The OPD had a porter responsible for transporting patient records to and from the department three times a day. The manager told us that the department aimed to have all patient records transported back to the correct department within 12 hours from the time that the patient was seen in clinic.
- We were told that across the hospital the location of patient records could be challenging. This was because staff were reluctant to let records go to a central store that was located outside of the hospital grounds. The offsite storage is 2 miles away and records are recalled when required. As a result we were told and shown that notes were being stock piled across different areas of the hospital. This practice created problems for staff when they were trying to locate patient records. However there was a patient record tracking system that recorded where records were taken from and where they were received. Records therefore could be located where ever they were dependent on staff updating and completing the computer based records tracking each time they received and relocated any records.
- We were told that clinic appointments would be cancelled if staff were unable to obtain the patients' medical records in time for their appointment. We were told that the OPD had trained staff on the use of the electronic tracking system for notes in order that patient records could be tracked down by OPD staff. As a result we were told by the OPD matron that, "A very small number of patients appointments are cancelled due to missing notes".

Outpatients

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 95% of OPD staff had received training in The Mental Capacity Act.
- The matron demonstrated that staff had a good understanding of The Mental Capacity Act 2005 (MCA) and had applied its principles in a recent case.

Safeguarding

- 94% of staff in the department were up to date with child protection training. Nine members of staff including all Band 7 and 6 staff had been trained to a level 3 in child protection.
- 98% of OPD staff had received Vulnerable Adult Safeguarding training at level 2.
- We spoke with staff during our inspection who demonstrated that they understood their role in the protection of vulnerable adults and children.
- OPD sisters that we spoke with gave us two examples where they had raised safeguarding concerns. They demonstrated that they had followed procedures when escalating their concerns.

Mandatory training

- The OPD kept their own records for mandatory training.
- 98% of staff had attended fire training within the last year. We were told that bespoke fire training had been delivered to staff within the OPD.
- 94% of staff had received moving and handling training and 100% of staff had received Health and Safety training. These had also both been delivered in the department in order to tailor the training to the area that staff were working in.
- The matron audited all mandatory training monthly. All senior staff that we spoke with were able to tell us how the department was performing with regard to mandatory training.
- The matron told us that they had difficulty accessing training in some areas due to availability of courses. These were in particular in relation to conflict resolution where 85% of staff had attended; and paediatric basic life support where 83% of staff had attended.

Management of deteriorating patients

- Staff that we spoke with were aware of their role in a medical emergency. For example, we spoke with a plaster technician who was able to describe their role in an emergency and described how this had worked in a recent medical emergency within their department.
- 93% of nursing staff in the department had received adult resuscitation and life support training within the last year. 83% of nursing staff had received paediatric life support training.
- We saw evidence that adult resuscitation equipment stored in the department to assist staff during an emergency had been checked regularly by staff. Staff had signed to say that the equipment had been checked, was available and within its expiry date. We were shown the procedure for checking the resuscitation equipment.
- Staff in the OPD had won a Trust Excellence award in March 2014. They had won this award for the way that the team had dealt with a medical emergency in the department.
- Staff told us that they were told to always call for the resuscitation team in the hospital if they had concerns about a patient's medical condition. They said that the team operated in a 'no blame' way. We were told that on occasions when the resuscitation team had been called when it did not prove to be necessary that the team had been supportive around the decisions made to call them. One member of staff described this as, "When in doubt, we shout". This meant that staff were able to deal with emergency situations when they occurred in the department.

Nursing staffing

- The nursing staff for the department included a management team of a matron, two band 7 senior sisters, and six Band 6 clinical sisters. These staff supported Band 5, Band 3, and Band 2 nurses in the department.
- Nursing staff told us that although they were busy they felt that they were able to deliver good and safe patient care. We were told by the matron that staff working in the department needed a good understanding of their role and needed to be assessed for competencies in the areas that they were working. This meant that it was not always possible to use staff from outside of the department to cover shifts during staff absence.
- Where staff were absent they were therefore replaced either by staff within the department who would work extra hours or alternative shifts; or the department gave shifts to particular NHS professional staff who had been trained in the competencies required to work within the department.

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- We were shown the process that the department used for staff wishing to book annual leave. The managers had ensured through this process that staff numbers and skill mix was maintained at safe levels.

Medical staffing

- The medical cover for clinics was arranged within the divisions, who agreed on the numbers of clinics and patient appointment numbers. The divisions had provided the appointment teams with templates which showed where appointment spaces were available.
- Doctor that we spoke with told us that they were happy with the way that the OPD was run and felt that clinics ran smoothly. One doctor said, "I have a good relationship with the managers in OPD. I feel supported by them, they are responsive and I feel they could resolve any issues I had".

Major incident awareness and training

- The matron and sisters that we spoke with were able to describe the department's role in a major incident. All senior staff in the OPD had completed major incident training.
- In the event of a major incident Area 5 of OPD was used for relatives and friends of patients being treated.
- We were shown the major incident communication tree. Staff were able to describe how the major incident plan had worked during a recent incident.
- Staff would refer to a specific 'Action Card' for instruction on their role in a major incident.
- Following a major incident staff involved in the incident attended a hot and cold debrief session. Hot being immediately following the incident. During the debrief staff discussed any learning from the incident.
- Staff were able to tell us about learning that had happened during a major incident and changes that had been made to improve future incidents. For example, pens and paper had been added to the major incident box for relatives to record important information.

Are outpatients services effective?

Not sufficient evidence to rate

There was evidence of use of some NICE guidance within the department, although compliance with relevant speciality guidance was not routinely assessed. We saw good multidisciplinary team working and some departments had moved towards 'one stop clinics' such as breast surgery. Some clinics were held at weekend mornings and weekday evenings.

Evidence-based care and treatment

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

Competent staff

- Along with mandatory training staff in OPD were expected to demonstrate competencies in the areas that they worked in. For example, we were shown Band 2 and Band 5 nurse competency assessments; along with competency assessments for wound care, drug administration, and MRSA screening.
- Staff attended a Trust Induction on starting work at the service. OPD also ensured that staff completed a local induction programme which related to OPD. We were shown the Band 5 Registered nurse orientation programme for OPD.
- Records demonstrated that staff had a 100% record for appraisals. These records showed that staff had all received an annual appraisal and a six month progress check.

Multidisciplinary working

- The department used specific wound care documentation which it sent to wound clinics in the community to ensure that any prescribed treatment was continued. The Sister who ran the clinic told us that they had good links within the community which meant that they were able to ensure consistent care.
- We were shown the falls flow chart which OPD staff used to refer patients at risk of falling to the falls service.
- The OPD had also made relevant referrals to services such as osteoporosis specialist nurses, occupational therapists, orthotics and the psychiatric liaison service where appropriate.
- The service ran multidisciplinary one stop clinics for patients with a suspected breast cancer.

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Seven-day services

- In order to manage the appointment waiting times the central booking team updated each division of the trust weekly. We were told that where it was identified that the demand for clinics was greater than the clinic appointments available the trust would create further clinics to absorb the extra appointments needed. We were shown an example of this where a recent increase in referrals for breast clinic had meant that the trust had supplied two extra evening one stop breast clinics for a period of eight weeks.
- OPD had extended clinic times to Saturday mornings and evening clinics. Diagnostic services also run at weekends.

Are outpatients services caring?

Good

All of the patients we spoke with were complimentary about the way the staff had treated them.

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

Compassionate care

- We observed staff interactions with patients as being friendly and welcoming. We saw staff stopped in clinics to greet patients that they knew and ask after their well-being.
- Staff were trained and expected to keep patients informed of waiting times and the reasons for delays. We observed this happened in all areas of the OPD during our inspection.
- All of the patients we spoke with were complimentary about the way the staff had treated them. A patient said, “It’s really good overall. They are too busy, but the staff are lovely”. Another patient said, “I can’t fault them”.
- On one of our comment cards one patient had written, ‘All staff were very pleasant and caring’. Another patient had written, ‘I have been treated with respect at every visit’.
- Patients also told us that they had been treated with dignity in the department. One patient told us, “I have always been treated with respect ”
- The OPD reception was in the main lobby of the hospital. The lobby was busy with patients arriving for appointments along with visitors to the hospital. There were signs to prevent people from crowding around the desk. Reception staff told us that when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk. The receptionist told us that as they checked patients personal information they ensured that other people stood back so that they could not be overheard. This showed that staff had considered ways to ensure that patient’s personal information was protected.
- All of the clinic rooms had privacy signs on the doors. We saw that staff adhered to these signs and always knocked and waited for permission before entering rooms.
- The OPD friends and family test for March 2014 showed that 87% of patients would be either extremely likely or likely to recommend the OPD to family and friends.

Patient understanding and involvement

- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account. One patient wrote on a comment card, ‘Doctors and radiologists explained procedures to me, and give time for questions or queries.’
- Where there was a planned change in a patient’s consultant this information would be sent to the patient so that they were aware of this before arriving for their appointment. We were shown one example where a patient had insisted on seeing a particular consultant. We saw that the OPD had ensured that this had happened.

Emotional support

- The OPD was a calm and well-ordered environment. We saw nurses constantly updating patients on clinic waiting times and checking that patients were comfortable and happy. One patient described the environment as, “Peaceful and clean”.
- We saw one person becoming distressed in the department after being given difficult news. Staff were quick to respond and took the patient to a quiet room set aside for patients who were upset. We saw staff supporting the patient in a kind, caring, and supportive manner.

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- We saw another example of staff supporting a frail elderly patient with compassion and dignity. The patient was very tired from their journey to the department and staff ensured that they were seen immediately, and supported during their stay in the department.
- We also observed staff supporting an elderly patient who had incurred an expensive taxis charge as they had been unable to rearrange their patient transport at short notice when their appointment time had been changed. We saw that the matron dealt immediately with the patient's complaint and ensured that patient transport arrived promptly to take the patient home.

Are outpatients services responsive?

Requires improvement

Some patients arriving for their appointment at the trust were waiting a significant length of time to be seen, and we received multiple comments regarding difficulties with parking. In many clinics allocated appointment times were shorter than the actual time needed which led to overrunning clinics on a regular basis.

Signage within the department was good and information was available in different languages. They identified patients living with dementia or with learning disabilities on arrival so that they could be given extra support during their time in clinic.

Service planning and delivery to meet the needs of local people

- Once a week the matron met with service managers to discuss staffing rotas on a four weekly rolling basis. This was done to ensure that the department's resources met the demands on the service.
- The department had recently renewed its signage in order to assist patients to find their way between departments. There was also a concierge service at the entrance to the hospital to assist people to find the departments or wards that they were looking for. Out of hours signs were placed in the entrance to the OPD to direct patients to the correct areas for their clinics.
- Car parking facilities were being raised as a concern throughout our inspection. The trust had provided staff with an offsite car park facility with a shuttle bus to the hospital which ran every few minutes at busy times. All the staff who used the service told us they were happy with the way that it was run. However not all staff used the service which was impacting on patients being able to park easily.
- Three patients told us that they had to arrive two hours before their appointment time in order to get a space in the car park. Another patient told us that they had needed to cancel their appointment as they were unable to find a space to park after one hour of trying. They said that although staff had understood and had rebooked their appointment they had needed to wait a further eight week for a new appointment.
- The department had worked with community stakeholders to ensure consistency of care for patients requiring wound care.
- All of the doctors we spoke with told us that the administrative support they received was insufficient. They told us that the administrative support offered to them had been reduced. The impact of this was that it now took longer to dictate, print and file clinic letters. This meant that on occasions doctors did not have clinic letter available at the patient next appointment.
- One doctor we spoke with told us that six of the 15 clinic letters from their clinic that day had arrived for filing in the notes on the day of the clinic appointment. They did however say that when this happened they were able to access the letter electronically but that this took time and could delay clinics.

Access and flow

- OPD first appointment referrals were made through two different sources; The 'Choose and Book' system (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic) or through a direct referral to the service.
- The trust had met the target for seeing all suspected cancer referrals mostly met national targets for the two week wait target for patients with a suspected cancer. The trust's July 2013 to December 2013 data shows that across all tumour groups the trust had 5208 referrals. The trust had breached the two week wait times on 323 of these referrals. This shows over 93% compliance (national average 93%). However although all specialties were meeting or above the national average, the colorectal cancer referrals fell below the national average with 81.9% of patients being seen within the two week target.

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- The 18 week targets had also mostly been met. We looked at data for 18 week targets from January 2013 until March 2014. A breakdown of these figures showed that some specialties had not consistently met the 18 week target and national average. For example Gynaecology which had fallen below target in October 2013 at 85%, and February 2014 where 89% of patients being seen within 18 weeks from referral. Orthopedics and trauma had also fallen short of the target on two months. In February 2014 where they achieved 79%, and in March 2014 when 81% of patients were seen within 18 weeks of their referral to the service.
- We had many complaints from patients about the waiting times for appointments. One patient at our listening event told us that they attended OPD for treatment regularly. They said that on top of arriving two hours early for their appointment in order to get a car parking space, they were also regularly kept waiting 2 – 3 hours due to appointments running late.
- The staff that we spoke with acknowledged that waiting times were an issue in the department. We were told that this was mostly due to either appointments taking longer than expected, or because patients were being squeezed into appointment slots because there were not enough appointments available.
- Most of the doctors we spoke with told us that clinics were routinely overbooked as the templates did not match the number of patients requiring appointments. For example, one doctor said, "I am informed when my clinics are overbooked, but there is always a good clinical reason for this so I don't mind". Another doctor said, "Every clinic is double booked, despite running extra clinics two nights a week and on Saturdays. Our biggest problem is the volume of patients".

Clinic waiting times

- The OPD audited its waiting times. We looked at the last 3 months results from these audits. Data showed that in March 2014 9% of attendees at OPD clinics were seen on time in clinic with 42% being seen between 5 and 15 minutes from their appointment time. 18% seen within 20-30 minutes, 8% within 35 – 40 minutes, 3% between 50 minutes and 1 hour, 7% waiting between 60 – 90 minutes, and 1% waiting between 90 and 180 minutes to be seen.
- We were given evidence collected by staff about clinic overrun times. This showed how late clinics had finished overall. The data showed that in March 2014 a total of 211 clinics had been held in the hospital. Of these two finished 3 hours late, two finished 2 hours 30 minutes late, two 2 hours 15 minutes late, 13 finished 2 hours late, 15 clinics finished 1 hour 45 minutes late, 28 finished 1 hour 30 minutes late, 17 finished 1 hour 15 minutes late, three finished 1 hour 5 minutes late, 38 clinics finished an hour late, and 36 finished 45 minutes late. Only one clinic of the 211 finished within 5 minutes of its expected finish time. 59% of clinics in this month finished between one hour and three hours late.
- Staff were recording the reasons for clinics running late. The most common themes recorded were, more patients booked than the templates allowed, appointments taking longer than expected, and doctors arriving late to start clinic.
- Most of the doctors we spoke with told us that clinics were routinely overbooked as the templates did not match the number of patients requiring appointments. For example, one doctor said, "I am informed when my clinics are overbooked, but there is always a good clinical reason for this so I don't mind". Another doctor said, "Every clinic is double booked, despite running extra clinics two nights a week and on Saturdays. Our biggest problem is the volume of patients".
- Where clinics do need to be cancelled at short notice we were told that the patient service centre makes every effort to contact patients and inform them. We were told that service managers would support this process and will ensure that patients are offered another appointment as soon as possible.
- The trust had a 'one strike' policy for patients who fail to attend their appointments. This means that patients who fail to attend are removed from clinic lists and needed to see their GP for a new referral to the service.
- The service provided a text reminder service seven and three days before appointments. This was an 'opt in' service and patients chose to be contacted in this way.
- Some patients told us that the letters inviting them for an appointment had not arrived; one patient told us that they had received a text reminder about an appointment that they knew nothing about.
- We discussed this with the manager of the appointments team. They told us that there had been an issue with letters not being delivered or being delayed but that the service had changed to another postal service recently due to complaints of this nature.
- Some patients also told us that there appointment letters contained the wrong information regarding the

location of their clinics. The team responsible for sending letters told us that the current templates for appointment letter writing were, "woefully inadequate". We were told that the letter templates did not allow staff to change locations or information in letters relating to individual clinics. We were told that the trust was changing to a new electronic booking system at the end of May which would alleviate this problem.

Meeting people's individual needs

- The OPD was able to access translators for patients when they knew that they needed. When a patient arrived at the service without a pre-arranged translator the OPD would access staff from other areas of the hospital who would be able to translate. The matron told us that the department rarely used telephone translation services as they found these made consultation difficult.
- The OPD had a box in each OPD area which contained tools to assist staff when caring for a patient with learning difficulties. The box contained a sticker with a smiley face which was used to identify patients with learning difficulties as they moved through the service. There was a similar box for patient living with dementia.
- The OPD also shared information booklets with the relatives or carers of patients with learning difficulties to help them to understand what would happen at their appointment. For example, we were shown a booklet which explained in an easy read format what would happen during a breast examination.
- The OPD had obtained some bariatric chairs for the waiting area and clinic rooms so that bariatric patients were able to sit comfortably in the department. The electronic couches in the department were also safe for use with bariatric patients.
- The department had hearing loops to assist patients with hearing impairment.
- There were patient leaflets in each waiting area which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We saw patients reading this information. When asked, they all said that the information was in a format that they understood. This information was available in different languages.
- In each outpatient area there were designated play areas for children. These were interesting and pleasant places for children to play. Some areas were themed for example one area was decorated as a boat with themed activities to keep children occupied.

Learning from complaints and concerns

- We discussed complaints with the matron and OPD sisters who all demonstrated a good understanding of the trust's procedures when dealing with complaints.
- One sister was able to describe how they had investigated a complaint about a member of staff. They described the process of investigating the complaint and outlined how the staff member involved had been supported with their professional development.
- Learning from complaints was discussed at staff meetings. We were shown staff meeting minutes as evidence that this had happened.
- The OPD ran a continuous patient experience survey which patients were encouraged to complete during their visit to the department. The survey had been recently modified to include a friends and family test.
- Each area of OPD had the survey results displayed for patients and visitors to the department to see. The display included a section on issues raised and what the OPD had done to address these concerns or suggestions.
- An example of how this survey had altered the patient experience was that people had complained in surveys about a lack of refreshments in the OPD. As a result water coolers had been placed in areas 2, 3, 5, and 7of OPD. The OPD had also arranged for a volunteer were possible who served refreshments to people for voluntary contributions.

Are outpatients services well-led?

Requires improvement

The department proactively monitored and reviewed clinic waiting time data and were attempting address the impact that this was having on patient experience within the department. This had escalated for improvements to be made to the current booking template. However this had not been seen as a priority by the trust.

The central booking service was not always able to give patients appointments within the NHS England and Clinical

Outpatients

Commissioning Groups (CCGs) regulations 2012 two and 18 week targets. We were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the trust met with these targets.

Templates set for some clinics did not meet with patient requirements. Data which evidenced this was being collected daily by the OPD, the central booking department, and medical secretaries. We were not assured of any work being done by the trust to alleviate this problem despite a number of staff including managers and doctors raising this with us as a persistent issue.

Vision and strategy for this service

- Trust wide communications had been displayed in staff areas for staff to read.
- The matron and sisters that we spoke with were all aware of the trust's current strategy. The matron said, "We have a clear idea of the strategic moves forward".
- The matron told us that staff were invited monthly to the Chief Executive Briefing; they said that where staff had not been able to attend that they were able to access the minutes from the meeting.
- Staff told us about open sessions that all staff were able to attend that had taken place the previous week. They said that the trust's Chairman had led this meeting the previous week and that staff from all grades and departments were invited to ask any questions that they had. Staff spoke positively about this experience. They said that it made them feel listened too.

Governance, risk management and quality measurement

- The OPD collected data monthly for the Trust Clinical Governance Report. They collected data on patient experience by reporting on positive and negative comments on the OPD surveys, along with gathering and collating information on patient waiting times, and patient complaints.
- This was fed back at monthly OPD clinical governance meetings which were attended by, the head of patient services, a senior sister from OPD, a senior sister leading on infection control, a clinical sister from OPD and the children's group, and the head of physiotherapy.
- During the OPD governance meetings staff discussed, incident reporting, complaints, infection control audits, the risk register, patient experience data, Medical devices Alerts (MDA), and National Institute of Clinical Excellence (NICE) guidelines.

Leadership of service

- Throughout our inspection staff in the OPD were welcoming, and happy to interact with us and answer our questions. There was an obvious sense of pride from staff about their department and they were keen to tell us about things that they were doing to improve patient experience.
- Doctor that we spoke with told us that they were happy with the way that the OPD was run and felt that clinics ran smoothly. One doctor said, "I have a good relationship with the managers in OPD. I feel supported by them, they are responsive and I feel they could resolve any issues I had".
- All of the staff that we spoke with were able to describe their individual roles. We saw evidence of competency assessments of staff that ensured that they both understood and were able to perform their roles to a required standard.
- All of the staff that we spoke to told us that they felt supported by the matron and sisters in the OPD
- The matron and senior sisters gave us examples of where they had supported staff who due to unforeseen personal circumstances had needed support within their workplace.
- Staff were also complimentary about the Chief Nurse. They said that he was approachable and friendly. We were told examples of support that the team had been offered by the chief nurse. One staff member said, "He is very visible, warm and approachable. He stops and speaks to staff, his leadership is working". Another member of staff said, "He is certainly leading by example".

Culture within the service

- Throughout our visit we saw that the department was calm and ordered. Patients told us that they were well informed and that staff were both friendly and supportive of them.
- We spent some time during the inspection sitting and observing the staff, the flow through the department and the experiences of patients. We saw that staff treated patients with respect, and worked hard to make their experience a positive one.
- We saw staff interacting with their managers and saw that they did this in a relaxed and friendly way. The managers were seen supporting more junior members of staff when it was required.

Outpatients

- Another staff member told us, "We have come under a lot of direct criticism as a trust. Despite that as a department we feel proud and proactive".
- One nurse we spoke with told us that when they had supported patients who had been given bad news this could leave them feeling upset themselves. When this happened they said that the managers in the OPD were caring and supportive of them.
- Nursing staff completed return to work interviews following an episode of sickness. This ensured that the OPD was able to support staff following an episode of sickness.

Public and staff engagement

- The OPD ran a Patient Experience Group meeting every month. We were shown the minutes from the last three meetings. During the meetings staff and patient representatives discussed improvements that could be made to the service.
- Notice boards in all OPD areas showed visitors and patients how their comments and complaints had been used by the OPD to improve patient's experience of the service.
- Staff within the department were rewarded for initiatives or behaviours which improved patient experience. Awards were given within the department for innovation, patient experience, flexible working and personal achievement. Staff awards were displayed in the department and staff spoke proudly about receiving these awards. We were told that the awards were presented at staff meetings and were recorded in staff personal files.
- The OPD team had also won a trust wide award for 'Team of The Month'. This had been awarded for the way that staff had managed an emergency within the department. We were told that once a year everyone in receipt of an award would be invited to an awards dinner.
- A plaster technician within the department had been awarded with a 'WOW' award. This was a national award for customer care and the technician had been nominated by patients.

Innovation, improvement and sustainability

- Staff we spoke to were aware of the issues in the OPD around overbooked clinics and waiting times for patients. Staff told us that they were sometimes dealing with the stress that managing sometimes angry patients due to waiting times bought about. One member of staff described this by saying, "I try to keep patients happy. I tell the patients why we are running late, because I put myself in their shoes and I would want to know if it was me". However, staff told us that these were decisions that were made and influenced outside of their department and did not therefore feel able to make changes.
- Although there was awareness amongst all staff groups about overbooked templates, and patient waiting times no improvements had been made. Staff had completed DATIX forms but were unable to demonstrate that the OPD had improved on these issues. The matron told us that they had been assured that the issues over templates would be addressed when the appointment booking system changed in late May. However, the appointments manager that we spoke with told us that this would not be addressed as a priority and would not be addressed by the end of May.
- The central booking service was not always able to give patients appointments within the NHS England and Clinical Commissioning Groups (CCGs) regulations 2012 two and 18 week targets. Staff managing the OPD were unaware of whether they were meeting these targets, as although this information was being collated it was being held within two separate divisions. We were unable to see evidence of clear strategies to monitor and maintain robust systems to ensure that the trust met with these targets.
- Templates set for some clinics did not meet with patient requirements. Data which evidenced this was being collected daily by the OPD, the central booking department, and medical secretaries. We were not assured of any work being done by the trust to alleviate this problem despite a number of staff including managers and doctors raising this with us as a persistent issue.

Outstanding practice and areas for improvement

Outstanding practice

- The Oliver Fisher Neonatal Intensive care Unit.
- Recent provision of the Bernard Dementia Unit.
- Improvements made by the maternity team since CQC's last inspection.
- WOW awards had been introduced, to enable patients and visitors to tell the trust about a member of staff who had delivered outstanding care.
- Use of 'Schwartz Rounds' to provide a forum for staff to debrief and explore some challenging or emotional experiences that they have encountered when caring for patients.

Areas for improvement

Action the hospital MUST take to improve

- Urgently address its poor data quality issues.
- Urgently review and standardise risk management and governance both at a local level and trust wide to ensure there are robust processes from board to ward.
- Continue to actively monitor its HSMR trends, including ensuring that consistent, robust, minuted mortality and morbidity meetings are being undertaken in all departments.
- Ensure that the Vanguard unit is not used as overnight accommodation for patients.
- Address its escalation policy within the A&E department to avoid the need to 'stack' patients; this should include formal agreement with specialities regarding expected professional standards.
- Ensure that the initial assessments of all patients (including children) are in line with national standards.
- Address the concerns regarding patient flow through the hospital, including improving discharge processes.
- Update its major incident policy in the A&E department and ensure that staff are trained appropriately.
- Ensure that there are a sufficient number of nurses with paediatric expertise in the A&E department.
- Ensure that all equipment is in date and is checked consistently.
- Ensure that all fire exits are accessible at all times.
- Ensure that mental capacity assessments (MCA) are undertaken where appropriate and staff are adequately trained in MCA and Deprivation of Liberty.
- Commence robust audit theatre utilisation to ensure clear allocation of elective and emergency lists.
- Improve the quality of cancellation of operations reporting.
- Ensure that all wards have appropriate equipment to meet peoples care needs.
- Ensure departments are sufficiently staffed by competent staff with the right skill mix, including out of hours.
- Review the current training matrix for mandatory training and improve the recording system so that there is a comprehensive record of compliance with training trust wide.
- Ensure all staff are aware of their roles and responsibilities to report incidents and that they have access to Datix. Feedback mechanisms and review processes need to be sufficiently robust to ensure that all staff groups are learning from incidents.
- Ensure that Consultant surgeons are undertaking ward rounds at weekends.
- Review the medical oversight of the medical high dependency unit and lack of regular input from critical care directorate.
- Review the current arrangement for protected consultant presence on the labour ward including the supervision of trainees performing elective caesarean sections.

Action the hospital SHOULD take to improve

- Review effectiveness of multidisciplinary team working hospital wide.
- Continue to work towards full provision of seven day services, including support services.
- Improve communication to staff regarding the use of staff car parking so that the improvement of parking availability for patients is fully implemented.

Outstanding practice and areas for improvement

- Review outpatient department booking templates to ensure allocated time for clinic appointments are appropriate.
- Improve the end of life care out of hours for all patient groups.
- Ensure that there is a robust system in place for reviewing risk assessments to ensure they are reflective of the clinical condition of women who are using the maternity service.
- Review the Clinical Risk Management Strategy to ensure it accurately reflects the recent changes which have been made to how clinical risk is managed within the maternity department.
- Ensure that local policies and protocols are reviewed to ensure they are consistent with national, best practice guidance throughout the hospital.
- Ensure that the staff who are responsible for taking blood samples from new born babies undertake revised training in the completion of blood sample labels to reduce the number of incidents whereby blood samples are rejected by the laboratory due to missing or incorrect information.
- Ensure that a formalised process is introduced for seeking feedback from patients and/or their parents/ carers who use children's services to help improve the overall quality of the service.
- Improve support and communication with staff at all levels.
- Review the storage of medicines in theatres and the accident and emergency department.
- Review the effectiveness of medical notes library.
- Review processes and effectiveness of equipment library.
- Review the completeness of records including detaining patients, medicine administration record in accident and emergency department and patients' weight on admission on surgical wards for high risk patients.
- Ensure that all agency staff have completed an induction before they start work and ensure an audit trial of inductions is retained by ward areas.
- Review and improve availability of specialist nurses.
- Ensure a standard approach to mortality and morbidity activity and encourage independent review and provide appropriate audit trail.