This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Details of sites and locations registered with Care Quality Commission.

- Darent Valley Hospital
- Gravesham Community Hospital
- Queen Mary’s Hospital, Sidcup
- Erith & District Hospital
- Elm Court

Specialist services provided at the trust

Darent Valley Hospital Has around 463 inpatient beds and specialties that include; day-care surgery, general surgery, trauma, orthopaedics, and cardiology, maternity and general medicine. Gravesham Community Hospital. The trust provides a fracture clinic at the Gravesham Community Hospital, which is owned by Kent Community Health NHS Trust. The service is provided under a separate service level agreement with Dartford, Gravesham and Swanley clinical commissioning group, and the trust rents space at the hospital from Kent Community Health NHS Trust. The trust also provides radiology support to the Minor Injuries Unit and General Practitioners direct access service at Gravesham Community Hospital, under a facilities charge service level agreement from Kent Community Health NHS Trust.

Queen Mary’s Hospital, Sidcup. The services being provided at Queen Mary’s Hospital, Sidcup include; cardiology, colorectal, dietetics & nutrition, endoscopy, gastroenterology, general medicine, general surgery, geriatric medicine, gynaecology, haematology, orthopaedics, urology, outpatients, paediatrics, radiology/x-ray/imaging, respiratory medicine, rheumatology, pre-assessment, and anaesthetics/pain clinic. Procedures can either be undertaken as day surgery or as an inpatient stay.
Erith & District Hospital. The trust provides x-ray and outpatient services from this site. Outpatient services include; orthopaedics, paediatrics, renal, surgery and urology.

Elm Court. The Trust has made arrangements to rent a (up to) 39-bedded facility at the British United Provident Association Priory Mews Care Home in Dartford for medically fit patients who require a short period of rehabilitation.

Background to the trust

Darent Valley Hospital offers a comprehensive range of acute hospital-based services to around 270,000 people in Dartford, Gravesham, Swanley and Bexley. The hospital opened in September 2000. The hospital building is run as part of a private finance initiative. This means the building is owned by The Hospital Company (Dartford) Limited, a private sector company, and the trust leases the building.

Darent Valley Hospital now has around 463 inpatient beds and specialties that include; day-care surgery, general surgery, trauma, orthopaedics, cardiology, maternity and general medicine. The hospital has a team of around 2,000 staff.

The trust has an ongoing relationship with Guy’s and St Thomas’ NHS Foundation Trust. The trust is part of the national acute care collaborative and is in the final year of the programme.

Facts and data about the trust

- The current composite indicator score is similar to other acute trusts that were more likely to be rated as requires improvement.
- This trust’s composite score is within the middle 50% of acute trusts.

There are currently 0 active outliers for maternity and 0 for mortality. For maternity, 0 are with the panel and 0 are with the regional team. For mortality, 0 are with the panel and 0 are with the regional team.

Of the 78 trust wide indicators, 1 (1%) was categorised as much better, 0 (0%) as better, 3 (4%) as worse and 0 (0%) as much worse. 35 indicators have been compared to data from 12 months previous, of which 3 (9%) have shown an improvement and 2 (6%) have shown a decline.

Summary Hospital-level Mortality indicator

For the 12-month period from Oct 15 - Sep 16, Summary Hospital-level Mortality indicator was as expected with a value of 1.04 (compared to 1.0 for England) and 1,424 deaths compared to an expected 1,373 deaths.

Hospital Standardised Mortality Ratio

For the 12-month period from Oct 15 - Sep 16, Hospital Standardised Mortality Ratio was as expected with a value of 92.13 (compared to 100 for England) and 846 deaths compared to an expected 918 deaths. Weekend Hospital Standardised Mortality Ratio is within expected range for this time period.

There are currently no active mortality alerts.

Incidents

The median time taken to report incidents was 41 days for this organisation compared to 26 for all trusts between Apr 16 and Sep 16.
Financial position

For the financial position, in month 3, 2017/18, there was a deficit of (£0.2m), which is a small overspend against the month 3 plan. The year to date position is a (£1.5m) deficit, which is a small favourable variance against plan. The pay expenditure year to date was (£0.8m) overspent against the plan of £36.6m.

What people who use the trust’s services say

In September 2013, 406 people completed the inpatient Friends and Family Test, which asks patients if they would recommend services to people they know. Of these, 95.1% were either ‘likely’ or ‘extremely likely’ to recommend the ward they stayed in to friends or family. Some 662 people completed the test for Accident and Emergency. Of these 96.1% of patients were either ‘likely’ or ‘extremely likely’ to recommend the trust’s Accident and Emergency department to friends or family.

In Care Quality Commission’s adult inpatient survey 2012 the trust performed about the same as other trusts in the nine areas of questioning. However, it performed worse than other trusts in the ‘Hospital and Ward’ area. The trust was in the bottom 20% nationally for four of the questions relating to poor choice of food, assistance with eating meals and sharing facilities with members of the opposite sex.

In the 2012/13 cancer patient experience survey, the trust performed in the top 20% of trusts in four questions. They performed within the bottom 20% of all trusts nationally for 19 out of 64 questions.

Is this organisation well-led?

To write this well-led report, and rate the organisation, we interviewed the members of the board, both the executive and non-executive directors, and a range of senior staff across the hospital. This included a wide group of clinical and non-clinical service and specialty directors. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes and papers to the board, investigations, and feedback from patients, local people and stakeholders.

Within the inspection period we had written to the trust asking for some immediate action and reassurance around a number of issues we had concerns around during the core service inspection of the trust. We reviewed the action plans around these concerns during our well led review.

Leadership

Since the inspection of December 2013, considerable change has been made to the leadership team, with new appointments to both executive and non-executive positions. The chair, interim chief executive officer, Director of Finance, Medical Director and Director of Nursing had all been appointed to the trust following our comprehensive inspection of 2013. With the exception of the chief executive officer, all were substantive appointments.

The leaders had the skills, knowledge, experience and integrity to lead the trust. The trust board members we met were a group of individuals with a wide range of experience, knowledge and skills, although most relatively new to their posts. The substantive Chief Executive Officer had been the Chief Executive Officer in Dartford since April 2010. They had recently been appointed to an interim role as Chief Executive Officer of another NHS trust. Therefore their deputy had stepped up into the Chief Executive Officer role at the trust on an interim basis four weeks before our inspection.
The interim Chief Executive Officer has served as the Director Of Operations and the Director Of Operations since joining the trust in August 2007. They became the Director of Strategy and planning in May 2014 and had been Deputy Chief Executive Officer in the trust since April 2017.

The Director of Nursing was appointed four weeks before our inspection. She had previously been in the post of Deputy Director of Nursing since February 2017. They had taken the post of Deputy Director of Nursing as a developmental role and were not expecting the previous Director of Nursing to leave the trust soon after her appointment. They had stepped into an interim role as Director of Nursing before being appointed substantively in October 2017.

The Medical Director was appointed in October 2016. They had previously worked in consultant roles and as a Medical Director in another NHS trust. The Medical Director holds a clinical role within the trust and is involved in wider external engagement with commissioners and the sustainability and transformation plan for Kent and Medway.

The Director of Human Resources joined the trust board in June 2008 from another NHS Trust where he was deputy Director Of Human Resources.

The Director Of Finance and performance joined the trust in June 2016 and has 30 years’ experience in the NHS, working within acute trusts and recently within NHS England. They were a qualified accountant, and had worked outside of finance for several years within both general management and planning. NHS Improvement have described as the Director Of Finance and as performance ‘providing stable financial leadership, following an extended period of frequent turnover in Finance Directors’.

The Director Of Operations was appointed in May 2014. They joined the Trust in 1997 and have both operational and management experience at the trust, most recently in the management of adult and emergency medicine. There most recent appointment was as Deputy Director Of Operations.

The Chairman was appointed in April 2017. They had been a Non-Executive Director at the trust since 2013 and had previously chaired the Trust Finance Committee and had also been a member of the Audit Committee. They had over 27 years’ experience working within the NHS and has been Chief Executive Officer of three NHS trusts.

The Chair was held in very high regard by the executive team. It was apparent that the Chair had a positive impact since their appointment. The impact of the new Chairperson was described by the executive as ‘higher and sharper’. The chairperson was meeting with the Non-Executive Directors and Board Secretary and was networking with other high functioning boards to bring back learning from this to the trust.

The trust had four Non-Executive Directors in post. We spoke with two Non-Executive Directors who were clear about their roles within the organisation. They expressed a confidence in their ability to provide sufficient challenge. We were told, “we challenge, we try to be constructive, we are listened to and our input is valued”.

The trust was satisfied that staff with director level responsibilities, including the Non-Executive Directors, were fit and proper persons in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We examined the files of four of the directors to check whether the information required had been obtained from these staff, and we found it was all in order. Our checks of formal documentation included fit and proper person reviews, appraisal information, recruitment processes and subsequent appointments indicated members of the executive team had a range of desired experience, knowledge and suitably fit for the needs of the services provided.
Board members

At the time of the visit 57% of executives who attend the board were female, and 14% were BME. Of the non-execs 33% were women and none were BME figure.

The Chief Executive and Chair were able to describe both the capability and capacity of the trust board. The previous Chief Executive had received a performance review in the past year with the Chair Person. This review was reported through the remuneration committee meeting. The board were up to date with performance reviews and had each member had completed a 360 degree appraisal in the last year.

Leadership development within the trust was co-ordinated by the clinical education department, through the leadership faculty. Programmes included leadership development days that provided an introduction to the tools required to be an effective leader. The new consultant development programme which consisted of six sessions over the year, aimed to provide the consultants with a better understanding of the role of a consultant in the modern NHS. The foundation leadership programme consisted of five sessions including leadership in multidisciplinary teams and service improvement.

We were told all directors had received a one to one with the Chief Executive Officer every two weeks, although we were unable to evidence this and these meetings did not form part of a key performance indicators. From the middle of 2017 the Chief Executive Officer had been having quarterly performance meetings with directorates (previously twice a year).

Leaders were visible and approachable. Discussions with staff as part of pre-inspection engagement largely drew positive comments about leadership. Most staff felt the executive team was visible, with the exception of lower banded staff who did not feel they had exposure to the board members. We were told the Chief Executive Officer visits the wards including the locations outside of Darent Valley Hospital regularly. Staff told us they felt they could approach the board with any issues. We were told the Chief Executive Officer had an ‘open door policy’ and were given examples where staff had used this to escalate concerns to the board and felt their issues were addressed.

Inspectors who undertook the core service visits did not receive any specific or detailed information to suggest there were any concerns about the executive leaders. During core service inspections there was acknowledgement of the newer members of the senior executive team, who were taking time to get to know staff. The Medical Director was cited by staff in a number of core service areas as being held in high regard, and of being visible and supportive. We found that the newer members of the executive team demonstrated good insight into the organisation and a drive to take the trust forward.

The Trust was split into five divisions. Each division had a general manager who reported to a clinical director. The clinical director for each division reported directly to the chief executive officer. All matrons reported to the general managers but were supported professionally by the Director of Nursing. The general managers reported to clinical directors but were professionally accountable to the Director of Operations. The clinical directors reported to the Chief Executive Officer but were professionally accountable to the Medical Director.

It was apparent from interviews that there was confusion amongst the executive teams and senior leaders in the organisation about the organisational structure. Some staff described the structure...
as a two/three directorate, and some as divisions. Staff told us there was a triumvirate leadership model, however, we did not find this to be the case. The structure in documents we were given and the structure depicted in the 2016/2017 annual report was incorrect. The Chief Executive Officer told us that the structure chart did not represent the current structure as it had not been updated for several years. From an accountability perspective, a lack of understanding of structure leaves the organisation vulnerable.

The hospital had recently implemented a new model of care that brought the emergency care directorate and adult medicine into one directorate. This included all staff under one umbrella. There was a new lead nurse for the directorate governance and a business operations manager in place since August 2017. This model also included streamlining the devolved leadership structure for medical workforce and charting the team under one management line. This new management structure was not fully embedded at the time of inspection.

The executive team were mostly able to describe the challenges to quality and sustainability, but had differing views on the actions needed to address them. At our interviews with the majority of the senior team, we recognised a common theme around challenges to the trust. This was centred on the increasing demand on all services and the imbalance between admissions and discharges, financial pressures, the recruitment and retention of staff, and governance systems that supported quality improvement. With the exception of governance these areas were reflected, as we would expect, in the trust’s corporate risk register and board assurance framework, where all these themes were assessed.

A number of initiatives were in development to support reduced turnover. This included working with vanguard partner Guy’s and St Thomas’ NHS Foundation Trust on leadership development, and the strategic education committee focusing on the development of career pathways for clinical staff. The trust did not currently have a development programme for band six and seven nurses. However, this formed a part of the Guy’s and St Thomas’ NHS Foundation Trust development work.

Development and succession planning for executive directors was overseen by the Remuneration Committee. In November 2016 the board presented a paper on deputising and succession planning arrangements for executive directors, noting that there had been a number of changes to the structure and membership of the executive team since the committee lasted reviewed arrangements in November 2015. The remuneration committee discussed the deputising and succession planning arrangements set out in the paper.

The trust had a workforce strategy (2017 to 2020) which included action plans relating to improving working life, sustainable workforce supply and enhancing workforce efficiency.

**Vision and strategy**

Staff had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The trust involved people working within the organisation to develop the trust values and behaviours. On our core service inspections we found that the vision and strategy was displayed across the trust with staff of band seven and above having a clear view on what this was. We found less engagement with the strategy from lower band staff who did not describe being involved in its development, and were not always able to discuss its content.

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust had developed a pictorial representation of its vision and strategy along with its sustainability and transformation plans. From this the trust had developed its values of care with
compassion, respect and dignity, striving to excel, professional standards and working together along with a behaviour framework.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans.

There was an up to date estates strategy which followed the clinical strategy, in terms of clinical service expanding and the clinical services future needs. The stakeholders involved in this strategy included the clinical commissioning groups, sustainability and transformation plans and the borough council.

There was no current nursing or quality strategy, the Director of Nursing had plans to refresh the quality strategy (published 2015/2016) following the findings in the Care Quality Commission core service reviews. The Director of Nursing recognised a gap in oversight and a need for a head of nursing role within directorate management teams in order to strengthen governance. The Director of Nursing held a ‘Friday Huddle’ with matrons and band seven nurses, along with a matrons meeting every six weeks which had a fixed agenda and was used as an opportunity to share important messages.

The trust had developed a pharmacy business plan developed to prioritise service goals for 2017/2018. The key drivers identified for this strategic plan were the Carter Review requirements to develop a hospital pharmacy transformation plan, the implementation of sustainability and transformation plans, and the growing vanguard collaboration with Guy’s and St Thomas’ NHS Foundation Trust.

The trusts annual objectives for 2016/2017 were based on five themes. Provide excellent, safe patient services. Deliver financial sustainability and efficiency, strengthen operational efficiency and effectiveness, promote excellent personal development and proactive partner engagement.
The board assurance framework outlined these objectives and the risks associated with achieving them. The board assurance framework was reviewed at each meeting of the audit committee, and the trust board every two months. The quality and safety committee and workforce committee reviewed the strategic risks from the board assurance framework which were relevant to their committees.

The annual plan for 2017/2018 was based around five objectives:
- Provide high quality, safe patient services
- Strengthen operational efficiency and effectiveness
- Proactive partner engagement
- Promote excellent workforce, education and personal development
- Deliver financial sustainability and efficiency

The trust had a risk assessment and action plan in place for mental health and child and adolescent mental health services provision at the trust.

Staff had access to a mental health liaison team, 24 hours a day, seven days a week that covered the whole hospital. The trust was in the process of bidding for the delivery of a CORE24 service. This would mean that psychiatric liaison service would be available for 24 hours (their current working hours are 9am-12 midnight).

We identified a gap in staff knowledge about the Mental Health Act 2015. There was a policy for enhanced observation of patients with mental health problems. Staff could access a Crisis Team if required but this had occasionally been problematic due to workload. This had been raised and discussed with the clinical commissioning group and was on the trust risk register. We found some areas of good practice for example, the matron in accident and emergency who was working closely with the trusts mental health partners; however this work had not been shared with the wider organisation.

The trust had a child and adolescent mental health services lead, who was also the person responsible for liaising with the child and adolescent mental health services service provided by Kent and Medway NHS and Social Care Partnership Trust.

The trust had one full time Dementia Specialist practitioner. We saw that a dementia bundle of policies and guidelines were available on the staff intranet. These included information on clinical and social assessment as well as support and discharge planning. The trust had a dementia buddy scheme which provided volunteers trained in the needs of patients with dementia, who assisted with the social care of patients in clinical areas and departments across the trust.

The trust had a specific action plan to continually improve services for patients with a learning disability. The trust learning disability nurse was responsible for ensuring services met the needs of people with a learning disability. The trust also had a ‘Carer’s Charter’ which explained the rights of carers to stay with patients during an admission.

Work was taking place at the trust to improve the services the trust provides to people with a learning disability this was being developed by the Specialist Nurse for Learning Disabilities. Special Register flags were added to the patient administration system to ensure all staff caring for people with a learning disability in emergency situations were aware there may be significant communication difficulties during the assessment and treatment of their patient. Additionally, the Trust had worked with local partnerships groups for people with a learning disability, their carer’s and support workers to provide key fobs which informed staff that they have a hospital passport which contains personal information about the person with learning disabilities, ensuring their care is tailored to their individual needs.
A learning disability liaison nurse was available to offer advice and help with care plans. The safeguarding lead was also a registered learning disability nurse. Ward staff told us they would alert the learning disability nurse when patients were identified as having a learning disability. The learning disabilities nurse was also able to make referrals to specialists who could confirm diagnosis for example, autism services and psychologists.

The trust made reasonable adjustments such as double appointment slots in outpatients so that extra time may be given. Hospital ‘tours’ had taken place for people with a learning disability. At this time there is not routine use of visual, braille or auditory versions of printed information, though assistance can be given by staff for the partially sighted patient or those with hearing loss not corrected by the use of aids, or literacy challenges.

A safeguarding committee met quarterly to discuss any learning points and report any incidences. These were also attended by the adult and child safeguarding leads. A biannual report was sent to the quality and safety committee to review and an annual report was sent to the trust board.

In line with national guidance, safeguarding was reported through a number of external bodies, for example a quarterly report to the clinical commissioning group (key metrics set by them), and an annual report to safeguarding adult board for Kent and Bexley respectively. The adult and child safeguarding leads also attended external safeguarding supervision with the local authority.

Culture

The trust’s strategy, vision and values underpinned a culture which was patient centred. The leadership culture in the trust was described by the Chief Executive Officer as ‘very focussed on getting it right for the patient’, and as a ‘friendly organisation where people felt free to express ideas and concerns’. Staff we spoke with during inspection all reflected that they cared and were focussed on providing good experiences of care for patients.

The trust recognised staff success by staff awards and through feedback. Department newsletters included a section labelled ‘special mentions and thank you’ and ‘you’re a star’. Staff were mentioned and thanked publically in this section for their dedication and hard work. The trust also had an annual awards programme to recognise staff excellence and commitment. Examples of this included leadership, excellence, care and compassion awards.

Most staff reported feeling supported, respected and valued. We met with different groups of staff including consultants, junior doctors, nurses, allied health care workers and support staff. Most said the trust was supportive to them. Staff described a friendly and supportive working environment. We saw supportive interactions from staff throughout our inspection. Staff reported feeling proud to work for the organisation.

Leaders and staff demonstrated they understood the importance of staff being able to raise concerns without fear of retribution. We witnessed open conversations in multi-disciplinary team meetings and board rounds which included challenging care decisions. This was welcomed and we felt staff interactions were positive. We were told that the culture encouraged, openness and honesty at all levels within the organisation but we were given a few examples where this had not been the case

Some of the junior members of staff we met said they did not always feel as well supported at times. They did not feel as engaged with senior executives, or felt their views were heard in consultations.

Staff side representatives felt that senior management mostly modelled the values and behaviours of the organisation. They said that although they had heard management talk to staff in ways ‘that they shouldn’t’ on occasions, they felt it was acceptable for trust leaders to have ‘bad days’.
The trust mission, ‘our family caring for yours’, adopted a family approach to trust behaviours. We found that although this culture had benefits it also had risks associated with performance management.

**NHS Staff Survey 2016**

Comparing 2016 Staff Survey results for Dartford and Gravesham NHS Trust to all acute trusts:
- Engagement score was 'higher' (70% response rate)
- Recommendation rates were 'much higher' (70% response rate)
- Staff reporting good communication was 'much higher' (75% response rate)

There has been some poor performance at Dartford & Gravesham NHS Trust in the 2016 staff survey, with the following areas showing as negative outliers:
- Witnessing errors, near misses or incidents witnessed in last month
- Reporting errors, near misses or incidents witnessed in the last month
- Significant difference between black and minority ethnic and white staff in three out of four indicators (KF26, KF21, Q17b)
- Staff experiencing harassment, bullying or abuse from other staff was 'higher' (50% response rate)
- Downward trend in a high proportion of staff survey indicators
- The trust has ten key findings where they are in the top 20% similar trusts in the 2016 NHS Staff Survey and one where they are in the bottom 20% of similar trusts.

<table>
<thead>
<tr>
<th>Key Findings where trust is in top 20%</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff satisfaction with level of responsibility and involvement</td>
<td>3.97</td>
<td>3.92</td>
</tr>
<tr>
<td>Staff satisfaction with resourcing and support</td>
<td>3.47</td>
<td>3.32</td>
</tr>
<tr>
<td>Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Staff recommendation of the trust as a place to work or receive treatment</td>
<td>3.93</td>
<td>3.77</td>
</tr>
</tbody>
</table>

In response to the staff survey the trust had developed an action plan which they reported progress on, through the workforce committee meetings. In response to staff feedback indicating a negative impact of operational pressures, which included a decline in staff recommendation of the trust as place to work or receive treatment. A reduction in reported staff motivation at work (from 4.01 to 3.95) and a reduction in staff satisfaction with the quality of work and care they are able to deliver (from 4.13 to 4.02). The trust had implemented workshops communicating the organisation vision/strategy to staff using a trust developed visual aid. They had also enacted a resourcing plan which included a nursing recruitment and retention plan and actions to address shortfall.

<table>
<thead>
<tr>
<th>Key Findings where trust is in bottom 20%</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month</td>
<td>32.0</td>
<td>25.2</td>
</tr>
<tr>
<td>Percentage of staff reporting errors, near misses or incidents witnessed in</td>
<td>88.0</td>
<td>90.0</td>
</tr>
</tbody>
</table>

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2 NHS Staff Survey 2016
The staff survey action plan responded to the above figures with an action of Director of Nursing and Medical Director to review survey feedback and identify specific actions for responding including increasing reporting and perceived fairness/effectiveness of incidence reporting with a plan to be confirmed end April 2017. This action had not been updated on the staff survey action plan and we were not given evidence that this work was underway or completed.

During core service inspections we found that staff in some areas were not reporting incidents that they should. This was due to staff either not understanding what constituted a reportable incident or staff not feeling they had the time to complete incident forms.

Staff diversity

The largest proportion of staff at the trust is from a white background (61.3%). A breakdown of all ethnic background can be seen below:

<table>
<thead>
<tr>
<th>Ethnic Background</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – White – British</td>
<td>61.3%</td>
</tr>
<tr>
<td>B – White – Irish</td>
<td>1.6%</td>
</tr>
<tr>
<td>C – Any other white background</td>
<td>7.1%</td>
</tr>
<tr>
<td>D – Mixed White and Black Caribbean</td>
<td>0.5%</td>
</tr>
<tr>
<td>E – Mixed White and Black African</td>
<td>0.6%</td>
</tr>
<tr>
<td>F – Mixed White and Asian</td>
<td>0.4%</td>
</tr>
<tr>
<td>G – Any other mixed background</td>
<td>0.6%</td>
</tr>
<tr>
<td>H – Asian or Asian British – Indian</td>
<td>8.0%</td>
</tr>
<tr>
<td>J – Asian or Asian British – Pakistani</td>
<td>1.1%</td>
</tr>
<tr>
<td>K – Asian or Asian British – Bangladeshi</td>
<td>0.4%</td>
</tr>
<tr>
<td>L – Any other Asian background</td>
<td>5.9%</td>
</tr>
<tr>
<td>M – Black or Black British – Caribbean</td>
<td>1.3%</td>
</tr>
<tr>
<td>N – Black or Black British – African</td>
<td>7.0%</td>
</tr>
<tr>
<td>P – Any other Black background</td>
<td>0.2%</td>
</tr>
<tr>
<td>R – Chinese</td>
<td>0.5%</td>
</tr>
<tr>
<td>S – Any other ethnic group</td>
<td>1.7%</td>
</tr>
<tr>
<td>Z – Not stated</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2016 – Performance on questions relating to harassment, bullying and equal opportunities

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and minority ethnic staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2015.
The response from black and minority ethnic and White staff at the trust was significantly different for Q17b.

In response to staff feedback about bullying and harassment, the trust had designed a respecting each other action plan, in conjunction with staff side and the trusts freedom to speak up guardian. The plan was designed to ensure there was clarity for all staff on what behaviour constituted bullying or harassment and ensuring structured intervention was in place at the right level to resolve concerns quickly. The plan also ensured managers were clear on the response expected from them to address behaviour below standards required and ensuring managers had the skills to discharge these responsibilities.

An equality and diversity workforce report was presented to the board annually through the workforce committee. We noted the annual workforce equality and diversity report for 2016/2017 contained a breakdown of the workforce equalities data and key trends, as well as the workforce race equality standard data for 2016.

The trust had produced an equality delivery system 2 in 2016/2017. Implementation of the equality delivery system 2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of equality delivery system 2 in accordance with the ‘9 Steps for EDS2 Implementation’ as outlined in the 2013 equality delivery system 2 guidance document. Equality delivery system 2 has four goals supported by eighteen outcomes. The four goals being: better health outcomes; improved patient access and experience; a representative and supported workforce; inclusive leadership.

The equality and diversity workforce report June 2017 noted that some findings suggest the trust could take more action to support its aim to be an employer of choice and more reflective of its local population particularly relating to:

- Age: lower proportion of staff under 25 years
- Disability: differences in the positivity of staff survey findings compared to non-disabled staff
- Ethnicity: disproportion of black and minority ethnic staff in more senior positions/differences within staff survey findings for both white and black and minority ethnic backgrounds
- Gender: disproportionate workforce trends in admin and clerical and medical and dental staff groups; disproportion of males within more senior grades; lower proportion of males

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2016</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White: 29%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME: 32%</td>
<td>26%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White: 24%</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME: 31%</td>
<td>27%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White: 90%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME: 82%</td>
<td>76%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White: 5%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME: 13%</td>
<td>14%</td>
</tr>
</tbody>
</table>
being managed in employee relations matters; statistically relevant differences in staff survey results)

- Religious belief: lower proportion of those holding non-Christian / Atheist religious beliefs going through formal employee relations processes.

‘Staff networks’ were not in place promoting the diversity of staff. It was not entirely clear how equality and diversity were promoted at the trust. We did not have any concerns raised with us, and all staff we met felt they were treated equitably. However, when we asked the trust to tell us about its staff networks, we were only told about support to overseas nurses who had come to work at the hospital.

There were no active support networks or forums, although plans were developing to create a black and minority ethnic support group. The board was not involved in establishing forums but the union stance was that they were neither encouraged nor discouraged from forming groups. A survey (September 2017) was sent out to black and minority ethnic staff at the trust requesting feedback on whether they would like a black and minority ethnic staff forum established. We were told by both unions and the Director of Human Resources that the response to the survey had been ‘luke warm’ and had not demonstrated a drive from staff to create a support group. Staff side were unable to describe a framework for how this group could potentially operate, or how they would get their voices heard at board.

We were told that there had been a Lesbian, Gay, Bisexual and Transgender Forum(LGBT), at the Trust but that it had, ‘gone by the wayside’ after a couple of meetings as no one was particularly interested’.

The trust worked in partnership with trade unions. Staff side described a good working relationship with board members and said that the trust was committed to be working in partnership with the unions. They said that problems within the trust were a result of the bigger national and economic picture and not unique to the trust.

Staff side representatives had an understanding of why decisions were being made at board level and were able to raise concerns openly with the board. The union representatives were not involved in any formal organisational changes or board decisions but there had been times that they were asked for comments. They described this as a mainly positive experience with occasional glitches.

Staff felt able to raise concerns without fear of retribution. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. The trust had appointed a freedom to speak up guardian in line with the principles and role profile produced by the National Guardian and following recommendations of the Francis report. The freedom to speak up guardian reported quarterly to the board. When we met with the freedom to speak-up guardian, they described their work and past cases as examples of workload. The freedom to speak up guardian reported themes to the board and described these as bullying, training, unfairness, management actions and staff ‘not being heard’. We had concerns regarding the capacity of one person to perform this role. The freedom to speak up guardian aspired to have an ambassador in post within a year. The Chief Executive Officer told us that they were reviewing the capacity of this role.

Staff knew how to use the whistle-blowing process and about the role of the freedom to speak-up guardian. The handling of concerns raised by staff met with best practice. Staff had a number of ways they could report concerns. The Human Resources Director told us that there was a number of different mechanisms for staff to raise concerns to ensure they could use the route that suited them best. We saw that the trust advertised methods for raising concerns on the intranet and on ward posters and newsletters. Most staff that we spoke with told us that they would know how to raise concerns if they needed to. On inspection we saw staff taking advantage of the Director of Nursing ‘open door policy’ as we saw staff coming to the executive offices to talk with the Director.
of Nursing when they had a concern. We saw that they were listened to immediately and their concerns were dealt with.

During October 2017 the trust bullying and harassment contacts undertook training in foundation level coaching to be able to best support staff that may contact them for advice and guidance around difficult/inappropriate behaviour they or others may be experiencing. The training supported the contacts to ensure they are able to listen as effectively as possible and provide the most helpful guidance. The trust human resources team were working with a counselling service to establish training for human resources team members on leading facilitated conversations designed to improve working relationships between individuals or teams where there has been a communication breakdown.

We had mixed feedback on whether managers addressed poor staff performance where needed. Some staff and directors felt that the family environment at the trust sometimes prevented challenge and difficult conversations.

The clinical education strategy quarterly Meeting which reported to the workforce committee oversaw all aspects of the trust approach to educating, training and developing its workforce. All directorates with below target core skills compliance had completed improvement trajectories as part of performance review meetings. This has supported an increase in directorate compliance rates including orthopaedics increasing from 79.7% to 85.4% compliance. A monthly detailed core skills training compliance report was published online showing by topic compliance at ward/service level and supporting management teams to target improvement action plans.
Sickness rates\(^5\)

Staff had access to support for their own physical and emotional health needs through occupational health. Sickness and absence figures were not outliers.

The trust’s sickness levels from July 2016 to May 2017 were generally lower than the England average, with rates increasing in line with the England average over the winter period and falling again in 2017 to a similar level with the England average.

The trust had installed automated health check stations in Darent Valley Hospital with over 1000 staff having had an assessment in the first three months of its operation, 26% of staff had visited the health check station more than once. The trust planned to use data from the health station to inform future health promotion. The health stations also support staff to understand options related to improving their health and wellbeing. The Darent Valley Hospital site is a smoke free environment which supports the overall health and wellbeing of both staff and patients.

**Governance**

We found that the board was not always assured of safety and quality through its governance structures. Although there was a governance structure in place inspection findings showed that it was not effective. We found that information and data type used by the board to gain assurance did not always provide the full picture. There were examples of where the board used outcome data for patients as their assurance, without assurance that practice was in line with best practice and policy. An example of this was in relation to infection prevention and control where the trust used the rate of infection as their assurance measure, but throughout the trust we saw hand hygiene practice was not in line with policy.

Key nursing metrics did not form part of the performance reporting framework. Balanced scorecards/ward dashboards for nursing were being developed but had not yet reached the stage of benchmarking. The trust were working towards an integrated scorecard, some departments had made good progress with this for example, maternity and urology.

\(^5\) Source: NHS Digital
Governance arrangements were not in place in relation to Mental Health Act 2015 administration and compliance. The trust did not have a mental health act strategy and a paper had not been presented to board. The Director of Nursing was planning to present a paper to board in the next quarter outlining a mental health strategy. The Director of Nursing acknowledged the trust had some work to do around meeting the requirements of the Mental Health Act 2015.

Each directorate had a monthly clinical governance meeting which was chaired by the clinical directors. A member of the governance team attended each meeting. A standard agenda was used through each meeting and directorates were invited to bring any issues for discussion at the quality and safety committee. We were told and found that there was variability in terms of the effectiveness of directorate governance meetings.

We were told that since the Care Quality Commission inspection of core services some challenging meetings had been held with clinical directors and general managers. The trust planned to hold a governance team summit following the Care Quality Commission findings to look at governance systems and streamline auditing processes.

Clinical directors reported governance through the chief executive. The trust had a governance structure along with a trust Board and sub-committee structure.

The trust board and sub-committee structure ensured that the remuneration committee, quality and safety committee, audit committee, partnership board, charitable funds committee, finance committee and workforce committee all fed into the trust board and Chairperson. These committees were each supported by further subcommittees.

Papers for board meetings and other committees were of a reasonable standard and contained relevant information. We reviewed the board papers for 2017. They were of good quality, well minuted and supported by action trackers. The new Chairperson had introduced a new front sheet for all board papers which linked to the board assurance framework, regulatory requirements, Care Quality Commission domains and financial performance and quality. The Chairperson had recently introduced teleconferencing for board meetings to support board attendance.

We found staff and directors acknowledged that organisational learning could also be improved upon. We found pockets of learning were demonstrated but that this learning had not been shared trust wide. We also found that assurance of embedded learning and improved practice were lacking because governance processes had not ensured best practice was adhered to, for example compliance with World Health Organisation checklists in theatres.

To address challenges to quality, the trust leadership team commissioned an external review of theatre safety in early 2017. The theatre review was following a number of serious incidents (called never events) in the operating theatres. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. We were told that the issues found during this review were similar to the issues we found during core service inspections.

The finance committee reported directly to the board and was chaired by a Non-Executive Director with a finance background. Non-Executive Directors also attended the audit committee. This committee, which was a sub-committee of the board focused on areas of finance, including fraud, internal and external audit, business planning, and information security.

Board Assurance Framework⁶

⁶ RPIR – Universal – submission P112 BAF July 2017
The trust have provided their board assurance framework which, for 2017/18, contains 33 objectives and risk action details.

In line with the risk management strategy, this year the board assurance framework is following the PRAG colour guide where purple is used for the risks rated 20 and above. There were no risks on the board assurance framework that after mitigation, are rated as 25. The status report provided shows that there are five rated purple, eight rated red, 15 rated as amber and five rated as green. The five purple rated risks are listed below:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description</th>
<th>Board Committee Overview</th>
<th>Current Risk Score (Q2) (2017-18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1860</td>
<td>Current endoscopy suite lacks capacity to effectively meet the demand (current and future). Business case for additional capacity has been submitted to NHS Improvement as part of the Kent and Medway sustainability and transformation plans.</td>
<td>Quality and safety committee</td>
<td>20</td>
</tr>
<tr>
<td>1845</td>
<td>Inability to maintain an appropriate level of admissions and discharges will mean that the trust cannot operate effectively and patient experience might be negatively impacted.</td>
<td>Quality and safety committee</td>
<td>20</td>
</tr>
<tr>
<td>1821</td>
<td>Failure to achieve financial sustainability and meet the statutory financial targets could destabilise the trust, threaten the future of the organisation and impact on the ability of the trust to influence its future direction.</td>
<td>Finance committee</td>
<td>20</td>
</tr>
<tr>
<td>1822</td>
<td>Capital resource not sufficient to meet the trust requirements resulting in loss of operational capacity and inability to meet strategic aims and priorities impacting on delivery of financial targets.</td>
<td>Finance committee</td>
<td>20</td>
</tr>
<tr>
<td>1861</td>
<td>Risk that clinical commissioning groups are unable to deliver their demand and capacity plans.</td>
<td>Quality and safety committee</td>
<td>20</td>
</tr>
</tbody>
</table>

**Management of risk, issues and performance**

Senior management committees and the board reviewed performance reports. However, due to the issues found on inspection, we found that clinical and internal audits were insufficient to provide assurance. Following the findings from our inspection the trust have commissioned an external review with the purpose of making improvements to the existing governance committee structures.

The trust held a serious incident declaration meeting weekly. This was chaired by the Director of Nursing and the Medical Director. Incidents relating to patient safety were presented and discussed by staff from the area where the incident had occurred. The purpose of this meeting was to ensure that those involved had an opportunity to review the event with the benefit of senior nursing and medical expertise, from which learning could occur.
The trust also had a patient safety committee which reviewed serious incidents and reported the data around these to the board. We looked at six serious incident investigation reports. We found that although there was some variance in quality they mostly showed that the trust had recorded the facts and findings, engaged the patient, and their family or carer, focused on learning from the incident, and was investigated in a credible way.
Provider Level risk register

Staff concerns matched those on the risk register. The trust have provided one document listed as their trust risk register which details 26 risks, including two new risks and the action plans regarding review and management of them. There were 24 open risks on the trust risk register as at August 2017.

The trust risk register also provides information regarding the top three risks from individual directorates, which are listed below:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description</th>
<th>Executive Responsible / Department</th>
<th>Current Risk Score (Q2) (2017-18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1353</td>
<td>Imbalance between admissions and discharges</td>
<td>Director of Operations / Trust wide</td>
<td>16</td>
</tr>
<tr>
<td>1376</td>
<td>Risk of insufficient nursing numbers and skill mix</td>
<td>Not stated</td>
<td>16</td>
</tr>
<tr>
<td>1751</td>
<td>Quality of care in the emergency department (performance of the ED department)</td>
<td>Director of Operations / Emergency department</td>
<td>16</td>
</tr>
</tbody>
</table>

Finances overview

<table>
<thead>
<tr>
<th>Financial Metrics</th>
<th>HISTORICAL DATA</th>
<th>PROJECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2 years ago)</td>
<td>Last Financial Year (2016/17)</td>
</tr>
<tr>
<td>Income (deficit)</td>
<td>£224.6m</td>
<td>£248.5m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£7.6m)</td>
<td>(£0.4m)</td>
</tr>
<tr>
<td>Full costs (deficit)</td>
<td>(£237.3m)</td>
<td>(£254.0m)</td>
</tr>
<tr>
<td>Budget (deficit)</td>
<td>(£3.8m)</td>
<td>(£6.1m)</td>
</tr>
</tbody>
</table>

The financial position in the trust was as follows: In 2017/2018 the trust was reporting a 1.6 million surplus and was on track until month four. They then reported a deficit which for the full year was estimated as 16 million, in month seven this deficit was 9.5 million. The Director Of Finance told us that this was due to clinical miscoding, extra activity and activity that the trust used to get paid for and is still carrying out the activity but not being paid. They said these factors contributed to the trust now reporting a deficit.

There was a cost improvement plan and financial recovery plan but all schemes that may adversely affect or reduce clinical care had all been rejected. The Director Of Finance was confident if the coding was rectified and the clinical commissioning groups paid for the extra activity along with the non payment of activity they were hopeful of a 1.6 million surplus at year end. This was aspirational and could not be evidenced. NHS Improvement told us that the trust had developed a financial recovery plan in order to improve its financial position in the remainder of the financial year to achieve its control total, however delivery of this was uncertain as material elements of the plan were not within the control of the trust.

Additional Evidence Requests - P112 – Agenda item 8.15 TRR – August 2017
RPIR – Universal – Finances tab
The trust was working closely with the SE London sustainability and transformation plans bank and agency lead to identify efficiencies in the way the trust managed temporary staffing across all staff groups.

The hospital is owned by a private finance initiative company which effectively manages both the hard and soft facilities management as the hospital is their building. The capital programme was developed each year and business cases were submitted to the capital group. These were assessed on risk and need and were submitted to the finance committee for final sign off. Capital funds were difficult to acquire as the building was not owned by the trust and as such there was no depreciation of an asset.

The Estates Director was proactive in his approach and was attempting to change the way that the contract worked. They were in talks with the private finance unit to try to, along with the hospital company, change the contract to a standard form three contract (a more recent type of private finance initiative contract).

Usually within a private finance initiative agreement the life cycle cost is kept to fund such items as new doors and new flooring within the building. The Director of Estates described the life cycle replacement works as inadequate as the trust has a standard form one private finance initiative contract. standard form one contracts were the first private finance initiative contracts to be let by the government and as time has gone on have proved to be very difficult to manage. The Director of Human Resources told us that these contracts were left deliberately weak on key performance indicators and compliance to entice the investors. A lack of control over these contracts also impacted on the governance around hospital cleaning and assurance. For example, the cleaning contractor declaring themselves as compliant, but not required to share the evidence of this.

We asked about the programme for back log maintenance and were told that there was no back log maintenance as the private finance initiative company had a programme of replacement via the life cycle to ensure all assets are kept maintained or replaced. The Estates Director had no sight of whether this is happening or not and only became aware of issues when the equipment failed.

The results of the condition survey were not seen by the Estates Director and this was the same for the six facet survey. This meant that the Estates Director has no oversight of the condition of the building and where to prioritise resources.

There had been issues with planned preventative maintenance which was tabled at board level and an action plan developed to try to ensure all planned preventative maintenance were completed.

**Information management**

The chief executive was the accountable officer, and as such had responsibility for ensuring an effective risk management system was in place. The Medical Director was designated as the individual responsible for leading on patient safety and risk management. In addition, the Director of Nursing, in conjunction with the Medical Director was required to maintain an overview of clinical governance arrangements, which included the reporting, management and investigation of adverse incidents.

The Director Of Finance had a joint responsibility on the trust board, which also included their role as the senior information risk owner.
In the wider governance of information, particularly that of patients, the trust was careful about sharing data. The trust recognised there was a benefit to the NHS and wider health and social care from sharing information for statistical and clinical research. However, we were told the trust was determined to be cautious with their approach, and the trust’s information guardian was closely consulted.

There were arrangements to ensure the availability and integrity of identifiable data, records and data management systems in line with data security standards. However, there was a lack of staff supervision of confidential patient information in some areas. During our unannounced inspection in November 2017, we found breaches in patient confidentiality across urgent and emergency care, surgery and medicine.

The breaches related to the use of a diary open on the desk in the emergency department and some computer on wheels not being locked when unattended. The trust had learned from these breaches and had put a new electronic system into the emergency department. Although the senior information risk owner could not guarantee that computer on wheels would be locked at all times staff had been reminded in the information governance newsletter to be mindful of protecting confidential data. We were also told that every incident that was reported that had an information governance concern was reviewed by the team and if necessary the team took immediate action.

The board received information on quality and sustainability. The board were informed of the trust’s performance at each monthly board meeting. However there was still work to be done to create a fully integrated performance report which looked at the quality of care, directorate statistics, and highlighted those rated as falling below standards or targets.

There were effective arrangements to ensure that data or notifications were submitted to external bodies as required. There had been no concerns from external bodies raised with the Care Quality Commission about the quality or timeliness of data required. Incidents, including serious incidents, were reported as required to the NHS national reporting and learning system or the NHS strategic executive information system.

The trust had completed the information governance toolkit assessment. The information governance toolkit is an annual assessment that all NHS organisations are required to complete. The trust information governance assessment report overall score for 2016/17 was 74% and was graded ‘green’. An independent team had completed the audit and the trust took action where needed. This was reported to the audit committee who monitored the progress on the actions relating to it.

We were told that the board was assured that the level of information they received was of the quality they required and the senior information risk owner was challenged at board and committee level. The challenges were mainly around the risk and the board were assured the risk was acceptable. The audit committee had challenged the senior information risk owner on the level of risk surrounding the NHS information technology cyber-attacks.

Staff had access to the information technology equipment and systems needed to do their work. The senior information risk owner felt that staff had access to sufficient computer resource particularly with the role out of computer on wheels and the electronic system on medical records.

**Engagement**

The trust had a patient engagement strategy plan in place but at the time of inspection this had not been embedded into practice. Involvement of patients with any of the nine protected characteristic was being developed in line with the strategy. There was no data collected from patients with
protected characteristic such as sexual orientation, civil partnership and gender reassignment. There was a diversity management group and we were told they would be discussing how this data could be collected in the future.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Ward managers held meetings with staff although these were not always delivered consistently, with some wards having meetings every six weeks and some not happening at all. This meant we found inconsistent learning from incidents and complaints and trust messages across different departments.

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The board invited patients to trust board meetings to give the board the opportunity to hear the patients’ perspective of their healthcare journey. We were told that the board learnt from these experiences to make improvements.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs, this included the friends and family test, patient surveys, ‘every thank you counts’ cards and the national inpatient survey which was conducted once per year.

The trust had a patient experience committee to which patient representatives attended. The patient experience was discussed at these meeting and actions were monitored in order to improve various aspects of the patient experience. The Board heard ‘patient stories’ directly from patients or carer’s on a regular basis to highlight positive and negative experience.

The trust had produced a *Guardian of Safe working hours report* in November 2017 which was presented to the workforce committee. From the 1 April 2017 to the 1 August 2017, there were a total of 135 exception reports. In comparison, the period stretching from the 2 August 2017 up to November 2017 where there were a total number of 314 reports. Since April 2017, there has been a total of 445 exception reports, 412 of which related to hours worked, and 33 to missed educational opportunities. Data showed that trauma and orthopaedics had the largest number of reports. This was due to discrepancies in the rota which have now been resolved.

Within the medical directorate, the largest number of exception reports originated from Ebony ward. Significant changes have been made to the workload of juniors working on Ebony, with the appointment of a second registrar, and the new allocation of junior doctors to Mulberry ward, which had previously also been covered by junior doctors from Ebony. In addition, a locum doctor replacing a trainee on long term sick leave on Ebony ward, had been appointed. The trust therefore anticipated an improved picture. However, we were unable to test the effectiveness and sustainability of this on inspection as changes had not had time to embed.

Junior doctors, through the junior doctor’s forum and service improvement projects, were working on improving handover mechanisms, aiming at helping to reduce the out of hours workload. This included the introduction of bleep filtering and a current proposal to change the electronic handover.

Junior doctors had raised concerns with the Care Quality Commission about roster management particularly at foundation one and senior house officer level. Junior doctors have since met with senior members of the adult medicine directorate to address the issues. A group of junior doctors have now put together a rota management group with the rota manager for adult medicine, which will be working to improve the overall situation going forwards. The clinical director for adult medicine will be meeting regularly with the guardian and deputy human resources director to review trainee concerns through the exception reporting process and junior doctors’ forum in order to proactively respond to issues as they arise. We were unable to test the effectiveness or sustainability of these measures at inspection.
Junior doctors had also expressed concerns about a recent increase in rota gaps, resulting in them being asked to cover duties on other wards, where staffing levels have fallen below ‘minimum staffing levels’. Some junior doctors believe that many of these rota gaps had not been unforeseen, but occurred predictably, with little being done to address the problem electively.

As of 20 November 2017 52% of front line staff had received a flu vaccination against the trust target of 75% to ensure ‘herd’ immunity (WHO recommended levels) and to achieve CQUIN. The directors of operations and nursing and quality were working with occupational health to ensure areas with low vaccination take up rates were supported to increase this.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust had been working with both the south east London and Kent and Medway sustainability and transformation plans.

The trust worked in partnership with Dartford, Gravesham and Swanley and Bexley clinical commissioning groups. Directors told us they had a good working relationship with the local community and mental health trusts, along with social services (Kent and Bexley) and Kent County Council.

The trust attended the health and wellbeing board in Dartford, Gravesham and Swanley. This board reported into the Health and wellbeing board in Kent. The COE attended health scrutiny committees in Bexley and Dartford. There is a discharge to access programme, this is being led by Social care and has a trust project manager.

**Learning, continuous improvement and innovation**

The trust took learning and action as a result of concerns raised. However we had concerns that learning from incidents and complaints was shared and experienced locally in teams but not shared across the trust.

The trust demonstrated it was prepared to learn from the death of patients, and support families and carers through any investigation process. The trust had responded to the 2017 NHS National Quality Board guidance on Learning from Deaths and the 2016 Care Quality Commission report ‘Learning, candour and accountability’ which requires a quarterly mortality report should go to the board, with the first by the end of 2017. The trust had delivered on this requirement with the first report to board presented in December 2017. It is too early to test the intention for these to be delivered quarterly.

The trust had a mortality review group, which directed the analysis, learning and reporting on patient deaths. The death of any patient in the hospital was reviewed by three consultants at an independent monthly review. Each death would be graded to determine where the care and treatment lay along a scale. This started from the death being unpreventable and the normal progression of the patient's illness or condition. At the other end of the scale was where the death was deemed as preventable and unacceptable standards of care or failure to follow procedures contributed to the death. Records showed these latter circumstances were rare. Any death where significant concerns were identified was sent to the serious incident review group for investigation. The mortality review group presented their findings to the patient safety committee.
Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>What is your internal target for responding to complaints?</th>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25</td>
<td>41% (June 2017)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your target for completing a complaint?</th>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25</td>
<td>41%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you have a slightly longer target for complex complaints please indicate what that is here.</th>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Up to 60</td>
<td>51%</td>
</tr>
</tbody>
</table>

* The trust qualified completing the complaint is defined as closing the complaint, having been resolved or decided no further action can be taken.

Complaints

The trust received 270 complaints between August 2016 and July 2017. Medicine received the most complaints with 60 (22% of all complaints) 222 of the 270 complaints (82%) were either closed within the 25 working day agreement or closed within an agreed extension deadline 48 complaints remained open.

The trust had a central team of three staff to deal with complaints, with additional leadership from a senior nurse. There was also a patient advice and liaison officer who supported this work. The medical care directorate provided complaint responses with actions to the central team for logging and these were then reviewed by the Director of Nursing who was the executive lead for complaints. The Chief Executive Officer saw every complaint response and had overall sign off.

We saw and heard evidence to suggest good learning from complaints in individual areas but did not see trust wide learning disseminated.

We saw information in all areas about how to complain and information leaflets on how to contact the patient advice and liaison office.

We saw evidence of complaint reports being reviewed at various committees for example the quality & safety committee who sent reports to directorate meetings so that local teams could have sight of relevant learning as well as performance issues and any required actions.

The trust applied duty of candour, as evidenced within our review of documents pertaining to adverse events and serious incident investigations. They took learning and action as a result of concerns raised, and were open and honest in their communications to individuals concerned. The trust discussed all reported incidents during a weekly serious incident declaration group. During this meeting duty of candour and disclosure to the patient or family was discussed and a communication process put in place for each case.

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9 RPIR – Universal – Complaints overview tab
10 RPIR – Universal – Complaints tab
NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust actively sought to participate in national improvement and innovation projects. The trust participate in several schemes however the table below shows which services within the trust have been awarded an accreditation together with the relevant dates of accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme</th>
<th>Details of accreditation and date (if available)</th>
<th>Related core service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy Unit. August 2016 and accredited for 2017</td>
<td>Medicine (including older people's care)</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189</td>
<td>Medical laboratories – 20/10/2016</td>
<td>Diagnostic Imaging (additional service)</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Yes - 2016</td>
<td>No</td>
</tr>
</tbody>
</table>

External organisations had recognised the trust’s improvement work. Individual staff and teams received awards for improvements made and shared learning. The trust worked with Guy's and St Thomas’ NHS Foundation Trust with their vanguard initiative. This acute care collaboration with Guy's and St Thomas’ NHS Foundation Trust had seen improvements in care delivery in a number of areas including vascular surgery, paediatrics and cardiology. Patients were able to be treated locally with support from the tertiary provider with the two trusts investing in clinically led models of care that had strengthened the clinical leadership and given patients a clearer more efficient pathway.

The trust had developed several performance dashboards including one for monitoring infection control performance. They undertook a number of initiatives involving staff across the trust including a Rapid Improvement Programme which focused on improving the discharge planning processes. This involved representatives from partner organisations across the Local Health Economy and was done in conjunction with NHS England and NHS Improvement. It has contributed to a significant reduction in average length of stay on the core inpatient wards.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented. The trust had completed the first phase of the THINK2020 Programme, which involved transforming the core services to work more efficiently and create the capacity to meet increasing demand.

A new patient information leaflet has been developed to help manage patient expectation around admission and discharge. The programme had been nominated for a health service journal award.

The trust has a Lean Thinking Transformation Programme which empowered staff to make small changes within their own areas with a view to improving patient care. They had implemented over
150 lean projects across the trust as a result. The programme formed part of their strategic objectives.

The trust had implemented several initiatives to improve patient flow through the hospital including Red and Green Days, the SAFER Bundle, EndPJparalysis and the Fabulous Fortnight. They had developed a ‘modernisation and improvement bubble’ to showcase improvements and share best practice.

Maternity services had employed a audit midwife. The audit midwife was involved in the Phoenix trial which looked at whether delivery in women with pre-eclampsia between 34 and 36 weeks of gestation reduced maternal complications without short and long term detriment to the infant compared to expectant management and delivery at 37 weeks of gestation.

The delivery suite was involved in ‘the safety culture, quality improvement and realistic evaluation project in 2016 and 2017. This was a project developed by the Kent, Surrey and Sussex Academic Health Sciences Network. The project was an evaluation study to identify effective strategies of working in particular settings. Work was still in progress on the project at the time of inspection.

The chief pharmacist collaborated with pharmacists at mental health trusts to produce a guide on common issues relating to medicines for mental health. This was now in use by pharmacy staff at the trust to improve medicines optimisation for people taking medicines for mental health.
Darent Valley Hospital

Urgent and emergency care

Facts and data about this service

The urgent care services at Darent Valley Hospital provided twenty four hour emergency care. The department comprised of a minors, majors, resuscitation area and Clinical Decision Unit. There was an additional area called majors B that provided additional capacity to meet sudden surges in demand. A recent investment has seen the service reconfigured to include a new GP streaming service. This was introduced to improve and manage increased demand and better meet local needs.

On average, Darent Valley Hospital's emergency department saw 300 patients per day and 80 ambulances. 50 majors patients, 80 sub-acute majors, 50 minor illness, 40 GP cases (including paediatrics), 30 minor injuries, 50 paediatrics. Around 65 young patients a day are seen in children's emergency department. However, we did not inspect the paediatrics service provision on this occasion.

In order to undertake this inspection, we gathered the views of patients, staff and external stakeholders, and reviewed care records, service feedback and trust performance data. We spoke with 10 patients, 40 staff and reviewed 23 care records.

Details of emergency departments and other Urgent and Emergency Care services

The emergency department saw 100,455 attendances in 2016/17. There are nine minors’ cubicles and 20 majors’ cubicles. One can be flexed into a rapid assessment and treatment cubicle or majors step-down area (by providing additional chairs). The resuscitation area has four bays which can stretch to five. There are approximately 120 doctors, nurses and other practitioners.

Walk-in patients are streamed by an advanced nurse practitioners between 8am - 8pm Monday to Friday. There was an on-site General Practitioner from 10am -11pm daily for re-directing non-acute patients.

There was a rapid assessment and treatment multidisciplinary team (running for up to 13 hours per day) led by a Consultant or middle grade doctor and assisted by a junior doctor (Foundation Year 2), nurse and emergency department assistant.

The acute medical unit has 31 beds with consultant decision making coverage for 14 hours Monday to Friday and 12 hours at weekends. The acute medical unit works closely with ambulatory emergency care unit to provide pathway based ambulatory care, seeing around 50% of referrals to acute medicine managed and discharged home same day.

The Clinical Decisions Unit has 4 non-ambulant bays (beds) and 8 ambulant bays (chairs) in use under strict protocols, and managed under the care of the Emergency Department medical team.

(Source: Trust Provider Information Request)
Activity and patient throughput

Total number of Urgent and Emergency Care attendances at Dartford and Gravesham National Health Service trust compared to all acute trusts in England.

There were 115,117 attendances between April 2016 and March 2017 at Dartford and Gravesham National Health Service trust as indicated in the chart above.

(Source: National Health Service England)

Urgent and Emergency Care attendances resulting in an admission

The proportion of urgent care attendances resulting in admission fell between 2015/16 and 2016/17. In 2016/17, rates were higher than the England average.

(Source: National Health Service England)
Urgent and Emergency Care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>27,523</td>
</tr>
<tr>
<td>Discharged*</td>
<td>72,022</td>
</tr>
<tr>
<td>Referred^</td>
<td>10,937</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,275</td>
</tr>
<tr>
<td>Died in department</td>
<td>87</td>
</tr>
<tr>
<td>Left department#</td>
<td>4,718</td>
</tr>
<tr>
<td>Other</td>
<td>3,404</td>
</tr>
<tr>
<td>Not known</td>
<td>944</td>
</tr>
</tbody>
</table>

^ Includes: to Accident and emergency clinic, fracture clinic, other OP, other professional
(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory Training

The department was not achieving the trust target for training compliance. This may have an impact on the quality of care delivered.

The trust provided regular mandatory training to all staff. Staff told us they attended training sessions when required but said there were occasions when getting to training was difficult due to the staffing levels in the department. Training compliance was monitored by the practice development lead and also by the Human Resources department. We were told the data held by Human Resources was not as accurate as local oversight. Staff described up to a two month delay with the central database being updated.

Examples of the training provided included health and safety, conflict resolution, information governance, infection control and prevention, resuscitation and moving and handling. The aggregated training compliance rate was reported as 82%. Data we received stated the total did not include the information governance compliance rates, and did not give a reason for this. Preventing radicalisation and emergency resilience training became mandatory requirement from April 2017.

The Clinical Commissioning Group set the trust a target of 85% for completion of mandatory training modules, apart from infection prevention level two where the target was set at 95%.

In their Provider Information Request the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and staff group.

We contacted the trust on 31 October 2017 and asked them to supply a breakdown by staff group for each core service. The below is a breakdown of compliance for mandatory training modules between April 2016 and March 2017 for all staff in the Urgent and Emergency Care core service at the trust.
The 85% training target was met for four mandatory training modules. The target was not met for the remaining ten modules.

(Source: Routine Provider Information Request P40 – Statutory and Mandatory Training)

The department reported achieving good compliance rates in some areas: for example, conflict resolution (88%), equality and diversity (89%), health and safety (89%) and resuscitation (88%).

We requested information about Chemical, Biological, Radiological and Nuclear defence training. We were not provided with the compliance rates for the department. The trust told us 44 staff in urgent care had received the training which equated to 44% of the team.

The trust provided assurance it was part of a joint training programme with other National Health Service hospitals in the area which ensured standardised training across Kent and reinforced the ability to call on mutual aid should an major incident occur.

The staff notice board had many examples of training available to staff. These included a diabetes update, patient safety training, tissue viability, team based trauma simulation course, prevention of falls, respiratory training, mentor updates, moving and handling training.

A training needs analysis had been recently undertaken to identify the training needs of the staff. This meant that the department was trying to identify training needs and provide staff with training to be able to undertake their roles. Staff told us that staffing shortages had an impact on their ability to attend training.

**Safeguarding**

We found a lack of robust systems and processes to protect adults and children from the risk of abuse.

The department raised safeguarding concerns by leaving a note in a diary in the major’s area for the safeguarding lead to review. Some staff we talked with actively used the diary to raise a concern whilst others told us they would fill out an online form to raise a concern. This meant there were inconsistencies with staff’s understanding of how to raise a safeguarding concern.

The diary system did not provide assurance that concerns were being reviewed and alerts generated. Staff told us that the safeguarding team worked office hours between Monday to Friday only. We asked staff what happened to any concerns recorded in the diary between Friday evening and Monday morning. Staff told us they were unsure and thought the safeguarding team reviewed these entries on the Monday morning. This meant that any concerns identified over the weekend were not reviewed or reported potential safeguarding concerns identified by staff at weekends, were not being raised in a timely manner.
We saw sensitive patient information recorded in the safeguarding diary that raised concerns around patient confidentiality, and compliance with national information governance requirements. The diary was stored on the desk in the majors area which meant it was not kept confidential or stored securely in line with the regulation 17 of the Health and Social Care Act 2008. We raised this concern with the trust during the inspection. Correspondence we received from the trust indicated these concerns were being addressed by the senior leadership team.

The Clinical Commissioning Group set the trust a target of 85% for completion of all safeguarding training modules.

As explained above under mandatory training, in their PIR the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and then by staff group.

We contacted the trust on 31 October 2017 and asked them to supply a breakdown by staff group for each core service.

In the meantime the below is a breakdown of compliance for safeguarding training modules for all staff in the trust’s Urgent and Emergency Care service.

Safeguarding children level 3 was the only safeguarding module for which the 85% target was met. Compliance was particularly low for safeguarding children level 2 (approximately 65%).

(Source: Routine Provider Information Request P40 – Statutory and Mandatory Training)

Training rates were broken down by the level of training staff received. Data we were provided in November 2017 reported compliance with safeguarding training as: safeguarding adults level 1 (78%), safeguarding children level 1 (80%), safeguarding children level 2 (76%), and safeguarding children level 3 (79%). This meant the numbers of staff attending safeguarding training fell below the trust compliance rates of 85%.

Cleanliness, infection control and hygiene

Patients were not always protected from the risk of acquiring health care associated infections.

We visited all areas in the urgent care department and found these were visibly clean. We saw records that showed cleaning was regularly undertaken.
Staff were observed washing their hands and wearing Personal Protective Equipment when attending to personal care. Generally, staff we observed during the inspection were arms bare below the elbows. However, we saw one member of the multidisciplinary team on Cypress ward not adhering to the trust infection control policy. They wore large rings, and nail polish. This went unchallenged by staff. We requested six months hand hygiene data (May to October 2017) to review department performance. No data was provided for May, and compliance rates for June to September 2017 were between 75% and 85%. October 2017 was reported as 90%. This meant that the department only met the required target once in a five month period.

During our inspection, we undertook a twenty minute observation of staff in the emergency department cleaning their hands, during our 20 minutes we saw there were 11 times when hands should be cleaned. We saw that on six occasions staff cleaned their hands in accordance with the trusts hand hygiene policy. However, on five occasions we saw staff did not clean their hands in line with policy. We saw on four occasions, staff did not clean their hands after having contact with the patient environment, and one occasion after touching a patient. This meant the trust could not be confident staff are applying consistent good hand hygiene to prevent the spread of infection.

There were systems to make sure commodes were kept clean. We saw there were posters on display that showed staff how to clean the commodes, and which cleaning wipe should be used. We saw completed daily clean chart, which showed commodes were cleaned at least once a day. During the inspection we saw all commodes were labelled with ‘I am clean’ labels. During our inspection we looked at two commodes, all were visibly clean. Audit data we reviewed between April and September 2017 showed compliance ranged between 0% to 100%.

We had concerns about the cramped and crowded conditions on Cypress ward which raised many infection control concerns. For example, staff not being able to move beds without infringing on at least two other bed spaces. We observed this during the inspection. Equipment was stored very close the ends of patients’ beds. The seated area housed patients in very close proximity to each other which made mitigating the risk of health acquired infections difficult.

We saw waste being disposed of in line with trust policy. Sharps bins were assembled and labelled in line with trust policy. Staff told us the department had two cubicles that could be used to isolate infectious or neutropenic patients. Neutropenia is an abnormally low level of neutrophils. Neutrophils are a common type of white blood cell important to fighting off infection. However, one of the cubicles did not have a solid door and would not offer more protection than a standard cubicle. This did not need the standards in Health Building Note 00-09; infection control in the built environment. One of the side rooms had an ensuite facility.

Linen trolleys were used in the department, but these were not covered in line with best practice recommendations.

We looked at two dirty utility rooms in the department. We found them tidy and uncluttered, and they had a separate dedicated hand hygiene sink with soap and paper hand towels available, a slop hopper for disposal of body fluids and a separate deep sink for cleaning equipment.

Disposable curtains were in use in the emergency department. Each curtain had a label showing the date changed; all were changed within the last six months in line with Health Building Note 00-09, which says curtains should be changed regularly to help reduce the chance of bacteria passing from one person or an object to another. Cubical curtains had the dates they were changed clearly recorded.

Environment and equipment
The service had a suitable premises and environment, with the exception of Cypress ward. We recognise the significant spending and subsequent improvement to the front end of the department since our last inspection. Equipment was well maintained in line with trust guidelines.

The environment on Cypress ward was not fit for purpose. We were told it was designed to hold five/six beds and had additional space for up to six patients on chairs. The number of chairs was adjusted by acuity and demand. It was an L-shaped area, with a nurse’s station in the middle of the layout. It was not possible to see patients from the nurse’s station. The area was very cluttered and due to the layout, made moving beds and equipment in and out of the area very difficult. We saw medical equipment stored along the wall in close proximity to the end of patient’s beds which could be an infection control risk.

During the inspection we carried out checks of the emergency equipment in Cypress ward. We were unable to find the check log and noticed the tamperproof seal on the trolley had been broken. We asked staff if there had been a recent emergency. We were told that there had not been. Staff said they had checked the trolley in the morning as part of their routine checks and had left the trolley complete. Staff began to search for the missing log book and tried to understand how the tamperproof tag had been broken. It later became apparent a patient with mental health problems had hidden the log book and tampered with the seal on the trolley. As there was a possibility the emergency equipment had been tampered with, staff responded immediately and rechecked its contents and moved it to behind the nurses’ station. However, this incident presented itself as a potentially serious risk to patient safety which had not been identified by the staff or the environmental risk assessment. We reviewed a copy of the last environmental risk assessment. It appeared to be a generic risk assessment that had not been tailored to Cypress ward. It was therefore not an effective tool to help staff identify potential risks.

We carried out a review of all the emergency trolleys in the department. The records we viewed demonstrated an inconsistent approach to undertaking safety checks. We were concerned that trust processes were not being undertaken in line with trust policy for example daily checks with weekly breaking of tamperproof seals to check drawer contents. We saw one example of checks being signed for that included checking the expiry dates of equipment. However, we found paediatric electrodes which expired in July 2017 on a trolley in majors.

In resus, we found a trolley that was labelled the ‘difficult airway’ trolley. Several key items were missing from the drawers. There was some confusion amongst staff about whether the trolley should have been removed from the area as there had been recent changes to difficult airway management. However, there was a lack of clarity surrounding why the trolley was present and predominately empty. The potential risks associated with this were immediately understood by staff. The trolley was removed from the resus area and all staff were provided with updated information on the recent changes to transferring these patients to theatre. We requested the difficult airway transfer to theatre procedure and the risk assessments to support the change in practice. We were not provided with documentation to evidence a specific risk assessment was undertaken prior to making the changes to protocol. We were told a ‘difficult airway assessment regarding suitability to transfer to theatres for further intervention is almost always done at a Consultant Anaesthetist/Intensivist level.’ We were not provided with evidence of this. The trust may wish to seek assurance that the new processes are clearly understood by staff.

The records we viewed across the department showed medicine fridges were not checked in line with trust policy. This meant that there little assurance that medicines were stored in line with the manufactures guidance and were safe for use. The inconsistencies we noted throughout the department meant there was little assurance the checks were carried out consistently and in line
with trust or best practice guidance. This meant we had concerns around the validity and quality of the department safety check list.

**Assessing and responding to patient risk**

Patients did not always have all their risks identified or managed consistently.

The department lacked a risk based nursing assessment tool to identify and manage risks effectively. Standardised risk based nursing assessment tools can help staff to quickly determine the level of risk and manage flow in a department with high patient demand. There was an additional benefit in providing obvious prompts for temporary staff to follow which ensured standardised care quality and compliance with best practice guidelines. When we brought this to the attention of senior staff, we were told the department was in the processes of considering changing its documentation.

We asked senior staff if there was a formal audit cycle to monitor the effectiveness of risk assessments or escalation processes. We were told that there was no formal process in place.

We asked staff if deteriorating patients had timely access to medical reviews. Staff told us patients were not always seen in a timely manner due to the workload, number of available medical staff, and demand in the department. Staff also told inspectors they felt pressured to move patients who had not had their clinical assessments completed just to avoid breaches. We asked if this was formally monitored. There was no process in place to measure this.

We reviewed three sets of mental health records. We found two out of three records did not contain a completed risk assessment. We raised this with the liaison team and immediate action was taken.

A new streaming process had been implemented just before the inspection. This was introduced to ensure patients were triaged effectively and moved to the most suitable area in the urgent care department based on their individual needs and risks identified.

The department used a National Early Warning Score to help identify deteriorating patients. National Early Warning Score can be defined as a guide used by medical services to quickly determine the degree of illness of a patient. We reviewed records that showed varying degrees of completeness. This meant that there was an alert system in place to help staff identify patient who's conditions may be at risk deterioration.

Patients who arrived by ambulance were taken to the majors area and triaged. This meant they were streamlined to be in the right place, to get the right care in a timely manner.

Patients with suspected stroke, sepsis and fractured neck of femur, were treated according to the trust pathway.

Pressure area damage was assessed with the Braden assessment tool. This was an assessment tool to help nurses help identify a patient's risk of developing a pressure ulcer. Documentation had a body map for staff to complete on admission. We saw this in use during the inspection.
Emergency Department Survey 2016

The trust’s scored “about the same as” other trusts for all of the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommended that the time patients should wait from time of arrival to receiving treatment is no more than one hour.

Performance against this standard showed a trend of improvement, following a similar trend to the England average. However, the trust met the standard for just one month over the 12 month period between September 2016 and August 2017. August 2017 was comparable to the national standard of 60 minutes. Performance has remained worse than the England average for all 12 months observed.

Ambulance – Time to treatment between September 2016 and August 2017 at Dartford and Gravesham National Health Service trust

(Source: National Health Service DIGITAL: Accident and Emergency quality indicators)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was similar to the overall England median over the 13 month period between September 2016 and August 2017. In the latest month, August 2017 the median time to initial assessment was five minutes compared to the England average of seven minutes.
Ambulance – Time to initial assessment between September 2016 and August 2017 at Dartford and Gravesham National Health Service Trust

(Source: National Health Service DIGITAL: A&E quality indicators)

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

**Darent Valley Hospital**

Between October 2016 and September 2017 there was an improving trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Darent Valley Hospital. In August and September 2017, 55% of ambulance journeys had turnaround times over 30 minutes which are the lowest monthly percentages over the last 12 months.

(Ambulance: Number of journeys with turnaround times over 30 minutes - Darent Valley Hospital)

(Source: NHS Digital: A&E quality indicators)

(Ambulance: Percentage of journeys with turnaround times over 30 minutes - Darent Valley Hospital)

(Source: National Health Service Digital: A&E quality indicators)

The paramedics we talked with during the inspection were very positive about the turnaround times. They told us they had “not filled out a delayed transfer form in months”. This was corroborated with the latest data which showed a significant improvement in the handover times being achieved.
Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between August 2016 and July 2017, the trust reported 1,082 “black breaches”. The highest numbers of breaches were reported in December 2016 (194) and January 2017 (249).

(Source: Routine Provider Information Request AC11 – Black Breaches)

Nurse staffing

The department was achieving its agreed staffing levels as outlined by the National Institute for Health and Care Excellence. However, due to the very recent service reconfiguration, there was some concern that the department staffing needs had changed.

Darent Valley Hospital

Darent Valley Hospital reported its qualified nursing staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Paediatric Staff</td>
<td>11.4</td>
<td>10.0</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>66.1</td>
<td>47.1</td>
</tr>
<tr>
<td>MSS/Cypress</td>
<td>22.3</td>
<td>10.2</td>
</tr>
<tr>
<td>Total</td>
<td>99.8</td>
<td>67.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – P16 Total numbers – Planned vs actual tab) A recent review of staffing had led to a reduction in the nursing establishment. This had resulted in the registered nurses per shift, being reduced from twelve to eleven, and the number of Health Care Assistant from five to four. The rota demonstrated the department had a 95% fill rate, and staffing levels that correlated with the new reduced staffing numbers. However, we were concerned the team appeared lean, given the skill mix required for the new streaming process, more regular use of the majors B area (an additional area that was opened to cope with ambulance handover times), and the lack of an allocated Health Care Assistant in resus.

Opening the additional majors B area had a positive impact on ambulance handover times and department flow. However, it put an additional strain on the department staffing levels. The recent...
streaming changes had a knock on effect on the staffing numbers and skill mix in the major areas. The team told us they were concerned that the staffing of minors appeared to be more of a priority than the high risk majors and resus area. Whilst staff understood the need for senior skilled personnel to support the new streaming initiative, they remained concerned about the impact of this on the rest of the department. Whilst staff were clear that colleague support was ‘great’, they felt the recent decision to reduce the work force was having a negative impact. They described a conflict between clinically managing the sickest patients and delivering holistic, good quality care.

On day two of the inspection we saw the department get very busy quite quickly. For example by twelve pm there were forty two patients booked in to be seen, and six resus patients in the department. At the staff huddle it was acknowledged it was “busy” and “a bit short of staff”. There was no Advanced Nurse Practitioner from 12pm, no middle grade doctor from 15:00 hrs and no Senior House Officer on minors as they were at their medical teaching. By 15:45, every available space in the department was in use.

We reviewed the department staffing rota on day two of the inspection. We saw the consultant nurse was rostered to work in a clinical capacity between 08:00 and 18:00. We asked why they were not present in the department and were told by staff that “it was a teaching day”. Staff were unsure why the roster had not been adjusted to reflect this. They confirmed no back fill was arranged. This presented a potential risk to the department and may have had a negative impact on team morale, and care quality due to an increased workload. It meant the roster appeared complete, demonstrating adequate staffing levels. However, in reality, this was not the case. On this particular occasion, there was a sudden surge in demand which required a full complement of staff to meet the needs of the service.

Whilst staff felt very proud of their attempts to improve ambulance handover times and patient flow, the use of the majors B area, was a persistent theme in our conversations. They told us there was not always enough staff available to provide safe staffing cover that met patient acuity.

The service had developed innovative approaches to meet the staffing requirements. The department had recognised and embraced the benefit of employing paramedics. This had been advocated by the National Institute of Clinical Excellence in its recently published five year forward view. However, we found the service had not managed to develop systems, processes and development opportunities to experience an effective benefit from these roles. This posed a potential risk to staff in terms of becoming deskilled, and of retention and future recruitment.

The department supported and invested in the development of a pharmacist to become an advanced practitioner. The purpose of this post was to support the assessment of patients with minor illnesses and was a positive example of innovation in the department.

Vacancy rates

Between July 2016 and June 2017, the trust reported a vacancy rate of 32.5% for qualified nursing staff in Urgent and Emergency Care. This did not meet the trust target of having a vacancy rate of 9% or lower.
(Source: Routine Provider Information Request P17 Vacancies)

Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 7.7% for qualified nursing staff in Urgent and Emergency Care. This met the trust target of a turnover rate of 9% or lower.
(Source: Routine Provider Information Request P18 Turnover)
Sickness rates

Between June 2016 and May 2017, the trust reported a sickness rate of 4% for qualified nursing staff in Urgent and Emergency Care. This did not meet the trust target of having a sickness rate of 3.5% or lower.

(Source: Routine Provider Information Request P19 Sickness)

Bank and agency staff usage

Systems and processes regarding the oversight of temporary workers required development required further development to ensure compliance with the Health and Social Care Act 2008 regulations.

As a result of a section 28 coroner’s response, the department designed a temporary workforce induction pack. This was a formal induction record of an agency staff’s declaration of skills and competence. This process was rolled out trust wide. We saw completed booklets during the inspection which indicated they were being used. However, we asked if the department had oversight of temporary staff professional registrations, and Disclosure and Barring Service checks. Staff told us that they relied on the supplying agency to carry out these checks. This meant the department had little assurance temporary staff had gone through routine employment checks prior to commencing work. This meant the department was not compliant with regulation 19 of the Health and Social Care Act 1988.

Between August 2016 and July 2017, the trust reported bank usage of 1,579 shifts and agency usage of 2,878 shifts for qualified nurses in Urgent and Emergency Care. Over the same period there were 388 shifts that were not filled by bank or agency staff to cover sickness, absence or vacancies. The data supplied by the trust doesn’t allow us to calculate the proportionate use of bank and agency.

(Source: Routine Provider Information Request P20 Nursing – Bank and Agency)

Medical staffing

The department was failing to meet the Royal College of Emergency Medicine guidelines on consultant cover.

The Royal College of Emergency Medicine believes there is a compelling argument for urgent Emergency Medicine Consultant expansion to establish sufficient Consultant numbers to provide Consultant presence in the emergency department 16 hours a day, 7 days a week as a minimum in all emergency departments.

There were six substantive consultants employed in the department. Additional support was provided by three locums. Consultant cover was provided from 08:00 to 22:00 daily. Outside of this, cover was provided by an on call consultant. There were 16 middle grade doctors in the department which was a reduction from the previous total of twenty four. These posts were redistributed to make way for one consultant nurse, and four Enhanced Nurse Practitioner posts in the establishment. We recognise there were improvements made to address locum usage and the support provided to these staff since our last inspection. Locum staff were used to back fill any vacancies on the rota. Staff told us they preferred to use regular locums to aid consistency and continuity.

The recent changes to the service saw two middle grade doctors moved to the Acute Medical Unit. This was an incentive to improve flow out of the department. Whilst the staff understood why this
approach was needed, there was a concern that it depleted the department of much needed medical capacity. There was an additional concern that the flow to Acute Medical Unit had not increased and therefore the reallocation may not be the most effective. As the changes were relatively new, there was no data to inform this.

The last General Medical Council survey identified a concern in terms of workload. Five trainees rated the intensity of their work as ‘heavy’ or ‘very heavy’. They reported having worked beyond their rostered hours on a weekly basis. One trainee felt this was true on a daily basis. Three trainees reported their working pattern left them feeling short of sleep when at work on a weekly basis, while three trainees felt this on a monthly basis. The department had an action plan in place to address this and we noted the recruitment of a consultant nurse and the introduction of advanced nurse practitioner to support juniors. Recent shift changes ensured better support. At night a senior middle grade who acts as emergency physician in-charge was responsible for the supervision and support of all the doctors including the locums and junior doctor.

The trust reported its medical staff numbers in Urgent and Emergency Care services as below as of June 2017.

<table>
<thead>
<tr>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>43.5</td>
<td>36.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

Between July 2016 and June 2017, the trust reported a vacancy rate of 20.6% for medical staff in Urgent and Emergency Care. This did not meet the trust target of having a vacancy rate of 9% or lower.

(Source: Routine Provider Information Request P17 Vacancies)

**Turnover rates**

Between July 2016 and June 2017, the trust reported a turnover rate of 32.3% for medical staff in Urgent and Emergency Care. This did not meet the trust target of having a turnover rate of 9% or lower.

(Source: Routine Provider Information Request P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported a sickness rate of 1.8% for medical staff in Urgent and Emergency Care. This met the trust target of having a sickness rate of 3.5% or lower.

(Source: Routine Provider Information Request P19 Sickness)

**Bank and locum staff usage**

Between August 2016 and July 2017, the trust reported locum usage of 1,200 shifts and agency usage of 2,397 shifts for medical staff in Urgent and Emergency Care. Over the same period there were no shifts that were not filled by locum or agency staff to cover sickness, absence or vacancies. The data supplied by the trust doesn't allow us to calculate proportionate usage of bank and locum.
The department had reduced its locum use since our last inspection. There was also evidence of improved support for these staff. The department used a ‘locum briefing’ sheet. This contained twenty useful information points that locums were expected to adhere to during their shifts. There was a space for the locum to sign the agreement as a commitment to adhere to all twenty points. A copy was retained by the department, and no payment for work was processes without obtaining a locum signature. This was a positive initiative in a department with high levels of locum use. Locum staff had their curriculum vitae reviewed by members of the consultant team prior to being offered work. This provided some assurance they had the right skills and competency to support the department.

**Staffing skill mix**

During June 2017, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Some staff we talked with raised concerns about middle grade cover in the department. Concerns related to the recent reconfiguration of two middle grades to Acute Medical Unit, and the impact on the wait time in majors for medical review and the pressure on the middle grade doctors. Whilst there was great support for more efficiency initiatives, there were concerns the recent changes had resulted in lost capacity in the department. We asked if the changes to the staffing model had been discussed with the clinical team. We were told the changes were not discussed or communicated at directorate level.

**Staffing skill mix for the 33 whole time equivalent staff working in Urgent and Emergency Care at Dartford and Gravesham National Health Service Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>59%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>2%</td>
<td>31%</td>
</tr>
<tr>
<td>Junior</td>
<td>12%</td>
<td>25%</td>
</tr>
</tbody>
</table>

(Source: National Health Service Digital Workforce Statistics)

**Records**

The standard of records lack consistency and varied greatly across the department.

We reviewed 20 sets of medical and nursing records during the inspection. The overall quality was variable. For example, some records did not have a patient name or number recorded, some fluid charts were incomplete, some medical reviews did not have an action plan documented, and pain scores were not consistently recorded in the medical records. Some of the records we viewed were not legible. Other records we viewed were complete and contemporaneous. However, there was a consistent lack of recording of consent to care or patient involvement in care decisions. Whilst the department took part in the national medical record audit, there was no effective local audit process in place to identify patterns or trends to improve record quality. This included an audit process for mental health records.
Patients were assessed using a nationally recognised early warning score to ensure the correct treatment and care was provided. When observations were undertaken, we saw the majority of the charts we viewed had a score recorded.

Personal property was not routinely recorded and patient disclaimers were not signed. This meant there was no audit trail or evidence that patients personal belongings was managed in line with trust policy. There was a set information governance target of 85% since March 2017.

Medicines
The service prescribed, gave, recorded and stored medicines well. Patients mostly received the right medication at the right dose, at the right time.

We carried out random checks of the controlled drugs in the department and found they were stored securely and accounted for on a regular basis. There were effective medicine reconciliation processes. Medicines to ‘Take Away’ were stored in a locked electronic dispensing machine.

There were effective systems and processes to take account of Free Prescription 10 prescriptions. These are defined as prescription purchased by the National Health Service organisations that are distributed free of charge to medical and non-medical prescribers. Prescriptions were stored security, labelled and each issue was recorded. The checking of these was incorporated into the regularly medication checks. There was a nominated nurse who had oversight of the process and ensured all prescriptions were stored securely, and adhered to trust policy and national guidance.

Patient Group Directives had been re-introduced to the service. A Patient Group Directive is a signed direction to a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. All the staff had completed a competency-based assessment to ensure they had the knowledge and skills necessary to dispense the medication.

All patients had their allergies and past medical history taken into account before medicines were prescribed or administered, in line with best practice. Medicines charts showed patients had pain relief prescribed and administered.

Patients were provided with information on how to use medicines issued by the service. Verbal instructions were provided during the consultation, and written information was provided with each prescription issued, for example, missed doses and potential side effects.

There was a medicines management committee that met quarterly to monitor compliance and ensure governance arrangements.

Incidents
The systems and processes used to manage patient safety incidents were not effective. Staff recognised incidents and reported them accordingly and managers investigated them. When things went wrong, staff apologised and gave patients honest information and suitable support. However, lessons learned were not always shared with the whole team and the wider service. This meant that the service was not using these to improve quality and prevent recurrence.

We saw the learning from a particular serious and historic incident had been embedded to prevent future recurrence. We were told about the continued engagement with the family affected who had been invited to the department to demonstrate the changes made. We found learning from other incidents was not being used to impact the quality of care or service delivered. Staff told us departmental learning was shared individually, at huddles and via email, departmental newsletters and a closed social media group. We reviewed the departmental newsletter and found no evidence of learning in the August/September 2017 issues. The majority of nursing staff we talked with struggled to provide inspectors with examples of learning and service changes from incidents.
There was no evidence of departmental or trust wide learning from incidents in the nursing team. This meant that the systems and processes to learn from and prevent recurrence was not effective.

We reviewed minutes of the senior nursing meetings and did not see any evidence of trend and theme analysis or learning in the department. There was also a lack of assurance that information was being disseminated effectively to nursing staff.

However, we observed a member of the governance team attending a medical handover to make staff aware of two incidents. They related to a patient going to x-ray with another patients request form and mislabelled bloods going to the lab. This meant on this occasion this staff group was provided with feedback about department incidents.

The medical staff we talked with provided inspectors with examples of learning from department incidents. However, there was little evidence that trust wide learning from these was embedded or effective.

Ten staff in the department had undertaken root cause analysis training. This meant that staff had training to undertake investigations.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between September 2016 and August 2017, the trust reported no incidents classified as never events for Urgent and Emergency Care.

*(Source: National Health Service Improvement - Strategic Executive Information System)*

**Breakdown of serious incidents reported to Strategic Executive Information System**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in Urgent and Emergency Care which met the reporting criteria set by National Health Service England between September 2016 and August 2017.

This was an incident of type treatment delay meeting SI criteria.

*(Source: National Health Service Improvement - Strategic Executive Information System (01/09/2016 - 31/08/2017))*

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, two falls with harm and no new urinary tract infections in patients with a catheter between September 2016 and September 2017 within Urgent and Emergency Care.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Dartford and Gravesham National Health Service trust

![Graph showing prevalence rate of pressure ulcers.]

Total falls (2)

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment
The service provided care and treatment based on national guidance and evidence of its effectiveness.

Policies and procedures used within the emergency department reflected evidence based practice.

Care was provided in line with ‘Clinical Standards for Emergency Departments’ guidelines. All policies and procedures were available through the hospital’s intranet. However, it was difficult to navigate and took some time to find relevant documents. We also found some policies and procedures that were not urgent care specific and were not regularly reviewed.

The departments used a validated triage tool (the Manchester Triage Assessment) to ensure patients were directed to the most suitable treatment areas, such as minor injuries, major treatment, or resuscitation departments.

The service used a sepsis screening tool and care pathway based on the ‘sepsis six’, which is a national screening tool for sepsis. The department followed the national sepsis six pathway. Sepsis is a potentially life-threatening condition, triggered by an infection or injury. There was an action plan to help the department to improve its treatment of sepsis. We were told during the inspection a recent audit had indicated significant improvements against the national standards. We were unable to access this data as it was being collated and analysed at the time of the inspection.

There were various clinical pathways to support staff to deliver effective care for specific conditions which reflected national guidance. For example, fractured neck of femur, acute stroke, sepsis and head injuries.

Nutrition and hydration
Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients’ religious, cultural and other preferences.

Staff in urgent care were able to provide food and drinks to patients. Provisions included a range of sandwiches, toast, tea and coffee. We saw a drinks trolley with two jugs of water for patients waiting to be triaged in the main reception area.

When required, patients were administered intravenous fluids for optimal hydration. Patients had their intake and outputs recorded on a fluid balance chart. However, we identified an inconsistent approach to their completion which meant that the clinical information they contained was not reliable.
The patients we talked with confirmed they were provided with adequate fluids and food during their admission.

**Emergency Department Survey 2016**

In the Care Quality Commission Emergency Department Survey, the trust scored 7.3 for the question “Were you able to get suitable food or drinks when you were in the Accident & Emergency Department?” This was about the same as other trusts.

*(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)*

**Pain relief**

Patients told inspectors their pain needs were met whilst in the department.

Records we viewed during the inspection demonstrated pain relief was being administered and recorded. A national pain scoring tool was used to determine the levels of pain experience and scores were incorporated in to the National Early Warning Scoring system.

The department had Patient Group Directives in place. These can be defined as written instructions to supply or administer medicines to patients, usually in planned circumstances. Patients presenting with acute pain were quickly assessed and analgesia administered. The medicine charts we viewed demonstrated that pain relief was prescribed and administered. We observed pain relief being offered to patients requiring it, and patients being asked later if it was effective. This meant that patient had their pain needs identified and were provided with pain relief. However, the outcome of the national pain audit shows the department performed worse than other trusts for question 32 (see below).

**Emergency Department Survey 2016**

In the Care Quality Commission Emergency Department Survey, the trust scored 5.8 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 6.5 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was worse as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>6.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*(Source: Emergency Department Survey (30/09/2016)*

**Patient outcomes**

The service monitored the effectiveness of care and treatment by taking part in national audit activity. The findings were used to improve the service.

Local audit activity was poorly developed and its importance was little understood. Staff displayed a lack of insight into the rational and benefits of local audit activity.

The department had an action plan to improve antibiotic delay in sepsis patients.
RCEM Audit: Moderate and Acute Severe Asthma 2016/17

In the 2016/17 Moderate and Acute Severe Asthma report, Darent Valley Hospital failed to meet any of the seven fundamental standards (which were all set at 100%).

The trust’s results for four standards placed it in the upper UK quartile:

- Vital signs should be measured and recorded on arrival at the ED. Trust: 52%; UK median: 26%.
- High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust: 92%; UK median: 25%.
- Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Trust: 93.2%; UK median: 77%.
- If not already given before arrival to the ED, steroids should be given as soon as possible according to RCEM guidance for the patient’s age group.*
  - Within 60 minutes of arrival (acute severe). Trust: 33.3%; UK median: 19%.

The trust’s result for the second part of this standard, that moderate cases should receive steroids within four hours of arrival, placed it between the upper and lower UK quartiles. Trust: 20%; UK median: 28%.

*Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

The trust’s result for one standard placed it in the lower UK quartile:

- O₂ should be given on arrival to maintain sats 94-98%.

The trust’s results for the one remaining fundamental standard was between the upper and lower UK quartiles:

- Discharged patients should have oral prednisolone prescribed according to Royal College of Emergency Medicine guidance for the patient’s age group.* Trust: 69.2%; UK median: 52%.

*Adults 16 years and over: 0-50mg prednisolone for 5 days
Children 6-15 years: 30-40mg prednisolone for 3 days
Children 2-5 years: 20mg prednisolone for 3 days

The trust submitted 50 patient records to the audit.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

The trust did not take part in the 2016/17 Consultant sign-off audit.

(Source: Royal College of Emergency Medicine)
RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe Sepsis and Septic Shock audit, the trust failed to meet any of the standards (all of which were set at 100%).

The trust was in the upper UK quartile for one standard:

- Blood cultures were obtained within one hour of arrival in 67.9% of cases, compared to 44.9% of cases nationally.

The trust was in the lower UK quartile for one standard:

- Urine output measurement/a fluid balance chart was instituted within four hours of arrival in 3.9% of cases, compared to 18.4% of cases nationally

The trust’s results for the other six standards were all between the upper and lower UK quartiles.

The trust submitted 53 cases to the audit.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital Signs in Children (2015/16)

In the 2015/16 Royal College of Emergency Medicine audit for vital signs in children, Darent Valley Hospital failed to meet any of the targets, all of which were set at 100%. Darent Valley Hospital was in the lower quartile for two of the six measures and between the upper and lower quartiles in three measures. No data was provided for one measure.

The measures that performed between the upper and lower quartiles were:

- All children attending the emergency department with a medical illness should have a set of vital signs consisting of:

  (a) Temperature, respiratory rate, heart rate, oxygen saturation, Glasgow Coma Scale or Alert Voice Pain Response score, with a score of 40% from 100 cases
  (b) Capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest, with a score of 29% from 100 cases

- There should be explicit evidence in the Emergency Department record that the clinician recognised the abnormal vital signs (if present), with a score of 60% from 60 cases

The measures that performed in the lower quartile were:

- Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set, with a score of 0% from 60 cases

- There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases, with a score of 51.7% from 60 cases.

No data was available for the measure: Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (Senior Trainee 4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor).

(Source: Royal College of Emergency Medicine)
RCEM Audit: VTE Risk in Lower Limb Immobilisation in Plaster Cast 2015/16

In the 2015/16 Royal College of Emergency Medicine audit for Lower Limb Immobilisation in Plaster Cast, Darent Valley Hospital performed:

- In the middle quartile for the measure ‘If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment’, with a score of 95.5% from 22 cases.

- In the middle for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for Venous thromboembolism has been given to all patients with temporary lower limb immobilisation’, with a score of 5% from 101 cases.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural Sedation in Adults (2015/16)

In the 2015/16 Procedural Sedation in Adults audit, Darent Valley Hospital was in the upper quartile for three measures, the lower quartile for three measures and the middle quartiles for the remaining one measure.

The measures that performed in the upper quartile were:

- Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. The trust result was 100% compared to the England median of 90%

- Procedural sedation requires the presence of all of the below a) a doctor as sedationist, b) a second doctor, Emergency Nurse Practitioner or Advanced Nurse Practitioner as procedurist, c) a nurse. The trust result was 92% compared to the England median of 40.8%

- Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:

  7a Return to baseline level of consciousness
  7b Vital signs within normal limits for the patient
  7c Absence of respiratory compromise
  7d Absence of significant pain and discomfort
  7e Written advice on discharge for all patients

  The trust result was 0% compared to the England median of 41%

The three measures that performed in the lower quartile were:

- Patients undergoing procedural sedation in the Emergency Department should have documented evidence of pre-procedural assessment, including a) American Society of Anaesthesiologists grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status. The trust result was 0% compared to the England median of 7.6%

- There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. The trust result was 18% compared to the England median of 51.8%

- Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) Electrocardiography. The trust result was 0% compared to the England median of 23.9%

The remaining measure that performed between the upper and lower quartiles was:
Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. The trust result was 50% compared to the England median of 41%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Paracetamol overdose 2013/14

In the 2013/14 Royal College of Emergency Medicine audit for paracetamol overdose, Darent Valley Hospital was in the upper quartile compared to other hospitals for two of the four measures and was in the lower quartile for one of the four measures.

The measures for which Darent Valley Hospital performed in the upper quartile were:
- Proportion where plasma level tested earlier than 4 hours after ingestion (excludes staggered doses) (3%)
- Proportion that received N-acetylcysteine within 1 was of arrival (25%)

The measure for which the site performed in the lower quartile was:
- Staggered overdoses receiving NAC within 1 hour of arrival (0%)

(Source: Royal College of Emergency Medicine)

RCEM Audit: Assessing for cognitive impairment in older people 2014/15

In the 2014/15 Royal College of Emergency Medicine audit for assessing cognitive impairment in older people, the site was in the upper quartile compared to other hospitals for two of the six measures and was in the lower quartile for one of the six measures.

The site did not meet the fundamental standard of having an Early Warning Score documented.

The measures for which the site performed in the upper quartile were:
- Documentation of Early Warning Score (96%)
- Communication of assessment findings with relevant services, carers and General Practitioner (if new onset or deterioration only) (50%)

The measures for which the site performed in the lower quartile were:
- Communication of assessment findings with relevant services, carers and General Practitioner admitting service (admitted patients only) (7%)

(Source: Royal College of Emergency Medicine)

RCEM Audit: Initial management of the fitting child audit 2014/15

In the 2014/15 Royal College of Emergency Medicine audit for initial management of the fitting child, the site was in the middle quartile compared to other hospitals for three of the six measures and the three remaining measures were not applicable.

The site did not report in the fundamental standard of checking and documenting blood glucose for children actively fitting on arrival.

The measures for which the site performed in the middle quartile were:
- Eye witness history recorded (all audited patients) (96%)
• Presumed aetiology recorded (all audited patients) (100%)
• Proportion of discharged patients whose parents/carers were provided with written safety information (all audited patients) (13%)

(Source: Royal College of Emergency Medicine)

RCEM Audit: Mental health in the ED 2014/15

In the 2014/15 Royal College of Emergency Medicine audit for mental health in the Emergency Department, the site was in the upper quartile compared to other hospitals for two of the six measures and was in the lower quartile for one of the six measures.

Of the two fundamental standards included in the audit, the site did not meet the fundamental standard of having a documented risk assessment taken. The site did not meet the fundamental standard of dedicated assessment room for mental health patients.

The measures for which the site performed in the upper quartile were:
• Risk assessment taken and recorded in the patient’s clinical record (88%)
• Assessed by mental health professional within 1 hour (17%)

The measures for which the site performed in the lower quartile were:
• Details of any referral or follow-up arrangements documented (32%)

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

Between September 2016 and August 2017, the trust’s unplanned re-attendance rate to Accident and Emergency within seven days was worse than the national standard of 5% and the England average. In latest month, August 2017, trust performance was 11.0% compared to an England average of 7.8%.

Unplanned re-attendance rate within 7 days - Dartford and Gravesham National Health Service trust

(Source: National Health Service Digital - A&E quality)
Competent staff

Staff had the necessary skills to meet peoples individual care needs.

Staff told us they were provided with an adequate amount of training to remain competent to do their roles. However, it was noted that there was some difficulty attending training due to the staffing levels.

We were told by staff that there had been some department debriefs provided and ad hoc support was provided as and when required. There was no formal clinical supervision processes for staff. This meant that the department was missing an opportunity to improve and develop staff, as well as improve care quality.

Appraisal rates

Between July 2016 and June 2017, 76% of staff within Urgent and Emergency Care at the trust had received an appraisal. The trust told us in their PIR that their completion target is 85%, though this only applies to staff that have been employed for more than one year.

The split by staff group at trust level and each site can be seen in the graph below.

The 85% completion target was not met for any staff group. There were only six members of National Health Service infrastructure support staff employed in the Urgent and Emergency Care core service, four of whom (66.7%) had completed an appraisal. The trust reported that they employed two members of qualified ambulance service staff in Urgent and Emergency Care, one of whom had completed an appraisal.

(Source: Routine Provider Information Request P43 Appraisals)

Multidisciplinary working

Staff told us they were proud of the multidisciplinary approach to care delivery. They told us about how various members of the urgent care team worked together to ensure patients had their individual needs met. Records we viewed demonstrated input from other disciplines, for example, occupational health, physiotherapy, integrated discharge team, mental health team. However, it was evident that support from the wider hospital departments was inconsistent and could be improved.
The medical handover did not have a multidisciplinary team focus. We were told that this was because of a clash of shift and handover times.

**Seven-day services**

The trust provided urgent care services twenty four hours a day, seven days a week. The service was supported by other departments, for example critical care, interventional radiology, endoscopy, emergency general surgery, haematology, pharmacy and physiotherapy.

Consultants were available from 8am to 10pm seven days a week, with on call facility from 10pm onwards.

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

Consent training was made available to staff.

We found evidence of a consent policy and guidance which reflected best practice guidance. We observed staff obtain consent before undertaking care. However, consent to care was not routinely documented in the records we viewed.

**Mental Capacity Act and Deprivation of Liberty training completion**

MCA and (DoLS) training was incorporated into the Safeguarding Adults Level three training since October 2016. Despite this training provided, staff demonstrated a variable degree of understanding of each. We also noted that safeguarding training was below the trust target of 85%. This meant that patients’ needs may not always be met in line with best practice guidance.

(Source: Trust Provider Information Return P14/P49)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We saw staff treat patients with dignity and respect during the inspection. We also spoke to patients and their loved ones to ask about their experience of the care they received in the department. All the feedback we received was positive in tone. Comments we reviewed included “they do a marvellous job”, “there is always someone to help” and “we were made to feel at ease”.

We observed many caring interactions between staff and patients. One in particular involved a patient experiencing an acute psychotic episode in the minors waiting room. A staff member took the patient and their family straight round to the major area for their own protection, and in an attempt to maintain their dignity and care for family members. The staff members approach was caring and tactful and kind.

Patients told us they received care that met their individual needs and respected their wishes. We saw the department newsletter highlight positive service user feedback sent to a named nurse who was described as ‘caring and patient’.
The majority patients told us the best thing about the urgent care department at Darent Valley hospital was the staff.

However, it is worth noting a theme identified from complaints indicated a concern with staff attitude. We were not provided with evidence that this was being addressed.

**Friends and Family test performance**

The department had recognised a low return rate on the friends and family testing questionnaire. Staff were actively encouraged to provide the questionnaire to patients. The department was also reviewing the impact of electronic feedback aids and text messages to improve the return rate.

We talked to relatives during the inspection. Examples of the comments we received included “my husband comes in regularly and he is always well looked after”, and “I'd recommend the service, the nurses and doctors are very kind”.

Feedback on National Health Service choices website rates the trust as 4.5 out of 5 stars. There were 232 reviews in total.

The trust's Urgent and Emergency Care Friends and Family Test performance (% recommended) was generally better than the England average fluctuating between 77% and 99%, comparable to the England average of ~86% between August 2016 and July 2017.

**A&E Friends and Family Test Performance - Dartford and Gravesham NHS Trust**

![Graph showing A&E Friends and Family Test Performance](image)

(Source: National Health Service England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Emotional support was provided in the first instance by the clinical staff in the department. The urgent care staff were further supported by specialist nurses, mental health teams, and chaplaincy to meet the emotional needs of patients and relatives. If required, a referral for psychological support could be made.

There was contact information on display in the department for a range of support groups which included, but were not limited to domestic abuse, alcohol and drug abuse and mental health support. This meant emotional support was provided to patients.
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients we talked with told us their ‘plans of care’ was openly discussed with them by the doctors and nurses. They felt well informed and involved in making key decisions about the care they received. Relatives expressed satisfaction with the way their loved ones needs were met.

Comments we received from patients included “they keep popping back to make sure all is okay and to keep me informed”, “they talked me through everything”. This meant that patients had their opinions taken into consideration when planning care.

Emergency Department Survey 2016

The results of the Care Quality Commission Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 17 of the 24 questions relevant to caring. The remaining seven questions scored worse than other trusts.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>7.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren’t there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your</td>
<td>6.9</td>
<td>About the</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>condition or treatment, did a doctor or nurse discuss them with you?</td>
<td></td>
<td>same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.1</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>4.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>4.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 30/09/2016)

Is the service responsive?

Service delivery to meet the needs of local people
The trust planned and provided services in a way that met the needs of local people.

The population growth in the local community has resulted in increased service demand, and this has posed a significant challenge to the service. Just before the inspection, the department underwent renovation and service reconfiguration relating to the way patients were triaged in the department. This was to ensure local needs could be met in the most effectively. This meant that the needs of the local community were taken into consideration and used to develop the service.
Meeting people’s individual needs

The service did not always take account of patients’ individual needs.

We saw a lack of intelligent assessment tools to help staff identify and manage concerns with mental capacity.

We asked staff if they had any support from the development of link roles within the department. For example, we asked specifically if there was an audit lead, mental health lead, diabetes, Venous thromboembolism, sepsis, learning difficulty, dementia etc. These roles had not been developed within the local team. However, we were told that there was a fractured neck of femur lead, who provided good quality support to the team.

We spent some time in the main reception area observing the flow and talking to patients, and relatives. We saw an electronic screen that provided very detailed information which included the numbers of patients waiting, and the expected wait time for all urgent care areas. We asked sixteen patients in the waiting room if they knew what their expected wait time was and not one could tell us. Other comments we received related to the process for booking in at reception included “there has to be a better way to prioritise booking in, I’ve seen one person bleeding and another in lots of pain having to wait to be booked in”, and “there are two windows and only one person at reception”.

Whilst we were in the area, we saw a long queue forming at the reception window. We saw a young man displaying signs of a mental health crisis, lying on the floor in the waiting room. The patient and their family were very distressed. We alerted the nurse to the situation and the patient was taken to the majors area for their own safety. However, as the only receptionist was busy attending to the queue which obscured the view of the waiting room, and the two Emergency Nurse Practitioners were inside rooms triaging patients. This meant there was no staff member with a view of the waiting room. Staff gave us another example of how parents with a baby who had been burned had to join the queue and wait to be checked in. These examples raised concerns about how effective the booking process was with one person checking patients in. This meant it was difficult for staff to identify risks, raise alarms, and prioritise patients who required immediate assistance.

There was a lack of consistency with the handover of patients to Cypress ward. This was acknowledged by the staff we talked to and in the meeting minutes we viewed. We also noted an additional concern about patients going to this area without medication charts. On one occasion this resulted in delayed medication administration for a diabetic patient. This meant that key patient information was not being communicated effectively between clinical staff.

We saw mixed sex breaches during the inspection on Cypress ward. There was little privacy, dignity or confidentiality for the patients who were in the seated chair area. We saw one patient with two police officers who spent the night in this area with other patients. This meant that the department struggled to meet people’s individual needs. We recognise recent guidance from National Health Service England has issued updated guidance on mixed sex breaches in urgent and emergency care for unusually busy periods. The trust was reviewing the policies and procedures for the management of mixed sex breaches on this ward.

The referral processes to Elm Court (a rehabilitation unit) appeared to exacerbate delays. All referrals to had to be referred and reviewed by the medical team before a patient would be considered for admission.

The department had a well thought out viewing room. A viewing room is a place where family can view their loved ones after they pass away. The facilities consisted of two conjoining rooms. One
was designed for the family had a very large window. This provided an option of viewing without entering the room. There was a separate access area for porters to take the deceased to the mortuary without having to go through the department.

In the main reception, a number of side rooms were used to undertake triage assessments. The availability of these promoted confidentiality during the assessments phase. We recognise the provision of these rooms as an improvement since our last inspection.

We saw the trust had a hospital passport document for vulnerable patients and those with a Learning Disability. A patient passport provides immediate and important information for doctors, nurses and administrative staff in an easy to read form, promoting a positive experience for people with learning disabilities going into hospital. Staff were not aware of the hospital Learning Disability link nurse and their role.

There was also a hospital communication book available. This was a pictorial guide to aid communication. These resources were available trust wide. We did not see these in use during the inspection.

The psychiatric liaison service provided adequate advice and support, although could be improved with more availability. The trust was in the process of bidding for the delivery of a CORE24 service. This would mean that psychiatric liaison service would be available for 24 hours (their current working hours are 9am-12 midnight). We identified a gap in staff knowledge about the Mental Health Act.

There was a system in place to monitor and safeguard vulnerable patients with mental health problems who frequently attended the department. There was multidisciplinary oversight to ensuring these patients and their individual health and social needs met.

There was a recently renovated mental health room that ensured those with mental health problems were cared for in a safe and suitable environment. This meant there was a safe, confidential environment for these patients’.

**Emergency Department Survey 2016**

The trust scored “about the same as” other trusts for all of the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*(Source: Emergency Department Survey 30/09/2016)*

**Access and flow**

The department had changed the patient flow two weeks before the inspection. Whilst the initial data indicated like the changes were having a positive effect on performance metrics, it was too early to comment on the overall effectiveness of these changes as they were not fully embedded. However, the data we reviewed demonstrated the department was achieving between 90% and 95% on four hour access target.
Changes included a new approach to patient streaming carried out by two General Practitioners and two Enhanced Nurse Practitioners. There was an additional majors B area (that could be opened up at busy times to create additional capacity) and a clinical decisions unit with five to six beds and a fluctuating number of chairs. There was overall recognition that the outflow to other departments in the hospital posed the biggest challenge to the team.

There was an escalation policy in place for staff to follow. This had been reviewed in September 2017 and was the safety and capacity optimising protocol for the department.

A ‘silver command system’ was in operation. This meant there was a senior member of staff who managed fluctuations in demand and coordinated flow with other hospital teams and departments. The system was held in high regard by all the staff we talked with, and was referred to as a ‘bridge to the rest of the hospital’. However, staff also recognised the system could cause conflict between operational and clinical need.

Referral pathways had been reviewed and strengthened: examples of these included Pulmonary Embolism, Venous thromboembolism, Frailty team, Integrated Discharge Team and fast tracking to the acute medical unit. The trust had developed a hospital at home team to mitigate pressure on the department by promoting admission avoidance.

Staff told us relationships with other departments and disciplines varied greatly across the trust. Some specialities were described as very supportive and accessible and others were described as ‘disengaged’ and challenged. We were told that this had negatively affected care delivery. As a result senior managers developed trust wide admissions guidance. The success of this relied on the commitment and cooperation from all divisions, trust wide. The Medical Director and clinical directors were required to formally record their commit to its successful implementation.

We recognised the department tried to improve access and flow, but we also recognised capacity elsewhere in the hospital, and cooperation from other specialities had an impact on this.

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the Accident and Emergency.

The trust breached the standard 12 times between October 2016 and September 2017.

Between October 2016 and September 2017 performance against this metric showed a trend of improvement, following a similar trend to the England average.
Four hour target performance - Dartford and Gravesham NHS Trust

(Source: National Health Service England – Accident and Emergency Waiting times)

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

Between October 2016 and September 2017 Dartford and Gravesham National Health Service Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust followed a similar trend to the England average. Performance against this metric showed a trend of improvement since hitting a high of 22% in January 2017 and was 2% in September 2017 compared to the England average of 12%.

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Dartford and Gravesham National Health Service trust

(Source: National Health Service England – Accident and Emergency Waiting times).
Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from October 2016 and September 2017, no patients waited more than 12 hours from the decision to admit until being admitted.

<table>
<thead>
<tr>
<th></th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-16</td>
<td>229</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
<td>82</td>
<td>0</td>
</tr>
<tr>
<td>Dec-16</td>
<td>347</td>
<td>0</td>
</tr>
<tr>
<td>Jan-17</td>
<td>506</td>
<td>0</td>
</tr>
<tr>
<td>Feb-17</td>
<td>354</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>302</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>243</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>337</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>227</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>76</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>130</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>48</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: National Health Service England - Accident and Emergency Waiting times)

Percentage of patients that left the trust’s Urgent and Emergency Care services before being seen for treatment

Between October 2016 and September 2017 the monthly median percentage of patients leaving the trust’s Urgent and Emergency Care services before being seen for treatment was generally higher than the England average.

Between October 2016 and September 2017 performance against this metric showed a trend of stability. In Aug-17 the median percentage of patients leaving the trust’s Urgent and Emergency Care services before being seen for treatment was the same as the England average which was 3.0%.

Percentage of patient that left the trust without being seen - Dartford and Gravesham National Health Service trust

(Source: National Health Service DIGITAL - Accident and Emergency quality indicators)
Median total time in A&E per patient (all patients)

Between October 2016 and September 2017 the trust’s monthly median total time in Accident and Emergency for all patients was consistently higher than the England average. Performance against this metric showed a trend of improvement.

In August 2017 the trust's monthly median total time in Accident and Emergency for all patients was 150, which is worse than the England average of 144.

Median total time in Accident and Emergency per patient - Dartford and Gravesham National Health Service trust

![Graph showing median total time in A&E per patient over time]

(Source: National Health Service DIGITAL - Accident and Emergency quality indicators)

Access and flow throughout the hospital was a concern. This had a significant impact on the department’s ability to care for patients during busy times and to meet its national targets.

There were four bed meetings a day to review patients flow throughout the hospital. However, we noted the lack of a trust wide intelligent bed monitoring tool. The department held a two hourly board round with the aim of assessing capacity and acuity. We recognised the important of positive reinforcement on morale and efficiency. However, the board round we observed appeared to focus on a “what we have done well” narrative rather than how the department would cope with a sudden surge in patient arrivals.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them. The systems and processes to learn from and improve the services were not effective.

Between August 2016 and July 2017 there were 53 complaints about Urgent and Emergency Care services. The trust took an average of 47 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 25 days, or “up to 60” days for complex complaints. There were six complaints had not been closed.

There was a main theme of patients being unhappy with level of care and treatment.
The department had a complaints reflecting best practice, and on average, received between five and seven complaints a month. A complaints dashboard was used to track complaint activity. The number of breaches to the twenty eight day response was very low when compared to the precious year. We reviewed the complaints documented between May 2017 and October 2017. The main these identified related to the quality of care and staff attitude. We were told that the department was actively involved in investigating and responding to the complaints. The numbers of complaints received were lower than other specialities.

The department carried out trend theme analysis to prevent recurrence and improve the service. We saw evidence of this in the governance minutes we viewed. Inspectors were told that department staff were provided with updates from investigations outcomes via email, team meetings and social media platforms. However, we did not find sufficient evidence of active learning from complaints and concerns. Staff were unable to provide inspectors with examples of learning and service change as a result of complaints management. We did not see any action plan to address the themes of poor care or staff attitude. The staff meeting minutes we viewed did not show that these trends and themes were communicated effectively with staff. This meant that the department was failing to prevent, learn from and improve from comments and concerns received.

**Is the service well-led?**

**Leadership**

The leadership in the department required further development, resilience and oversight of clinical quality.

The senior leadership team consisted of a service manager, an assistant service manager, a general manager, a clinical director (providing 1.5 programme activities support) and two band eight matrons, (1.8 Whole Time Equivalents). The team had recently been joined by a consultant nurse. There was no head of nursing for this department.

The general manager held responsibilities for business planning, departmental governance, financial and clinical performance. This manager, with a deputy, also had managerial responsibilities for the adult medicine service since July in 2017 following a management restructure. It was clear that this was an unsustainable arrangement given the leadership structure in both departments. We recognised the capabilities and expertise of this manager who was held in high regard by staff. Comments we received were unanimously positive about their commitment to the department, as well as the level of support and duty of care for staff and patients.

We found an inconsistent approach to how the band eight nurses supported the department. Different levels of clinical and managerial support was provided which affected the quality of leadership and managerial efficiency.

We found a significant deficiency in nurse leadership which had a substantial impact on the department’s ability to monitor care quality, and develop and support effective leaders. Many staff we talked with commented on what they perceived to be ‘different approaches’ of the nurses in charge in terms of individual leadership styles, and their ability to evaluate patient risk and acuity during a shift. Additional comments we received included a wish for greater clinical input and consistency from the nurses in charge in terms of clinical leadership, rather than ‘coordinating from the desk’. The difference in the support provided was summarised in the following statement “some people work together, and other don’t”.

(Source: Routine Provider Information Request P61 Complaints)
Whilst there was consistent input and visibility from some senior managers, staff felt the visibility was not equitable. The majority of staff we talked with felt the silver command was helpful, but some told us it was about meeting targets and not about delivering good quality care. Staff described what they perceived as a ‘conflict between very senior management in terms of how well they listened and responded to their feedback and concerns.’ This had a negative impact on meaningful candid communication. We found a disparity in the staff group where some felt very confident to raise concerns and others feared repercussions of doing so. We found a concerning correlation between how empowered and supported staff felt and their seniority.

Staff meetings were held in the department. These had a varied attendance rate, which again correlated to staff grade. Staff told us there were difficult to attend due to staffing levels. Minutes of meetings were made available and pinned to the staff notice board.

We were sent four sets of minutes for the senior nursing team meetings for May, June, July and October 2017. We were provided with an explanation that August and September meetings were cancelled due to annual leave. We reviewed the four sets of minutes and we found several examples of identical entries throughout the documents dated May to October 2017. This may indicate the meetings were ineffective, as well as raise concerns with the quality of the records kept.

The trust had successfully focused on strengthening recruitment in the department. This was identified as an improvement since our last inspection.

**Vision and strategy**

There was a suitable vision and strategy within the urgent care department. Staff were aware of the vision and strategy and were committed to its implementation. It was simplified into a three year approach, where the department ‘gets safer’, ‘gets better’ and ‘gets faster’. We received a mixed response from staff when we asked how involved they felt in its creation and design. We noted a correlation between the levels of input and consultation, directly with staff grade. Senior staff reported feeling involved, however, conversations with staff below band 7 suggested less involvement and input being sought. Despite this, we found an overwhelming drive from staff to want to work together to deliver the best service possible to patients.

**Culture**

The culture of the department was complex. We saw a staff group who displayed an overwhelming dedication to patients, and their immediate team. Staff showed a solid commitment to the trust, its board leadership and to the values and ethos of the organisation. However, morale throughout the department was low. The senior management team were aware of this. As stated above under the headings leadership, vision and strategy, we detected signs of a department hierarchy that may have a negative impact on the morale and inadvertently, productivity.

There was a concerning disconnect between urgent care and other hospital departments. This was exacerbated by silo working, and was responsible the feeling in the department that managing the hospital front door, and patient flow, was exclusively an ‘A&E problem’. This played a major role in the urgent care team feeling disenfranchised by the lack of active support from the rest of the hospital. Comments we received included “we are in a little bubble and support each other” and the front door is just our problem, and “it feels very lonely”. We asked staff if they were aware of the Speak up Guardian role. We had a mixed response which may indicate staff were unaware of the role, its function or benefits.

It is worth noting that a significant number of staff had worked in the service for many years. This indicated a dedicated and loyal workforce. Staff told us they were proud of their long service
record, the care delivery, and the team’s ability to cope with continuous change and increased demand. All the staff we talked with would recommend the trust to family and friends. They team felt very proud of the care they provided. Comments we received included "It’s a good cohesive team, with an overall good atmosphere" and "I would definitely recommend the service". All the staff we talked with expressed a unanimous feeling that the trust was a good place to work with a genuine emphases on team working.

Student feedback was positive and there was good links with educational organisations.

We saw a notice board that displayed positive messages from staff, to staff.

General Medical Council survey showed doctors were supported but felt there was "pressure in the system".

However, many staff we talked with told us they found it difficult to take their breaks. They felt this was a result of a fragile workforce in a busy department with high patient acuity.

Governance

We were told that the governance systems and process had been recently reinforced in the department. Governance meetings were held monthly and a standardised, formal agenda was kept for consistency. However, we reviewed the minutes from these meetings and found concerns with the content and timeliness of the action resolution. We did not see a record of trend and themes analysis from incidents and complaints, nor was there any mention of how the department could learn and improve from these. We did not see any evidence of trust wide learning from incidents, or complaints. We saw a record outlining what Care Quality Commissions expectations was in terms of evidencing learning. However, the staff we talked with and the minutes we viewed did not provide us with the required level of assurance. Staff were unable to tell inspectors about the departments governance arrangements or provide any feedback about what happened at these meetings. We were not assured information flowed through these processes as effectively as well as the senior management team perceived it to.

Management of risk, issues and performance

There was an inconstant approach to the way risk and performance was managed in the department.

The department had developed tools to monitor performance with the national targets in the form of a score card and dashboard. However, it appeared performance targets appeared to overshadow the oversight of care quality and the strength, and ability of the nurse leadership in the department.

There was an established risk register to monitor the risks in the department. The electronic incident reporting tool was linked to the risk register which provided an enhanced level of oversight of risk. Risks were scored between five and fifteen to determine the level of risk. Eleven risks were recorded on the risk register. These included risks related to urgent care performance targets, sepsis management, delayed care for patients with mental health problems, and major incident handling and inability to lock down the department due to ill-fitting glass doors. There was one entry added in September 2017 that indicated all never events must be discussed at all future governance meetings regardless of where they happened. Whilst we recognise best practice is to ensure trust wide learning from such events, we were unsure why this had been added to the risk register. There was an expectation that trust wide learning was a normalised part of governance process. Urgent care has not reported a never event within the inspection timeframe. There was a process to escalate risks to the trust register when required.
The majority of staff we talked with, which included senior staff, struggled to tell inspectors what the departmental risks had been identified. Some staff told us about the inability to lock down the department due to the main glass doors. This meant that information about the key risks was not effective. Staff who were unaware of the risks were not in a position to mitigate, improve or prevent future occurrence.

We requested minutes of the departmental Morbidity and Mortality meetings for review. We were not provided with formal minutes to evidence attendance, regularity, and quality of the reviews and learning. We were provided with a word document with five bullet points for our consideration which were listed as the following: Dedicated sessions at departmental teaching, weekly presentation given at morning handover by governance managers, Informal case discussions at the departmental governance meeting, "top 10' pitfalls to locum doctors and the 'Governance Apprenticeship' for middle-grades is unique to our department. There was no formal evidence submitted to demonstrate a formal standardised and structured approach to Morbidity and Mortality activity in the department. Staff told us during the inspection that there was no formal Morbidity and Mortality process in operation. This meant the department was, missing an opportunity discuss errors and adverse events in an open manner, review care standards, and make changes if required.

**Information management**

We found eight boxes of medical records on the floor in an office. Staff told us they had escalated their concerns to senior managers and were awaiting funding to pay for transportation to the main storage unit. We recognise the door to the office was locked at all times by the staff, because they were in working in an isolated area. It could not be accessed by members of the public. This meant these records were not held in line with regulation 17 of the Health and Social Care Act 2008, or the data Protection act 1998, and posed a fire risk.

The department used a high proportion of agency staff. These staff did not have access to the many Information technology systems to undertake their duties and effectively support the team. In order to ‘get things done’ permanent staff felt they had to either log onto the system to get access to results, or share their passwords to ensure that care was not delayed, especially at busy times. This included providing access to diagnostic devices. The sharing of passwords was not in line with trust policy or national guidance. However, staff felt they had raised concerns about this but no action had been taken. Staff wanted realistic solutions to balance care needs with effective temporary workforce support, and information governance regulations.

We found a different approach to Information technology passwords for locum doctors who were provided with passwords to undertake their roles.

**Engagement**

We were told by staff the department used a wide range of resources to engage with staff. This included email, social media platforms, staff meeting minutes and a monthly newsletter.

We saw the department newsletter had a section labelled ‘special mentions and thank you’s’ and ‘you’re a star’. Staff were mentioned and thanked publically in this section for their dedication and hard work.

The trust had an annual awards programme to recognise staff excellence and commitment. Examples of this included leadership, excellence, care and compassion awards. We noted a member of staff from the urgent care team came second in the care and compassion 2017 awards.

We were told there was a staff forum that met regularly. However, these meetings were not formally minuted so we were unable to assess their efficiency.
The trust had implemented a self-referral process for physiotherapy. This was much appreciated and used by staff.

Learning, continuous improvement and innovation

The department was committed to supporting a pharmacist to become an advanced practitioner. This role was able to provide additional support to the team, by undertaking assessment of patients with minor illnesses. This was a positive example of innovation in the department.

The department had developed a useful locum doctor briefing sheet which provided twenty information points that needed to be adhered to whilst working in the department.

One member of staff who was involved in a major incident at another trust had learned from an experience regarding the difficulty crossing a police cordon without an identity badge. The majority of staff kept their badges in their work lockers. If a major incident occurred whilst they were not on duty, they would not be able to cross the cordon. As a result staff were issued with a second badge to keep at home to overcome this.

There was a system in place to monitor and safeguard vulnerable patients with mental health problems who frequently attended the department. There was multidisciplinary oversight to ensuring these patients and their individual health and social needs met.
Medical Care (including older people’s care)

Facts and data about this service

The Adult Medicine Directorate includes: respiratory, neurology, ageing and health, diabetic, stroke and dementia services, ambulatory care, general medicine, rehabilitation, nephrology, endoscopy and gastroenterology.

The Ageing and Health Department is currently responsible for inpatients on Spruce, Ebony, Linden, Maple (ortho-geriatric and medical outliers), medical outliers on Mulberry, Cherry and Rosewood wards.

Stroke services include thrombolysis, acute care and rehabilitation. There is a Monday to Friday Transient Ischaemic Attack clinic with Doppler and Magnetic Resonance imaging. The service is waiting for the outcome of the Kent-wide Stroke Services Review. The endoscopy service is, Joint Advisory Group on Gastrointestinal Endoscopy, accredited with inpatient and outpatient slots. Respiratory wards conduct specialist ward rounds in chronic obstructive pulmonary disease, asthma and non-invasive ventilation services which are supported by the Specialist Nurse. Endobronchial ultrasound procedures are also carried out.

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 31,991 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 11,835 (37%), 5,994 (19%) were elective, and the remaining 14,162 (44%) were day case.

Admissions for the top three medical specialties were:

- General Medicine 11,496
- Gastroenterology 5,718

(Source: CQC Insight)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training figures had improved since our last inspection. However, they were still not meeting trust targets. The most recent mandatory training figures showed an overall compliance of 81.4% which was below the trust target. The lowest completion rates were in emergency and resilience training and preventing radicalisation, where 48% and 51% of staff had completed the training respectively.

Completion rates for infection control level 1, resuscitation, conflict resolution, equality and diversity and health and safety were better than the trust target of 85%. All of which had a completion rate of more than 86%.

The trust set a target of 85% for completion of mandatory training modules, apart from infection prevention level 2 where the target was 95%.
In their PIR the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and then by staff group.

We contacted the trust on 31 October 2017 and asked them to supply a breakdown by staff group for each core service.

In the meantime the below is a breakdown of compliance for mandatory training modules between April 2016 and March 2017 for all staff in the Medical Care core service at the trust.

Preventing radicalisation and emergency resilience training became a mandatory requirement from April 2017.

**Trust wide**

![Mandatory training completion rate (all staff groups)](image)

Completion rates were above target for six modules, and below target for the remaining four modules. Completion was particularly low for infection prevention level 2 (approximately 55%).

**Darent Valley Hospital**

![Mandatory training completion rates (all staff groups)](image)

Completion rates were the same as or similar to those at trust level for all modules.

(Source: Routine Provider Information Request -P40 – Statutory and Mandatory Training)
Mandatory training was tracked online and reviewed at weekly matrons’ meetings within the department. We saw evidence in the minutes of discussions around low attendance and were told that staff numbers had increased recently.

We saw action had been taken both at operational and executive levels to identify and improve mandatory training figures. Staff told us time was now allocated for mandatory training. The trust had also aligned incremental progression with completion of mandatory training from January 2017.

The trust launched e-learning in December 2016, and used the e-learning platform. Staff reported this enabled them to complete their mandatory core skills at a time and place that was convenient with their work schedule.

In April 2017 all mandatory core skills monitoring and recording was centralised within each department. In medical care this had enabled each Matron and ward sister to have oversight of mandatory training figures and address issues as they arose.

Directorate compliance was discussed with each directorate at directorate performance meetings, with low compliance followed up by the respective Executive Director.

**Safeguarding**

Although staff understood how to protect patients from abuse and report abuse, safeguarding training figures showed the department was failing to meet the trust target of 85%. There were 267 children aged 17 or under treated on medical wards since January 2017 and the majority of staff did not have the correct level of training. ‘Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document, Third edition: March 2014’ states: All staff working in health care settings should be trained to level one. All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers, Level two. All clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns needs to be trained to level three. Across the medical department we saw that no-one had safeguarding training in children at level three or above.

Staff we spoke with had a good understanding of adult safeguarding procedures. Staff gave recent examples where a safeguarding concern had been raised on Ebony and Linden wards. We reviewed the notes and patient records and found the correct processes had been followed.

The trust set a target of 85% for completion of safeguarding training.

As noted above under mandatory training, in their PIR the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and then by staff group.

We contacted the trust on 31 October 2017 and asked them to supply a breakdown by staff group for each core service.

In the meantime the below is a breakdown of compliance for safeguarding training modules between April 2016 and March 2017 for all staff in the Medical Care core service at the trust.
The 85% completion target was not met for any of the three modules for which staff in Medical Care were eligible.

**Darent Valley Hospital**

Staff told us they would often ask for guidance from the safeguarding lead, we saw this documented in patient notes. Phone numbers and contact details for the safeguarding leads were available on the computer system, in staff rooms and offices.

A safeguarding committee met quarterly to discuss any learning points and report any incidences. These were also attended by the adult and child safeguarding leads. Safeguarding leads were trained to level 3 in line with national guidance. A biannual report was sent to the Quality and Safety Committee to review and an annual report was sent to the trust board.

In line with national guidance, safeguarding was reported through a number of external bodies, for example a quarterly report to the Clinical Commissioning Group (key metrics set by them), and an annual report to safeguarding adult board for Kent and Bexley respectively. The adult and child safeguarding leads also attended external safeguarding supervision with the local authority.
Cleanliness, infection control and hygiene

We saw some poor compliance with infection control policies throughout the hospital. The service did not always control infection risk well. We saw some poor management of medical equipment and found areas of the hospital were not clean.

Monitoring whether safety systems were implemented was not robust and we had concerns about the consistency of staff awareness and understanding of them.

On the Acute Medical Unit we checked the cleanliness of each bay, from beds one to 24 and found consistent levels of high dust that was of an unacceptable level. In particular on television support arms, bed curtain rails, over bed lights and the electrical conduit that encompassed the back ground lighting for the bays. On checking the cleaning schedule we found that high dusting was carried out once a week. We saw records that this had been carried out according to the checklist. However, on checking the levels of cleanliness, they were not consistent with the levels of dust we found.

The auditing scores in Acute Medical Unit showed a risk category of high risk which is consistent with the National Standards of Cleanliness and the ward should achieve 95% on a monthly basis. Of the ten audits that should have been completed from January 2017 to October 2017 nine were completed, and of the nine completed three failed to meet the standard expected therefore 33% of audits in the period failed to meet the expected standard. There was no score for October 2017 so a comparison of the last audit against what we found could not be done.

We consistently found high dusting had not been carried out to a satisfactory standard particularly on bed curtain rails, over bed lights and waste bins throughout the medical wards. On Ebony ward we checked the cleaning in bays three to eight, nine to 14, and 15 to 20, and on Spruce ward in bed bays four to nine and16 to 21. We found thick dark coloured dust on bed curtain rails, over bed lamps and underneath the waste bins. This was neither consistent with weekly high dusting regime or the audit results for October which was 99.5% on Spruce and the100% reported in September on Ebony ward.

On Palm ward we also saw thick dark coloured dust on the bed curtain track in beds 10 to15 and 16 to 21 but only on the bay curtain track. In side room number: 3W. 062 within the patient toilet the waste bin was dusty underneath, there was scale build up on the shower head, shower riser and the support rail. Within the new four bedded bay there was thick light coloured dust on the bed curtain rails and the cupboards. In September 2017 and October 2017 the audit score for Palm ward was 100% and this score was not consistent with our findings on the day of inspection. National Standards of Cleanliness, Page 18, states regarding waste bins “the waste receptacle should be visibly clean including the lid and pedal with no blood or body substances, dust, dirt debris, stains or spillages.”

We saw mandatory training records which showed us from October 2017, 92.4% of staff in the directorate had completed level 1 infection control training which was above the trust target of 85%.However, only 63.4% of staff had completed the level 2 training which was considerably worse than the target set.

During our previous inspection in June 2016, we observed mixed compliance with the correct use of personal protective equipment, this refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. During this inspection we also witnessed staff did not wear personal protective equipment correctly. On Ebony ward we saw bins were placed under the personal protective equipment storage units and aprons were resting on top of the bins, which could result in cross contamination. We also witnessed a staff member wearing gloves that went from one bed space to another; they did not clean their hands following removal of gloves. Gloves can transfer bacteria in the same way hands can, this
meant, as the staff member did not change their gloves between bed spaces there was a potential for cross infection. We saw another member of staff not wearing personal protective equipment while carrying dirty laundry to the sluice.

On the Acute Medical Unit, we saw a member of staff carrying a used bedpan to the sluice that was not covered and they did not have an apron on to protect their uniform in the event of a spillage. Preventing Healthcare Associated infections (epic3), says staff should wear aprons when there is close contact with materials that poses a risk of clothing becoming contaminated. We observed that no staff challenged other staff who were wearing personal protective equipment incorrectly; this was consistent with our previous inspection in June 2016. According to the training records by October 2017 96% of cleaning staff had completed their infection control training.

Additionally on Ebony, we saw they advised a patient’s relative to wear gloves and aprons when visiting. We checked with the infection control team, this was not in line with trust policy. They confirmed that visitors are not required to wear protective clothing unless providing or assisting with direct care but must be asked to decontaminate their hands on entering and leaving the room. This meant staff on the ward were not familiar with infection control policies.

We witnessed inconsistent practice among staff and saw staff failing to wash their hands between patients or after delivering care to patients. During our inspection, we undertook a 20-minute observation of staff on the Acute Medical Unit cleaning their hands, during our 20 minutes; we saw there were 17 times when hands should be cleaned. On 10 occasions, we saw staff did not clean their hands after contact with the patient environment (moment 5). This included staff that went to the patient bedside to review documentation at the end of the bed, passing a patient a drink of water, and moving the patient’s bedside table. We saw two members of staff did not clean their hands before helping a patient to stand, and one member of staff did not clean their hands after they removed their gloves. This meant there was the potential for cross infection as staff did not clean their hands correctly. However, when we did see staff washing their hands the correct technique was used. This was in line with ‘five moments for hand hygiene’ from the World Health Organisation guidelines on hand hygiene in health care.

We looked at the results of the medical care directorate monthly hand hygiene audits. The overall score between August and October 2017 was 96.5%. We looked at 12 areas and the results ranged from 70% to100%. What we witnessed on inspection was not consistent with recent hand hygiene results.

We looked at seven sets of medical records for patients who had a peripheral intravenous line in place, during our inspection. A peripheral intravenous line is a tube that is inserted into a vein and used to administer fluids and medication.

We saw there were two types of documentation in use for the monitoring of peripheral lines. One required checks to be taken twice daily (day and night), for three days. The second required checks to be taken in 12-hourly intervals, up to 72 hours post insertion.

On the review of documentation that required twice-daily checks, we found multiple occasions where the checks had not been documented. We saw this was mainly checks to be undertaken at night. For example on Palm ward we looked at a patient’s record and saw that no night checks had been undertaken on the three days the peripheral line was in place. In addition to missed night time checks, we also saw there were some days when checks had not been documented. For example on Ebony ward we looked at a record that showed a peripheral line had been inserted on 2 November 2017, there were no documented night time checks on 4 November 2017 and 5 November 2017, and no documented checks for day or night on 3 November 2017. This meant the trust could not be confident that peripheral intravenous lines were being monitored in line with policy.
On review of the documentation at required checks to be taken at 12-hour intervals up to 72 hours post insertion, we saw there were some intervals when checks had not been documented. In addition, we saw checks that were recorded at 24-hourly intervals, resulting in the peripheral intravenous line being in place for longer than the trust’s policy of 72 hours. For example on Spruce ward we saw a peripheral intravenous line was inserted on 15 October 2017, the 12-hourly check was 16 October 2017, 24-hour check was 17 October 2017, there was no documented check for 36 or 48 hours, the 60-hour check was documented 20 October 2017 and 72 hour check on 21 October 2017. The peripheral line was removed on 21 October 2017, having been in place for seven days. This meant the trust could not be confident staff were reviewing and removing peripheral intravenous lines in line with policy.

The trust’s ‘MRSA Management (Methicillin resistant staphylococcus aureus) Policy’ version 9 (dated May 2016), says all adult patients admitted to hospital (except Maternity), should be washed in an antimicrobial body wash daily, during their stay. During our inspection, we spoke with staff who told us patients were given an individual bottle of the body wash.

On Ebony ward we checked eight patients and found only five had an individual bottle. However, on our previous inspection in June 2016, we found all bottles were individually labelled to ensure individual use only. On this inspection, we found three of the five bottles were labelled. Of the three bottles that were labelled, the patient name had been written in pen, which was wearing off with use. We also found a bottle of the body wash in a patient shower, this was not labelled, which meant multiple patients could use it.

On the Acute Medical Unit, we saw that the antimicrobial body wash was not given to individual patients. We witnessed staff putting the body wash directly into a bowl of water. This bottle would be used for multiple patients. This was not in line with the Methicillin resistant staphylococcus aureus policy, which gives instructions for use.

People in hospital are particularly at risk of a Methicillin resistant staphylococcus aureus infection and screening is usually carried out in people who need to be admitted to hospital for planned or emergency care as per national guidance. The results of the trust wide audits for Methicillin resistant staphylococcus aureus screening compliance between August and October 2017 on medical care wards was 94% for admission screening, audits showed that between 85% and 100% of relevant patients across all medical care were screened weekly for.

Patients who were found to have Methicillin resistant staphylococcus aureus on admission or during their stay were started on an “Methicillin resistant staphylococcus aureus Pathway” which included actions such as Methicillin resistant staphylococcus aureus screening and treatment was to be completed daily.

During our inspection, we looked at four pathways and saw they were not consistently completed. We confirmed with the infection control team, the pathway should be completed daily during the patient’s stay. We found on three out of the four, there were days where the pathway had not been completed. In one case, the pathway had been discontinued following the completion of the medication used to treat Methicillin resistant staphylococcus aureus, this was not in line with policy.

Between April 2017 and October 2017 there had been three Methicillin resistant staphylococcus aureus, bloodstream infection assigned to the trust, against a National Health Service objective of no avoidable bloodstream infection. We saw that one was in medicine and one in surgery, both were deemed avoidable. The third was a contaminated blood culture, this meant that the patient did not have a bloodstream infection, but bacteria entered the blood culture, whilst it was being taken. The trust undertakes a post infection review of all Methicillin resistant staphylococcus aureus, bloodstream infection, to identify any themes or trends with outcomes and lessons learned shared with staff. A member of the infection prevention and control team reviews all patients who are found to be Methicillin resistant staphylococcus aureus positive weekly during their stay. Staff told us they felt supported by the infection control team and valued their input in ensuring they were delivering good care.
We saw patients with indwelling devices such as urinary catheters had care planned as care bundles in line with Department of Health Guidance. During our previous comprehensive inspection in 2013 we saw that, in response to the above average rates of catheter and UTI infections, a catheter care pathway had been introduced. A checklist had been introduced to ensure the right checks were carried out and dated. During this inspection we saw that the trust audited catheter management on a monthly basis and between August and October 2017, results ranged from 74% to 100% compliance. The average across all areas was 90% which was in line with trust targets. This showed that care was being given in accordance with national guidelines.

There were monthly commode cleaning audits and we saw the results between August and October 2017. The results ranged from 0% to 100% with an average score of 83%, this was below the trust target of 90%. There were also four gaps in the audits, meaning the audits had not taken place that month. For example on Spruce ward no audit took place in August or September. We saw staff clean commodes after each use using disinfectant wipes and ‘I am clean’ labels were applied. We checked 10 commodes over several wards on inspection and they were all visibly clean and were dated indicating they had been cleaned that day.

The endoscopy suite had separate clean and dirty utility areas for the preparation and cleaning of equipment which minimised the risks of infection to patients. Staff transported dirty scopes from the treatment area to the dirty area in a covered, solid walled, leak proof container. This was in line with the Health and Safety Executive Standards and Recommended Practices for Endoscope reprocessing Units, QPSD-D-005-2.2. In the endoscopy department, we saw there were adequate systems to ensure that scopes were safely decontaminated. We saw documentary evidence showing that the use of scopes was tracked and the use of a specific scope was linked to each procedure. Staff we spoke with could explain the correct decontamination process. Staff stored scopes safely in a drying cabinet for up to three days. There were processes in place to ensure staff reprocessed scopes at the correct time.

There were sufficient numbers of hand washing sinks available, in line with Health Building Note: 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. Information was displayed demonstrating the ‘five moments for hand hygiene’ near hand washing sinks. Sanitising hand gel was readily available throughout the wards and the hospital. On wards we visited we found some patients were isolated for infection control reasons. These patients were nursed in single rooms and we saw necessary precautions were clearly displayed on the doors and staff observed these precautions.

**Environment and equipment**

The service had mostly suitable premises. However, we saw some equipment was not well maintained and not always available. Safety of equipment could not be guaranteed as service records were not consistent.

On the Acute Medical Unit we inspected 19 pieces of medical equipment, seven had no indication as to when they had been last cleaned. There were five pieces of equipment that required stickers indicating when they were due a service, we saw four were within their service scheduled dates and one was not. This means that the staff would not know if the eight pieces of equipment were safe to use as they could not be assured they were clean or serviced adequately.

On Ebony ward we inspected ten pieces of medical equipment for cleanliness and service due by dates. All of the equipment, 100%, had a label indicating the item had been cleaned on the day of inspection. Of the five pieces of equipment that required service due by dates one piece of equipment, weighing scales, was out of date having been last serviced in July 2017. This potentially meant the scales could be inaccurate.
On Spruce ward we inspected seven pieces of equipment. One had a label within the expected date range, two had no label, two had a label but no date on and two were out of the expected date range. One hoist had a label on it indicating it had been last cleaned in April 2017, five months prior to our inspection. Of the five pieces of equipment that required service due by dates two were out of date having been last serviced in July and August 2017. This meant that there was the potential the equipment could be faulty. This was brought to the attention of the ward manager who said they would take immediate action to rectify.

On Palm ward we inspected eight pieces of medical equipment for cleanliness and service due by dates. All of the equipment, 100%, had a label indicating the item had been cleaned on the day of inspection. Of the four pieces of equipment that required service due by dates all were within the expected date range on the day of inspection.

Staff generally reported no problems with equipment and felt they had enough equipment to run the service. We were told there were no issues around securing the necessary equipment for individual patients. However, we were given an example on Oak ward where requests for drip stands had not been fulfilled. We were told this was ongoing and that sometimes they had to use paperclips on lampshades to deliver Intravenous fluids, staff told us they reported this as an incident. This was unsafe practice and could lead to the drips falling and consequent patient harm.

We were also told that there was an ongoing issue with the new ‘slow and steady’ (an aid to help people to mobilise). At the time of the inspection there were two in the department which were shared between two wards. This could cause delays in getting them to the patient.

Access to clinical areas was controlled by entry phone systems. We noted that all systems were working. We did not see posters reminding visitors not to let other visitors ‘tailgate’ on entry. We witnessed this happening and were also able to gain entry onto wards by tailgating visitors and staff. Therefore, staff could not fully control the access of unauthorised people toward ward areas and restrict access to patients to ensure their safety.

Emergency equipment was located on all wards and in the endoscopy unit. The resuscitation trolleys contained all the required equipment including a defibrillator, to manage a medical emergency such as a cardiac arrest. We saw the trolleys were mostly secure, fully stocked and ready for immediate use. However, we did see a resuscitation trolley on Palm ward that was not tamper evident and had open and accessible drawers; this meant items could be taken from the trolley without staff being aware. There was a system for checking these daily with a more thorough weekly check. We saw the fully completed records of checks.

We saw equipment was available for patients with pressure ulcers in line with Royal College of Nursing: Management of Pressure Ulcers: Patients with pressure ulcers should have access to pressure-relieving support surfaces and strategies. We saw, for example, mattresses and cushions were available 24 hours a day. Patients had access to pressure relieving mattresses. We were told that a mattress could be requested and received on the same day. This was in line with Royal College of Nursing: Management of Pressure Ulcers: All individuals assessed as having a grade 1-2 pressure ulcer should, as a minimum provision, be placed on a high-specification foam mattress or cushion with pressure-reducing properties.

The endoscopy lead told us the number and size of scopes met the needs of the service. We saw a variety of scopes available to perform a variety of examinations. Equipment was maintained by an external contractor. We saw documentary evidence of this was filed in the sister’s office. We also saw the equipment was labelled to show it had been maintained at the required frequencies. We saw competency certificates in endoscopy which indicated staff were competent in a variety of procedures and in the decontamination of equipment.
There were ‘sharps’ bins available in all clinical areas we visited. However, we found not all sharps bins were correctly labelled or assembled correctly. We also found sharps bins that were overfull. This was not in line with HTM 07-01.

For example on the Acute Medical Unit, we found a full sharps bin attached to a drugs trolley opposite the nurses station, which was open. The open bin meant there was a risk of someone being able to put their hand in the bin, and either remove the contents or sustain a sharps injury. This presented an immediate safety risk and we spoke with the ward manager, who secured it immediately. In addition, we found another two sharps boxes that were not labelled. In addition, we reviewed another four and three of the four were not labelled before being put to use. We also found incorrect items in the sharps bin, such as gauze swabs, outer packaging, and a glove.

On our previous inspection in June 2016, we found sluice rooms were cluttered items, such as mattresses stored in them. We asked the trust must ensure sluice rooms were decluttered and consistent practice put in place to ensure the correct use of the room.

On this inspection, we looked at four dirty utilities in medicine; all were tidy and uncluttered, and had a separate dedicated hand hygiene sink with soap and paper hand towels available, a slop hopper for disposal of body fluids and a separate deep sink for cleaning equipment. However, we saw in two of the dirty utilities that boxes were stored on the floor. Items on the floor impede adequate cleaning; we found the floor to be dusty.

Assessing and responding to patient risk

We reviewed several patient notes across all areas of medical care. There were risk assessments in key safety areas using nationally validated tools. For example staff assessed the risk of falls and pressure damage. We noted when risks were identified, relevant care plans (which included control measures), were generated. We checked a sample of these control measures and found them to be in place.

We saw risk assessments were reviewed and repeated within recommended timescales. The risks of venous thromboembolism were assessed for each patient and prophylactic measures were in place as a result of this, for example the use of anticoagulant medication when required.

All patients were risk assessed on entering any ward area for falls. We saw a falls escalation process was in place. We also saw falls risk noted on all handover sheets. Risk of falls were also communicated to staff using a symbol displayed on a magnetic whiteboard above each patient’s bed and in patient notes.

Ebony ward had just been allocated six new low rise beds following on from high numbers of falls being reported. Staff reported that this had started to make a positive impact on the number of falls. From the data provided we saw that in January 2017 there were eight patient falls reported, this number had shown a steady decrease throughout the year, however, in October seven falls were reported on the ward.

The hospital had implemented the National Early Warning System and we saw this was routinely used for inpatients. We noted on observation charts these scores were calculated consistently and accurately. We tracked several instances of increased scoring, indicating a potential deterioration, and saw where escalation protocols were followed, or the rationale for not doing so was documented. This indicated that a potential deterioration in a patient’s condition was escalated.

We found patients’ physiological parameters such as pulse and temperature were monitored in line with National Institute for Health and Care Excellence guidance CG50 Acutely Ill Patients in Hospital. We watched observations being taken and noted the technique used to monitor their condition would give accurate results. We checked observation charts and saw physiological parameters were conducted at recommended frequencies. The trust also audited the use of
observations and vital signs. From August to October 2017 100% of patients had their temperature, pulse, blood pressure and saturation levels checked. The audit also looked at whether the correct National Early Warning System score was recorded and escalation occurred if needed.

We saw consultant cover was good across the medical department. Consultants would do daily ward rounds to assess any new patients as well as ongoing treatment plans. In Ambulatory care for example there was a dedicated consultant to review all patients on arrival. We also saw that on general medical wards such as Linden, Ebony, Palm and Oak the consultants had a good relationship with patients indicating they had regular interaction with them and opportunity to assess risks early.

All patients on the Acute Medical Unit received post take ward round and a senior review consultant input within 4-12 hours. This was in line with Priority Clinical Standards: Standard 2, Seven day services.

The medicine directorate employed five band 7 clinical navigators. They worked seven days a week from 7:00am to 7:30pm to ensure diagnostic investigations were carried out in a timely manner. This was in line with Priority Clinical Standards: Standard 5, Diagnostics.

The hospital had a 24hr critical care outreach Medical Emergency Team which could be accessed by all medical wards.

Wards could escalate patients via the internal 111 line; the patients are then triaged and allocated to medical staff accordingly. This helped medics to use time effectively.

There was a newly appointed sepsis nurse specialist and a new consultant lead for sepsis. They completed regular audits of sepsis cases.

The trust provided the numbers of ward moves at night (between 10 pm and eight am) between July 2016 and June 2017.

Chestnut and Palm wards reported the joint second highest number of ward moves at night: 20. Both wards again reported their highest number of night time ward moves in August 2016: five for Chestnut and six for Palm.

Otherwise no ward reported more than four ward moves at night in any one month. (Source: trust Routine Provider Information Return P51)

We saw evidence of a new nursing handover sheet for patients transferred from the emergency department. This was introduced in part as a result of a recent Serious Incident where a patient’s full history was not passed over during handover. The handover sheet included sepsis protocols on the reverse. These were also being audited by the sepsis lead, although there were no results at the time of inspection.

Patients admitted acutely with suspected/confirmed sepsis were also continually assessed and monitored using National Early Warning System tool. We saw good adherence to antibiotics being administered within an hour, in-line with recommended guidelines. However, two patients had recently been transferred from Ebony and Pine wards in Darent Valley hospital to Elm Court, one patient in August 2017 and one patient in October 2017. Both patients were transferred back to Darent Valley Hospital on the same day with sepsis. This could indicate they were already suffering with sepsis before transfer and the signs were not picked up by staff. We spoke to a consultant who also indicated that medical and nursing staff on the wards were not always identifying sepsis quickly enough.

We saw clear pathways and processes for the assessment of people using services within the endoscopy unit. This included patients who needed a hospital admission following procedures.
Staff had access to the hospital’s mental health liaison team 24 hours a day, seven days a week. We saw examples where patients required an urgent referral and this was arranged via the mental health lead for medicine.

**Nurse staffing**

During our comprehensive inspection in 2013 we told the trust they must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there are sufficient staff to meet people’s needs. During our recent inspection we found that although there were still vacancies the trust had taken measures to improve staffing.

National Institute for Health and Care Excellence guidelines recommend a systematic approach to nurse staffing at ward level to ensure that patients receive the nursing care they need, regardless of the ward to which they are allocated, the time of the day, or the day of the week. It sets out that the occurrence of nursing red flag events (shown in section 1.4 of the National Institute for Health and Care Excellence guidance) is monitored throughout each 24-hour period.

The data collected for the nursing and midwifery establishment review was undertaken twice a year the most recent being from April/May 2017.

Actual staffing data was reviewed over a six month period along with patient dependency and acuity data, in line with the Safer Nursing care Tool recommendations. Recommendations from National Institute for Health and Care Excellence guidelines for ‘safe staffing in adult inpatient wards in acute hospitals’ (2014), registered to unregistered staffing ratios, skill mix (Royal College of Nursing, 2012), National Quality Board (March 2017) ‘Safe sustainable and productive staffing’, Care hours Per Patient Day and nurse sensitive quality indicators had also been taken into consideration.

All ward managers and their matrons attended a 1:1 meeting with the corporate nursing team and the Assistant Director of Finance, where their staffing establishment was reviewed. The review looked at several areas including: patient acuity and dependency, a comparison of current establishment review data with previous reviews, ward changes including the use of escalation beds.

The review also included an in-depth look at numbers and skill mix of staff against national guidance and included the use of Care Hour per Patient Day standards and current staffing shortfalls for each ward, alongside a review of nursing and midwifery quality indicators, this included falls, hospital acquired pressure ulcers, complaints, friends and family rates and ‘harm events’ as per national guidelines.

On inspection we saw that staffing was adequate across most wards. Staff reported feeling busy and overworked, however acknowledged that staffing had improved recently and that pressures had slightly relieved.

There was a high use of agency staff on some wards, in particular the Acute Medical Unit, which had led to staff feeling overworked. The table below shows there were 12 posts unfilled in the Acute Medical Unit as of July 2017. We saw evidence that 10 of these posts had been filled. At the time of the inspection five had already started and five were due to start January next year.

Senior staff on the Acute Medical Unit and other wards told us they tried to use regular agency staff to maintain consistency but if new agency staff were present it could add to the workload of staff as they had to orientate new starters and sign off competencies.

We saw there was a comprehensive induction booklet given to agency staff on arrival to the ward which set out operational arrangements and expectations of how the nurse would work and report their actions. We spoke with several agency nurses who confirmed they had completed their induction booklet. Induction booklets were filed once completed, these could be accessed in the sisters’ office and we were shown these during the inspection.
The endoscopy service was provided by a team of regular staff which included consultants, nurse endoscopy specialist, nurses, ward clerks, health care assistants and decontamination technicians.

Darent Valley Hospital reported its qualified nursing staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Unit</td>
<td>27.0</td>
<td>15.3</td>
</tr>
<tr>
<td>Adult Medicine Directorate Management</td>
<td>4.6</td>
<td>4.6</td>
</tr>
<tr>
<td>Adult Medicine Specialist Nurses</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Ambulatory Care Unit</td>
<td>7.8</td>
<td>10.4</td>
</tr>
<tr>
<td>Beech Ward</td>
<td>20.7</td>
<td>11.1</td>
</tr>
<tr>
<td>Cancer Services</td>
<td>21.4</td>
<td>20.8</td>
</tr>
<tr>
<td>Cardiac Care Nursing</td>
<td>7.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Cardiology Nursing</td>
<td>8.4</td>
<td>8.1</td>
</tr>
<tr>
<td>Chestnut Ward (CCU)</td>
<td>19.0</td>
<td>16.9</td>
</tr>
<tr>
<td>DCU Endoscopy Area</td>
<td>28.0</td>
<td>23.9</td>
</tr>
<tr>
<td>Diabetes Centre</td>
<td>3.9</td>
<td>3.9</td>
</tr>
<tr>
<td>Discharge Lounge</td>
<td>0.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Ebony Ward (Elderly Care)</td>
<td>20.0</td>
<td>13.4</td>
</tr>
<tr>
<td>Evergreen (was Hornbeam Day Centre)</td>
<td>13.0</td>
<td>10.4</td>
</tr>
<tr>
<td>Hospital at Home Team</td>
<td>6.6</td>
<td>5.5</td>
</tr>
<tr>
<td>Integrated Discharge Team</td>
<td>4.8</td>
<td>6.6</td>
</tr>
<tr>
<td>Laurel Ward</td>
<td>17.9</td>
<td>17.6</td>
</tr>
<tr>
<td>Linden Ward</td>
<td>18.0</td>
<td>11.5</td>
</tr>
<tr>
<td>Oak Ward (Medical)</td>
<td>17.5</td>
<td>14.3</td>
</tr>
<tr>
<td>Palm Ward</td>
<td>26.3</td>
<td>16.8</td>
</tr>
<tr>
<td>Pine Therapy Unit</td>
<td>14.5</td>
<td>14.5</td>
</tr>
<tr>
<td>Respiratory Services</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Resus Training</td>
<td>1.6</td>
<td>1.0</td>
</tr>
<tr>
<td>Rosewood Ward</td>
<td>15.5</td>
<td>11.1</td>
</tr>
<tr>
<td>Short Stay Unit (Prev Obs)</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Spruce (New)</td>
<td>24.4</td>
<td>12.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>333.3</strong></td>
<td><strong>265.4</strong></td>
</tr>
</tbody>
</table>
There were 16 wards/units at Darent Valley Hospital that were below establishment:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Unit</td>
<td>27.0</td>
<td>15.3</td>
<td>11.7</td>
</tr>
<tr>
<td>Spruce (New)</td>
<td>24.4</td>
<td>12.7</td>
<td>11.6</td>
</tr>
<tr>
<td>Palm Ward</td>
<td>26.3</td>
<td>16.8</td>
<td>9.6</td>
</tr>
<tr>
<td>Beech Ward</td>
<td>20.7</td>
<td>11.1</td>
<td>9.6</td>
</tr>
<tr>
<td>Ebony Ward (Elderly Care)</td>
<td>20.0</td>
<td>13.4</td>
<td>6.6</td>
</tr>
<tr>
<td>Linden Ward</td>
<td>18.0</td>
<td>11.5</td>
<td>6.5</td>
</tr>
<tr>
<td>Rosewood Ward</td>
<td>15.5</td>
<td>11.1</td>
<td>4.5</td>
</tr>
<tr>
<td>DCU Endoscopy Area</td>
<td>28.0</td>
<td>23.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Oak Ward (Medical)</td>
<td>17.5</td>
<td>14.3</td>
<td>3.2</td>
</tr>
<tr>
<td>Evergreen (was Hornbeam Day Centre)</td>
<td>13.0</td>
<td>10.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Chestnut Ward (CCU)</td>
<td>19.0</td>
<td>16.9</td>
<td>2.1</td>
</tr>
<tr>
<td>Hospital at Home Team</td>
<td>6.6</td>
<td>5.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Cancer Services</td>
<td>21.4</td>
<td>20.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Resus Training</td>
<td>1.6</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Laurel Ward</td>
<td>17.9</td>
<td>17.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Cardiology Nursing</td>
<td>8.4</td>
<td>8.1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between July 2016 and June 2017, the trust reported a vacancy rate of 18.3% for qualified nursing staff in Medical Care. This did not meet the trust target of having a vacancy rate of 9% or lower.

The site-level breakdown was as follows:

- Darent Valley Hospital: 18.3%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Between July 2016 and June 2017, the trust reported a turnover rate of 11.7% for qualified nursing staff in Medical Care. This did not meet the trust target of having a turnover rate of 9% or lower.

The site-level breakdown was as follows:

- Darent Valley Hospital: 11.7%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Between June 2016 and May 2017, the trust reported a sickness rate of 3.9% for qualified nursing staff in Medical Care. This did not meet the trust target of having a sickness rate of 3.5% or lower.

The site-level breakdown was as follows:

- Darent Valley Hospital: 3.8%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Between August 2016 and July 2017, the trust reported bank usage of 4,876 shifts and agency usage of 5,763 shifts for qualified nurses in Medical Care. Over the same period there were 1,147 shifts that were not filled by bank or agency staff to cover sickness, absence or vacancies. The data supplied by the trust do not allow us to calculate usage rates.

The site-level breakdown was as follows:

- Darent Valley Hospital:
  - Bank: 4,269 shifts
  - Agency: 5,407 shifts
  - Not filled: 978.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

We reviewed three months of staffing data and saw that the planned and actual staffing hours were not met for August, September or October for both day and night nurse staffing. For example on Spruce ward we saw in September day shifts were planned with 1760 nursing hours and 1588 hours were actually staffed. This was consistent for most of the medical department throughout the three months we looked at.

**Medical staffing**

Overall, we judged there was sufficient medical staff with the correct skill mix to meet the needs of the patients on a day-to-day basis. Specialty consultants such as cardiologists, renal and respiratory medicine consultants worked in the Acute Medical Unit and medical wards across the directorate. These ensured patients were seen and reviewed by consultants with relevant skills and expertise in their condition. They also saw patients who were waiting for a bed on their specialty wards daily.

We spoke with consultants and junior doctors who told us there were always two consultants rostered both day and night from 8:00am to 8:00pm then 8:00pm to 8:00am to cover medical care wards.

A recent change in consultant cover had been introduced at Darent Valley Hospital. It involved consultants in the Acute Medical Unit also covering two other wards during their shift. We were told that they were not consulted on the change and felt it added pressure to an already stretched team.

We saw there were suitable systems for medical staff to hand over care from one shift to the next. Handovers occurred at differing times across the medical wards, and allowed staff members to attend handovers on different wards as needed.
Darent Valley Hospital reported its medical staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCU Endoscopy Area</td>
<td>0.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Adult Med - Acute Medical Unit</td>
<td>2.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Adult Med - Cardiology</td>
<td>9.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Adult Med - Diabetes &amp; Endocrinology</td>
<td>8.0</td>
<td>5.8</td>
</tr>
<tr>
<td>Adult Med - Gastro</td>
<td>12.4</td>
<td>12.0</td>
</tr>
<tr>
<td>Adult Med - Nephrology</td>
<td>3.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Adult Med - Neurology</td>
<td>3.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Adult Med - Respiratory</td>
<td>12.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Adult Medicine</td>
<td>17.1</td>
<td>17.4</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>9.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Elderly Care</td>
<td>18.2</td>
<td>20.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95.7</strong></td>
<td><strong>99.9</strong></td>
</tr>
</tbody>
</table>

There were four wards/units at Darent Valley Hospital that were below establishment:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Med - Diabetes &amp; Endocrinology</td>
<td>8.0</td>
<td>5.8</td>
<td>2.2</td>
</tr>
<tr>
<td>DCU Endoscopy Area</td>
<td>0.6</td>
<td>0.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Adult Med - Gastro</td>
<td>12.4</td>
<td>12.0</td>
<td>0.4</td>
</tr>
<tr>
<td>Adult Med - Respiratory</td>
<td>12.0</td>
<td>12.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Between July 2016 and June 2017, the trust reported a staffing surplus of 1.2% above establishment for medical staff in Medical Care. The trust target was a vacancy rate of 9% or lower.

The site-level breakdown was as follows:

- Darent Valley Hospital: a surplus of 6.7% above establishment.

This was within the trust target of having a vacancy rate of 9% or lower.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Between July 2016 and June 2017, the trust reported a turnover rate of 39.8% for medical staff in Medical Care.

The site-level breakdown was as follows:

- Darent Valley Hospital: 40.3%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
Between June 2016 and May 2017, the trust reported a sickness rate of 2.8% for medical staff in Medical Care. This was within the trust target of having a sickness rate of 3.5% or lower. The site-level breakdown was as follows:

- Darent Valley Hospital: 2.8%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Between August 2016 and July 2017, the trust reported locum usage of 1,709 shifts and agency usage of 2,378 shifts for medical staff in Medical Care. All but three of these shifts were at Darent Valley Hospital. Over the same period there were no shifts that were not filled by locum or agency staff to cover sickness, absence or vacancies. The data supplied by the trust do not allow us to calculate usage rates.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

During June 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average. The proportion of junior (foundation year 1-2) staff was also higher than the England average.

**Staffing skill mix for the 74 whole time equivalent staff working in Medicine at Dartford and Gravesham NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>51%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>15%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source: NHS Digital - Workforce statistics (01/06/2017 - 30/06/2017)

**Records**

Staff kept good records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. However, we saw patient confidentiality was not always maintained.

We looked at 13 sets of patient records which were multi-disciplinary and we saw doctors, nurses and therapists contributed to a single document. The records were well maintained and easy to navigate. They were compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. The records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received. For example, we saw care plans in line with the Royal College of Nursing: Management of Pressure Ulcers: All individuals assessed as having a grade 1-2 pressure ulcer should have a documented positioning and repositioning regime.
We saw good identification and diagnosis to antibiotic times. When people were prescribed an antimicrobial they had the clinical indication and we saw dose and duration of treatment documented in their clinical record. This was in line with National Institute for Health and Care Excellence, QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record.

Once a patient had been discharged all notes were scanned and shredded. The electronic records were available online to all areas of the hospital and levels of access were given according to need. The records could be viewed by multiple people at the same time.

Some staff reported problems accessing patient records after patients had been discharged. All patient records were now scanned and shredded after use. This had caused problems when staff needed to access specific notes for investigations or complaints. Notes were placed on the system in no clear order so it was not possible to know when a set of notes that wasn’t already on the system would be uploaded. Another issue staff reported was the increase in paperwork that needed to be filled in. Nurses reported that each new patient record took up to 45 mins to complete, this could prevent them from nursing on the wards as paperwork was time consuming.

We reviewed three sets of note containing details of patients with mental health needs, three with dementia needs, and a set of notes belonging to a patient with learning disabilities. We found alongside their physical health needs the complex and individual needs of these patients were being recorded and considered. For example when a patient had been seen by a member of the mental health liaison team, the mental health assessment, care plan and risk assessment was accessible to all staff on the ward. This was in line with National Institute for Health and Care Excellence, QS15 Statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.

Staff on the endoscopy unit kept full scope-tracking and traceability records. These indicated each stage of the decontamination process. We saw the audit scope log book was completed and up to date. The service audited these records and we saw results of these audits, which indicated all stages of the process were completed. This followed guidance from the British Society of Gastroenterology on decontamination of equipment for gastrointestinal endoscopy (2014).

On this inspection we saw paper records were generally stored in open trolleys which were kept at the staff stations, which were in constant sight of staff. This maintained security and prevented unauthorised access of patient records. However, on several occasions patient records were visible on computer screens. These included patient names and confidential details about the care they were receiving. We also saw a handover sheet on a reception desk in view of visitors and other patients. This meant the records were not secured according to information governance standards and patients’ confidentiality was at risk.

We saw mandatory training records which showed us that in October 2017, 73.7% staff in the directorate had completed information governance training. This was worse than the trust target of 85%.

**Medicines**

The service prescribed, gave and recorded medicines well. Patients we reviewed received the right medication at the right dose at the right time. However, medicines were not consistently stored securely to minimise unauthorised access.

Doors to medicine rooms had a Digital lock and only authorised staff had access. We saw medicine cupboards, fridges and trollies were also locked. The nurse in charge on the wards and department areas held the keys and only authorised staff had access to these. However, on Spruce ward the key code lock on the clinic room did not always click shut, meaning people could
gain access to the room. We also observed a medicines trolley left open on the ward during a medicines round. This was left open for approximately 15 minutes.

Medicines trolleys and fridges were clean and tidy and all the items stored were within date and there was a system of expiry date checks by pharmacy. Temperature monitoring of medicines refrigerators was not always consistent. For example on Palm ward six days were missed in October 2017, 11 days missed in September 2017, nine days were missed in August 2017 and 12 days were missed in July 2017. Additionally, temperatures of below 2°C had been recorded 14 times between August 2017 and September 2017. No actions had been documented.

Although resus trollies were checked daily, not all medicines contained in it were tamper evident, in line with Resuscitation Council (UK) Guidelines.

On the Acute Medical Unit two recent medication errors had been reported. One was a missing vial of midazolam. An agency nurse had omitted to sign the drug out, this had been picked up on the following shift during routine checks and was, at the time of the inspection, under investigation. The second was an omitted dose of Metformin; this had only recently been reported and was also under investigation. This showed that the reporting and medicine checks that were carried out were embedded and trust policy had been followed.

We checked several prescription charts across the department and most had been correctly and clearly completed. However, a patient’s body weight was not always recorded on prescription charts; body weight is sometimes needed to ensure both safe and effective prescribing.

The prescriptions we looked at met legal requirements and were legible, signed and contained information about the patient’s allergies. For example on Redwood ward we reviewed two current patients’ prescriptions, they were clearly dated and signed by the nurse and Doctor, in-line with best practice.

Controlled drugs were stored, recorded and handled correctly and within national guidance. Spot checks on balances showed that contents of the cupboard matched the register. Staff wore red ‘do not disturb’ tabards when undertaking the medicines round, to help promote safe administration.

The trust had a medicines management policy dated 2016. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs. We observed the administration of medicines met the guidance issued by the Nursing and Midwifery Council standards of medicines management 2015.

We saw local microbiology protocols for the administration of antibiotics and Pharmacists conducted daily ward rounds with microbiologists to support antimicrobial stewardship and safe antimicrobial prescribing. We reviewed four patient records and saw that patients were prescribed antibiotics in line with National Institute for Health and Care Excellence, QS61 Statement 1: People are prescribed antibiotics in accordance with local antibiotic formularies.

Pharmacy services were available from Monday to Friday 9:00am -5:30pm for ward-based clinical pharmacy services, dispensary, stock and procurement. Pharmacists attended 8:00am consultant ward round on the Acute Medical Unit, with pharmacy technician support for medicines reconciliation. On Saturday and Sunday the service was available onsite from 10:00am to 3:00pm. Outside of these times an out-of-hours pharmacy service was available via pager.

The pharmacy department comprised 102 whole time equivalent staff, 31 whole time equivalent, pharmacists, 33 whole time equivalent, pharmacy technicians, 30 pharmacy assistants and 8 pre-registration trainees. There was a senior pharmacist and technician leadership for each division including medical care. Pharmacists and pharmacy technicians supported optimisation of medicines through medicines reconciliation, routine prescription review, patient counselling, and close liaison with clinical teams, discharge medicines transcription and supply.
Pharmacy formed part of the Integrated Discharge Team and also attended the post-take ward round to support early medicines reconciliation and review of medicines as needed.

The Ambulatory Care Unit has access to a pharmacist who works with hospital-at-home team to support safe medicines use for example if a patient is discharged home with IV antimicrobial therapy. We saw an example of this discussed at a multidisciplinary team meeting, this contributed to the discharge of a patient who otherwise would have had to stay in hospital.

We spoke with two pharmacists; both felt that team working was good within the hospital. They reported having time to educate patients about new medications for example starting a new anticoagulant.

There was no protocol for starting patients on methadone, methadone is an opioid used to treat pain and as maintenance therapy or to help with tapering in people with opioid dependence. Pharmacists told us there was a “rough guide” available via medicines information on the intranet. As a result they often receive out of hours phone calls of concern from staff wanting advice on starting methadone. Pharmacists felt a more detailed protocol for medical teams to access would be helpful.

A medicines information patient helpline was available to all patients. We witnessed older people with complex needs having medication explained to them before discharge and saw discussions in multidisciplinary team meetings about involving family members and carers to ensure everyone involved with the patient was clear on the medication they would need and how to take it.

Medicines reminder charts were given to people upon discharge to help them take their medicines correctly at home. We saw an anticoagulant counselling pack was held on the ward, to help pharmacy staff ensure that people had enough information to take their medicines safely when at home.

National Institute for Health and Care Excellence guidance relating to technology appraisals are discussed at the Medicines Management Committee. Medicine was then added to the formulary within three months of publication of the guidance.

Incidents

During our comprehensive inspection in 2013 we saw the trust needed to ensure that learning from the reporting of incidents was cascaded and that any changes to practice required following a serious incident are implemented in a timely manner. During our recent inspection we saw that feedback was routinely given and staff could give us examples of learning from incidents.

There were arrangements to ensure serious incidents were investigated promptly through a root cause analysis and actions were taken. We saw examples of these investigations and noted they were sufficiently thorough, identified lessons learnt and actions to be taken. Staff told us, and we saw from meeting minutes, information regarding serious incidents was shared with the matrons and sisters who then reported anything to staff on the wards via, handover or departmental meetings.

There was suitable discussion about the lessons learnt and changes in practice needed to prevent recurrence. We were given examples of changes in practice as a result of incidents. For example, Ebony ward received funding for six low rise beds following on from increased falls data. All patients admitted to wards now have a full body map completed to help reduce Pressure Ulcers and to determine if a pressure ulcer occurred before a patients stay or after. Further to this handover sheets had recently been enhanced to include more information when patients were transferred from the emergency department to the Acute Medical Unit.
All staff were able to access the Datix system to report incidents. We saw that correct reporting of pressure ulcer and falls, in line with the Royal College of Nursing: Management of Pressure Ulcers: All pressure ulcers grade 2 and above should be documented as a local clinical incident.

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

Between September 2016 and August 2017, the trust reported no incidents classified as never events for Medicine.

Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)

In accordance with the Serious Incident Framework 2015, the trust reported 44 serious incidents (SIs) in Medicine which met the reporting criteria set by National Health Service England between September 2016 and August 2017.

Of these, the most common type of incident reported was

- Pressure ulcer meeting SI criteria with 26 (59% of total incidents)
- Slips/trips/falls meeting SI criteria with 14 (32% of total incidents)
- HCAI/Infection control incident meeting SI criteria with three (7% of total incidents)
- Treatment delay meeting SI criteria with one (2% of total incidents)

(Source: Strategic Executive Information System (STEIS))

All incidents are reviewed by the matron or ward sister and escalated if needed. We observed ‘lessons learnt’ boards on Linden ward and in the Acute Medical Unit. The trust also fed back about trust wide incidents via a monthly newsletter which was e-mailed to all staff. Staff reported they were aware of this newsletter but not all reported they read these. We also had reports from some staff that they did not receive regular feedback about incidents.

Patient safety alerts were issued via the Central Alerting System, a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the National Health Service and other organisations, including independent providers of health and social care. The trust has an alerts officer and alerts administrator but did not audit compliance.

There were monthly mortality and morbidity meetings held by the ‘Mortality Surveillance Committee’ these were well attended by a multidisciplinary team including representatives from the medicine directorate. They also had Clinical Commissioning Group representation. We reviewed minutes of these meetings and saw they reviewed crude mortality, mortality flags and
prepared learning summaries to be shared amongst staff.

We reviewed two Root Cause Analysis reports following on from serious incidents, they were suitably robust and included lessons learnt and showed correct protocol in reference to the duty of candour. Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008.

**Safety Thermometer**

It was not clear how the service was using safety monitoring results to improve the service. We saw Safety Thermometer information displayed in all areas across medicine. All showed the percentage of harm free care and individually listed the total number of falls, pressure ulcers, Methicillin resistant staphylococcus aureus and clostridium difficile. On the final day of our inspection we noted that the displayed harm free care for Ebony ward was 100% however there had been seven falls reported in that month. This meant the harm free care data displayed was inaccurate and could mislead patients on this ward.

Safety Thermometer data was discussed at the monthly matrons’ meetings and reports sent to the patient safety committee which met monthly to discuss trends and themes.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 22 new pressure ulcers, 18 falls with harm and 16 new urinary tract infections in patients with a catheter between September 2016 and September 2017 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Dartford and Gravesham NHS Trust

Is the service effective?

Evidence-based care and treatment

We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example National Institute for Health and Care Excellence guidance CG161: falls in older people assessing risk and prevention, QS24: nutrition support in adults, QS3: venous thromboembolism in adults reducing the risk in hospital, QS66: intravenous in adults in hospital therapy, QS90: urinary tract infections in adults, QS2: stroke quality standard and the Royal College of Physicians national clinical guidelines for stroke.

We reviewed a range of clinical policies and found that all expected topics were covered by a policy framework, either locally or at trust wide level. We were shown protocols used in the ambulatory care ward. We noted they were referenced and based on relevant National Institute for Health and Care Excellence guidance. Staff were able to access national and local guidelines through the trust’s internal computer system. This was readily available to all staff. Staff demonstrated how they could access the system to look for current trust guidelines. We noted there were links in place to access national guidelines if needed.

National Institute for Health and Care Excellence guidance was circulated to the identified lead within each directorate or department together with a link to an on-line pro forma. The designated lead completes the pro forma and returns it to the governance department who collate the information. Quarterly reports were prepared for the Quality and Safety Committee who, in turn
reported to the trust board on the status of National Institute for Health and Care Excellence guidance. In addition an annual report was prepared for the Quality and Safety Committee. This gave the committee the opportunity to scrutinise whether the guidance was being complied with.

In addition to national audits, we found there was a range of local audit activity which was given due consideration and prompted changes to practice and other actions. For example, the renal department on Redwood ward had carried out an Acute Kidney Injury review which looked at recent National Confidential Enquiry into Patient Outcome and Death key findings and reviewed causes of Acute Kidney Injury and clinical outcomes. The results of this review led to more integrated care, raised awareness of Acute Kidney Injury and aimed to improve bed management to allow timely Intensive Care Units step downs. The review used the audit standards set out by National Institute for Health and Care Excellence, Quality standard [QS76]: Acute kidney injury: prevention, detection, and management of acute kidney injury up to the point of renal replacement therapy in adults.

Patient records showed the care patients received was consistent with National Institute for Health and Care Excellence guidelines and protocols in use at the hospital. For example we saw documentation that patients, once transferred from the acute area of the hospital to a general ward, were reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it had been determined that this would not affect the patient’s care pathway.

Consultants on the Acute Medical Unit were working non-consecutive days. This meant that they would not see the same patient over a series of days and did not maximise the opportunities for continuity of care. Consultants we spoke with had raised this as an issue and we were told this was currently planned for review, but at the time of inspection it was as reported. We were told by consultants that a consequence of this was doubling up on patient reviews and some discharge delays.

The ward sister on Linden and Ebony wards told us that patients who displayed violence and aggression were offered one to one care. If this was not available there had been times when hospital security had been used to “keep an eye” on patients. Staff were unaware if the security staff were specifically trained to deal with patients’ needs, for example had dementia awareness training. This could mean patients were not treated in the correct way on wards and was not in-line with National Institute for Health and Care Excellence, NG10 - Violence and aggression: short-term management in mental health, health and community settings; Staff training: 1.2.1 Health and social care provider organisations should train staff who work in services in which restrictive interventions may be used in psychosocial methods to avoid or minimise restrictive interventions. This training should enable staff to develop: skills to assess why behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors.

We observed many staff handovers across different areas in medical care; they routinely referred to the psychological and emotional needs of patients, as well as their relatives and carers. This included patients who are suspected to be experiencing depression being referred for a mental health assessment. We reviewed two sets of notes for patients who had depression identified, which included individual patient needs and referral and suggestions from the mental health team.

The trust has a multidisciplinary, Sepsis Steering Group. The role of the group was to review sepsis care across whole acute care system. Improvements included the ‘Vital signs’ policy being updated to incorporate reference to sepsis screening and escalation process.

The trust had been participating in the Royal College of Emergency Medicine ‘Severe sepsis and septic shock audit’ for past three years where data was sent for review. The results have shown steady progress on various sepsis related quality indicators including sepsis-6.
**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other dietary requirements. However, more care was needed to ensure the right food was given to patients and patients’ needs were consistently met.

Risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a malnutrition universal screening tool which identified patients who were at risk of poor nutrition or dehydration. In line with National Institute for Health and Care Excellence, QS24 statement 1: Screening for the risk of malnutrition. All records we checked showed malnutrition universal screening tool scores had been recorded. We noted patients who were identified as at risk, had nutritional care plans in place. Staff could request a dietician if needed, we were told on Spruce ward that dieticians were available daily and were easily accessible for advice or assessment.

Patients had drinks left within reach and all wards had protected mealtimes. These are periods on a hospital ward when all non-urgent clinical activity stops. During these times patients were able to eat without being interrupted and staff offered assistance.

Patients with dementia had specially trained volunteers called ‘Dementia Buddies’ who helped on wards with tasks such as feeding. Staff and patients reported they were invaluable, and staff said without them feeding would be particularly hard.

We saw food and fluid intake was monitored using food charts and fluid balance charts. There was a ‘red-tray’ and ‘red-jug’ system in operation so all staff could identify patients who needed help eating and encouragement to drink. We saw magnetic signs on Ebony ward were above patients beds indicating when a patient required assistance with eating and drinking and were seen to be unobtrusive and discreet.

However, we were told that on Spruce ward, to ensure the catering staff knew which diet a patient was on the wipe board in the kitchen was used with each patient’s name and bed number on it as well as their dietary requirements. On both days of inspection the board on Bed 19 indicated that the diet the patient required was a fork mashable diet. However, when we observed the service of lunch on Spruce on the 8 November 2017, the patient in bed 19 was given a fork mashable diet. After the patient had been served the fork mashable diet a nurse questioned this as the nurse said the patient was now on a pureed diet. There was no indication on the wipe board that this had changed and the catering member of staff had not been advised of the change. This meant that a patient received a meal not suitable for their dietary requirements and as the diet had been changed to a softer diet the patient could have choked on the food presented to them.

We also spoke with a patient on Ebony ward who was visually impaired. They said that in the past staff had “just plonked food down” and they had not been told what was on their plate or assisted to eat. When the ward sister was told this she said staff were told to tell the patient what was on their plate and observe dinnertime to ensure they got help if needed.

**Pain relief**

Patient pain scores were completed as part of routine observations by nurses but not always consultants. A system of scoring 1-10 was in use and this was used to evaluate the effectiveness of pain relief given. We saw pain scoring documented in patient notes. Patients who had difficulties communicating used picture boards. However, there was no formal pain scoring used such as the ‘Disability Distress Assessment Tool’ for patients with severe communication difficulties. Staff told us they use facial expression for pain scoring in these cases. However, that could lead to inconsistent scoring of patients’ pain as different staff may not notice a difference from day to day.
We saw a patient's pain medication was reviewed on a drug round as the patient was having difficulty swallowing. There was a pharmacy technician on the ward who reviewed the drug and changed it immediately to a liquid form that the patient found much easier to take. This showed good adherence to National Institute for Health and Care Excellence, QS15 Statement 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

Patients we spoke with told us they received adequate pain relief and it was administered promptly when requested.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Information about the outcomes of people's care and treatment was routinely collected and monitored. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit. For example all departments carried out a series of weekly and monthly audits to identify trends and themes and areas for improvement.

Weekly audits included hand hygiene, commode cleanliness and cannula management. We reviewed the most recent results and found for example that cannula management across Lindon, Ebony, Oak and Redwood were all in line with the trust targets of 90% compliant. Chestnut, the Acute Medical Unit, Spruce and Palm were only slightly worse than trust targets with the lowest of 75% compliance reported on Palm ward. We saw there was a system for local audits to be formally presented at the directorate's audit and governance meetings. This meant results and lessons learnt were shared to improve services.

Monthly audits included falls, malnutrition universal screening tool compliance, and pressure ulcers. We saw that there were 18 falls with harm across the directorate from September 2016 to September 2017. In the same period there were 22 hospital acquired pressure ulcers reported. The most recent malnutrition universal screening tool compliance audit compiled data from October 2017 and showed over 90% compliance in all areas apart from patients receiving a malnutrition universal screening tool assessment within 24 hours, this was achieved 77% of the time across all wards, with the lowest scoring wards being Spruce (stroke ward) and Palm ward, with a quarter of patients not receiving this assessment on time.

The endoscopic services demonstrated compliance with British Society of Gastroenterology guidelines. The service had Joint Advisory Group on gastrointestinal endoscopy accreditation incorporating the endoscopy global rating scale, which was the quality improvement and assessment tool for the gastrointestinal endoscopy service. As part of Joint Advisory Group monitoring the hospital demonstrated good audit practice in the department for example, patient sedation levels, consent and note audit, biopsies quality and perforations.

The Renal service on Redwood ward was such a small service it could not submit data to the Renal Registry but continuously conducted local audits, for example, renal biopsy and dialysis outcomes.

**Trust level**

Between June 2016 and May 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in Clinical Haematology had a lower than expected risk of readmission for elective admissions
• Patients in General Medicine had a higher than expected risk of readmission for elective admissions

• Patients in General Medicine had a lower than expected risk of readmission for non-elective admissions

• Patients in Geriatric Medicine had a lower than expected risk of readmission for non-elective admissions

• Patients in Respiratory Medicine had a lower than expected risk of readmission for non-elective admissions

**Elective Admissions – trust Level**

**Non-Elective Admissions – trust Level**

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/06/2016 - 31/05/2017))

**Darent Valley Hospital**

Between June 2016 and May 2017, patients at Darent Valley Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

• Patients in Clinical Haematology had a lower than expected risk of readmission for elective admissions

• Patients in General Medicine had a higher than expected risk of readmission for elective admissions

• Patients in General Medicine had a lower than expected risk of readmission for non-elective admissions

• Patients in Geriatric Medicine had a lower than expected risk of readmission for non-elective admissions

• Patients in Respiratory Medicine had a lower than expected risk of readmission for non-elective admissions
Elective Admissions - *Darent Valley Hospital*

Non-Elective Admissions - *Darent Valley Hospital*

**Sentinel Stroke National Audit Programme (SSNAP)**

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade D in latest audit; December 2016 to March 2017.
The trust has seen a decline in the Sentinel Stroke National Audit Programme audit with domain 2: overall team-centred rating score for key stroke indicator worsening from level C in April to June 2015 to level E in April to July 2016 and performing much worse in comparison to the national average.

The trust had just received a D, which had improved from an E on the previous audit. We spoke with staff who told us this was largely to do with seven day services not being available at the time due to staffing issues. There was still an ongoing issue with therapists being able to offer a seven day service.

The unit was not meeting the target for direct admissions. There was a dip in September 2017. This was due in part to stroke patients not being picked up as such in the emergency department and bed pressures.

To address this the matron and band six staff had asked the sister in the Acute Medical Unit to inform the ward if a patient had been diagnosed with a stroke, for example after a magnetic resonance imaging or computerised tomography scan, they must contact the stroke team immediately.
The unit experienced some bed pressures and had medical outliers. At the time of the inspection there were two medical outliers on the ward. If a stroke patient is admitted to another ward the CNS will visit the ward with the consultant and review patients until a bed was available on Spruce ward. When the ward was full of stroke patients and no one was fit to leave this affected the direct access data. Staff reported September 2017 was a “bad month” as all beds were filled with stroke patients.

There was a Kent wide on call rota for thrombolysis. We saw the rota and saw Dartford and Gravesham contributed.

There was a Telemedicine system in place which allowed the computerised tomography images to be sent to the consultant at home. This information was also emailed to the stroke nurse and hospital consultant.

**Heart Failure Audit**

**In-hospital Care Scores**

Results for Darent Valley Hospital in the 2016 Heart Failure Audit were better than the England and Wales average for all of the four standards relating to in-hospital care.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Darent Valley Hospital</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology inpatient (%)</td>
<td>51.5%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Input from consultant cardiologist (%)</td>
<td>72.8%</td>
<td>56.9%</td>
</tr>
<tr>
<td>Input from specialist (%)</td>
<td>94.9%</td>
<td>79.0%</td>
</tr>
<tr>
<td>Received echo (%)</td>
<td>94.9%</td>
<td>90.1%</td>
</tr>
</tbody>
</table>
Discharge Scores

Results for Dartford and Gravesham NHS Trust results were better than the England and Wales average for five of the seven standards relating to discharge.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Darent Valley Hospital</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEI on discharge (%)</td>
<td>52.8%</td>
<td>61.1%</td>
</tr>
<tr>
<td>ACEI/ ARB on discharge (%)</td>
<td>82.1%</td>
<td>73.7%</td>
</tr>
<tr>
<td>Beta blocker on discharge (%)</td>
<td>88.5%</td>
<td>80.4%</td>
</tr>
<tr>
<td>MRA on discharge (%)</td>
<td>48.5%</td>
<td>45.4%</td>
</tr>
<tr>
<td>Received discharge planning (%)</td>
<td>88.3%</td>
<td>87.3%</td>
</tr>
<tr>
<td>Referral to HF nurse follow up (%)</td>
<td>42.6%</td>
<td>54.8%</td>
</tr>
<tr>
<td>Referral to HF nurse follow up (LVSD only)</td>
<td>70.5%</td>
<td>70.8%</td>
</tr>
<tr>
<td>Referral to cardiology follow-up</td>
<td>67.5%</td>
<td></td>
</tr>
<tr>
<td>Referral to cardiac rehabilitation (%)</td>
<td>4.2%</td>
<td>12.1%</td>
</tr>
</tbody>
</table>

**SOURCE:** NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)

**National Diabetes Inpatient Audit**

The National Diabetes Inpatient Audit measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 percent, whereas quartile 4 means that the result is in the highest 25 percent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 60 inpatients with diabetes at Darent Valley Hospital, 73% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which placed this site in quartile one, which was comparable to the 2015 score of 67.3%

(Source: NHS Digital)

**Myocardial Ischaemia National Audit Project (MINAP) 2015/16**

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

In the published report, no data were reported for Darent Valley Hospital for the four metrics relating to primary percutaneous coronary intervention reperfusion therapy for patients with ST-elevation myocardial infarction. This was because the hospital submitted fewer than 20 relevant
records to the audit, meaning that there would have been a risk of identifying the individuals concerned.

Between April 2015 and March 2016, 47.5% of nST-elevation myocardial infarction patients were admitted to a cardiac unit or ward at Darent Valley Hospital and 97.7% were seen by a cardiologist compared to the England averages of 55.8% and 96.2% respectively.

The proportion of nST-elevation myocardial infarction patients who were referred for or had angiography at Darent Valley Hospital was 60.6% compared to an England average of 83.6%.

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

National Audit of Inpatient Falls 2015

According to the National Audit of Inpatient Falls 2015 (published in 2017) the trust has a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 22.2%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 17.4%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a mobility aid in reach (if applicable) was 62.5%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

The trust appraisal compliance target was 85%. Appraisal compliance rates were monitored and reported each month at directorate and department level, and to the trust board. Appraisal rates were also monitored by the Workforce Committee, a sub-committee of the trust board which met every two months.

From January 2017 staff that had not been appraised in the last twelve months were not eligible for incremental pay progression.

The 2016 staff survey reported an 86% of respondents had an appraisal in the last twelve months. This was comparable with the national average of 86%. Training was offered to appraisers on how to conduct an appraisal meeting.

Between July 2016 and June 2017, 72.9% of staff within Medicine at the trust received an appraisal. The trust told us in their PIR that their completion target was 85%, though this only applies to staff that have been employed for more than one year.

The split by staff group at trust level and each site can be seen in the graphs below.
We saw there was a wide range of specialist nurses, for example palliative care team, discharge co-ordinators and specialist learning disabilities nurses and noted their presence on the wards. Staff told us they felt supported by these specialists and valued their input in ensuring they were delivering competent care.

We saw specific competencies completed on appointment to posting in some areas, for example on Redwood ward. The staff all had to complete renal dialysis competencies before starting work. On inspection three nurses had completed the course, with two further nurses due to complete the competencies before the end of 2017. There was a band seven nurse completing competencies checks. They came to this trust from a neighbouring trust once a week.
Training could be accessed through the online computer system available to all staff who worked in the hospital. Staff reported that they were encouraged to do training but sometimes were restricted due to staff shortages. However, many reflected they felt this had improved over the last few months.

Agency staff had their competencies assessed on wards before being allowed to undertake routine tasks, for example, medicine rounds. However, we observed two members of staff using a drug trolley on the Acute Medical Unit at 10:30 on the 7 November 2017. One was a new starter who was supposed to be observing the drug round. We saw poor practice by the nurses as drugs were taken from the trolley in the corridor to the patient. Correct procedure would be to take the trolley to the patient bedside allowing staff to double check medication with the patient notes, and identifying wrist band. We also saw the new nurse dispatching drugs and taking them to patients. We brought this to the attention of the senior sister who said that the new nurse had not completed their drug competencies and should not be handing out drugs. She addressed this with the staff nurse but we observed them doing the same thing within an hour of us bringing this to the sister’s attention.

New starters were assigned a mentor but we were told that due to the high workload that sometimes the mentor could not observe new starters as frequently as needed. There was no longer a practice development nurse assigned to the medicine directorate and as a result senior staff were undertaking this role. This could have led to delays in training as staff pressures meant they did not have as much time to spend training staff as they would want. We were told this had been raised and a request for a practice development nurse had been made. The issue had also been raised to the serious incident group but at the time of inspection there was no plan to employ a practice development nurse for the medicine directorate.

Managers assessed staff to ensure competency before they used any medical devices, for example the glucometer, a medical device used for determining the approximate concentration of glucose in the blood. We saw examples of competency assessments in staff records in the Acute Medical Unit, which were kept in ward areas. However, agency staff did not have the training to use the new device. This had led to delays in treatment, as agency staff had to wait for trained staff to access the glucometer. We spoke to the Matron and ward sister, who explained this had been raised with the trust, but there was no plan to improve the situation at the time of inspection.

We saw staff that had extended their skills, for example in phlebotomy and healthcare assistants had access to National Vocational Qualification competencies. Staff training was monitored through appraisals, the revalidation process and was signed off by managers.

There was no formal clinical supervision undertaken by nursing staff, we were told it was provided by some senior staff but it was on a voluntary basis and was not recorded in staff records.

The medical department had several volunteers recruited in the role of ‘Dementia Buddies’ they had specialist dementia training to carry out the role.

A psychiatric liaison team was accessible to staff when further advice or knowledge was needed, the team had further experience and training to work with patients with mental health conditions.

**Multidisciplinary working**

We saw patients with complex needs received prompt screening by a multi-disciplinary team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multidisciplinary team assessment was undertaken and care plans were put in pace from admission.

There were weekly multidisciplinary team meetings for people with complex needs, and daily board rounds and handovers were attended by a range of specialist staff. This included the integrated discharge team who helped ensure patients were discharged correctly and in a timely manner.
The Integrated Discharge Team took care of many practical aspects of discharge including liaising with family members, checking keys, chasing care packages and working with social services. The OT and PT work generically in the team staff we spoke with felt this was a positive initiative as it enabled staff to improve and maintain their skills and reduced delays waiting for a specific therapist.

The department had a ‘Hospital at Home’ service. This enabled patients who were identified as fit for discharge to go home, even if they still required medical treatment. For example patients who require IV antibiotics or oxygen. Staff told us the team would proactively identify patients for this service. Staff felt they had good capacity to take on patients and were easily accessible. We witnessed reference to this service on numerous times on both days of our inspection.

Patients also had access to the ‘Discharge to Access’ service. The Discharge to Access service was accessed via social services and was based in the community. They undertook home visits for patients awaiting a package of care bundle; this included liaising with the Integrated Discharge Team and could do same day visits if patients were discharged by 2pm.

The department had a ‘Hospital at Home’ service. This enabled patients who were identified as fit for discharge to go home, even if they still required medical treatment. For example patients who require IV antibiotics or oxygen. Staff told us the team would proactively identify patients for this service. Staff felt they had good capacity to take on patients and were easily accessible. We witnessed reference to this service on numerous times on both days of our inspection.

The medical directorate employed five, band seven, clinical navigators, they worked seven days a week to expedite diagnostic investigations. Staff reported there were no delays in receiving diagnostic results in a timely way.

We saw established links with mental health services, learning disability and dementia services. We saw collaborative working and staff really trying to understand patients’ needs and working together to arrange care.

The service did not discharge a self-caring patient after 10pm and would not discharge with care package unless they were receiving a care visit as soon as they were home.

However, on Spruce ward we heard a multidisciplinary team assessment should be completed within 14hrs. However, this was not always completed. This was due to the lack of seven day work, due to staffing. Treatment management plans should have been developed within 24 hours but delays were possible due to the lack of seven day working.

**Seven-day services**

All patients on the Acute Medical Unit were seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who had deteriorated. This was in-line with National Health Service, Seven Days a Week, Priority Clinical Standard 8: Ongoing review. However, consultants were not working in multiple day blocks which did not maximise continuity of care.

Once patients were transferred from an acute area of the hospital to a general ward, they should be reviewed during a consultant-delivered ward round at least once a day, seven days a week.

Patients and staff had daily access to several specialist clinical staff, for example dieticians, psychologists and safeguarding leads. On Spruce ward therapists did joint sessions which included the patient’s family, this showed good holistic working. We were given examples where families were invited to the multidisciplinary team discussions to ensure they were part of the discussion.

Ambulatory Care Unit was open seven days a week, 8am to 10pm weekdays and 8am to 6pm weekends. Endoscopy services ran a six day service but were on call every night and 24 hours at the weekend for emergencies.
However, the dialysis service only ran on Monday, Wednesday, and Friday from 7am to 7pm at the time of the inspection. There were several members of staff undergoing training and the service aimed to have a seven day service once staffing had been addressed.

We were also made aware that there was no stroke consultant available on site at weekends. Staff on Spruce ward said that therapy staff could also be hard to access due to staffing issues. We were told that surgical consultants could also be hard to track down. On the day before our inspection staff on Spruce had bleeped the orthopaedic consultant three times and had no response. The patient was followed up by a locum doctor the next day.

**Health promotion**

We witnessed occasions in board rounds where additional risk factors were identified that required additional support or intervention. There was a multidisciplinary team approach to these changes and we saw staff working quickly to make decisions and put them in place.

The trust had a Palliative care team working across the hospital. The team were able to complete fast track Continuing Healthcare checklist assessments and support family to find placements alongside the Integrated Discharge Team.

We saw independence encouraged and occupational health and physiotherapists worked with patients and discussed progress with fellow staff members. If patients were worsening, options and interventions were discussed daily.

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

During our previous inspection in 2013 a large number of staff we spoke with were not sure of their responsibilities in relation to the Mental Capacity Act and the Deprivation of Liberty Safeguards. During our most recent inspection staff had a better understanding of their roles and responsibilities. Staff we spoke with had good awareness of what to do if patients lacked the mental capacity to make decisions; they understood best interests decisions and showed good awareness of the Mental Capacity Act 2005. We spoke to several staff members who showed compassion and caring attitudes towards people who may have needed extra support.

There was a policy for enhanced observation of patients with mental health problems. Any patients kept in hospital under a ‘section’ were supported by the mental health team with paperwork. Being ‘sectioned’ is the term that is often used when someone is detained under the Mental Health Act. The Mental Health Act is the law which can allow someone to be admitted, detained (or kept) and treated in hospital against their wishes. Staff could access a Crisis Team if required but this had occasionally been problematic due to workload. This had been raised and discussed with the Clinical Commissioning Group and was on the trust risk register.

The safeguarding and mental health team supported staff to care for patients with mental health problems. Staff reported they would contact them if they had any questions around consent or mental health issues. All incidents and deaths of patients with known mental health problems were discussed at weekly Serious Incident group and any deaths were reviewed by the Medical Director.

The trust has a consent policy which described those situations where consent could not be taken and how to address this. We were given a recent example where a sister on Linden ward had a complex patient with additional needs. The Director of Nursing spent time going through the patient’s notes and sister’s worries and formulating a specific care plan.

There were e-learning modules for both consent and mental capacity assessment which were tracked through the clinical education department. All junior staff and staff on induction received training in consent processes including managing patients unable to consent.
The consent policy had been updated taking into account recent changes resulting from a court case. The Medical Director has a number of actions from the last consent audit which showed good documentation, but a number of areas where practice could be improved. As a result a series of talks with senior clinical staff were planned to address these.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff understood and respected the personal, cultural, social and religious needs of patients; we witnessed these being discussed in relation to their care needs. Staff took account of psychosocial aspects of care as well as physical.

Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. We saw kind interactions from all medical staff across many wards. Staff were seen to be encouraging, sensitive and supportive towards patients and when discussing patient’s needs. We saw multidisciplinary discussions about patient’s care being held throughout the days on inspection.

We were given examples of how staff members had raised concerns about disrespectful, discriminatory or abusive behaviour from patients. There was a ‘red and yellow’ card system for patients with capacity. If patients were issued with a yellow card they would receive a written formal warning and a flag on the hospital wide computer system. If patients received a red flag they were no longer welcome at the trust.

We spoke to 12 patients across several areas in medical care. Most reported feeling well cared for. Patients reported, “Staff make you feel at home”, and “Always busy, but always kind.” We witnessed a compassionate response to an elderly patient who was showing signs of distress which was followed up by staff returning to check on the patient to gain assurances they were feeling better.

We saw staff introducing themselves to patients and their carers in line with National Institute for Health and Care Excellence, QS15 Statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

On discharge a Friends and Family survey was given to patients and their family/carers to enable their feedback to be provided to the trust. There was no format available to enable people with a learning disability to access this form. This had been identified by the department and was under development at the time of inspection.

The Friends and Family Test response rate for Medicine at the trust was 15% which was worse than the England average of 25% between September 2016 and August 2017.
Friends and family Test – Response rate between September 2016 and August 2017 by site

Ward-level breakdown

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Highest score to Lowest score

Key

- 100% 50% 0%

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

The worst overall performance was seen on Ebony ward (85%). This was based on only two months’ data. The worst monthly scores were reported by the Acute Medical Unit (75% in March 2017, Beech ward (67% in October 2016 and 71% in July 2017), Cherry ward (67% in February 2017) and Oak ward (75% in March 2017).

(Source: NHS England Friends and Family Test)

Although we saw several instances where patients’ dignity and privacy had been respected we did witness staff had been too busy to notice two patients who were not covered correctly in the Acute Medical Unit. This compromised their dignity.

We also witnessed a healthcare assistant who appeared impatient with a patient who was hard of hearing on Ebony ward. At all other times staff were seen to be caring with patients and had kind and respectful interactions.

Emotional support
Staff involved patients and those close to them in decisions about their care and treatment. Staff showed they understood the impact that a person’s care, treatment or condition would have on their wellbeing and on those close to them. We heard of examples such as the ‘Interactive me’ being used. This was a system where family could record messages for patients which were played if a patient became distressed.

The trust had a Multi-Faith Chaplaincy, the Chapel/Multi-Faith Prayer Room was open 24 hours a day. Visits to wards were also undertaken and offered listening and support to patients whether they practiced a formal religion or not. We were given examples where patients were put in touch with the spiritual advisor of their choice, for example an imam or Sikh priest. The trust had an out of hours care service for deceased patients of the Muslim or Jewish faith. This included the completion of the Medical Certificate of Cause of Death documentation protocol. The service aimed to ensure that doctors treating any Muslim or Jewish patient likely to die out of hours could hand over to the on-call doctor. The on-call doctor then visited the patient to gain an understanding of their condition and treatment. In the event of the patient's death out of hours they were then able to complete the Medical Certificate of Cause of Death, this meant the body could be released within 24 hours to Muslim or Jewish families for burial.

The trust conducted an Annual Dementia Carers Audit. We saw a copy of the questionnaire which included information for carers on how to access further support and what services the hospital provided for carers and people suffering with dementia. Carers could also access a clinic for 1-1 advice and carers could be signposted to community support.

Understanding and involvement of patients and those close to them

Staff provided emotional support to patients to minimise their distress. Family members and carers were involved in all discussions around a patient’s care. We witnessed family involvement being discussed at board rounds, multidisciplinary meetings, handovers and with the patients themselves.

When speaking to family members on inspection they were positive about the involvement they felt in their relatives’ treatment and discharge processes.

People’s carers, advocates and representatives including family members and friends, were spoken to using first names on the wards and it was clear that good relationships had been formed between nurses, doctors and therapists.

Patients were given time to ask questions when being told about new treatment options in line with National Institute for Health and Care Excellence, QS15 Statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.

We heard a discussion with the Integrated Discharge Team and nurses which involved then ensuring that an older patient with complex needs had clothing brought in by family members for discharge later that day.

Is the service responsive?

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

We saw that services were delivered in a way that focused on people’s needs and individual preferences.

On Ebony ward we were told that a patient was enabled to have breakfast at a later time as they did not want to get up early. Their needs were thought about throughout the day as they were enabled to go about hospital routines such as showering and eating at times that best suited their
preference.

The hospital had an Ambulatory Care Unit which opened seven days a week from 8am to 10pm Monday to Friday and 8am until 6pm at weekends. The aim of this service was to expedite care through the emergency department and to help to reduce the number of patients who were admitted into general wards.

Of the total medical admissions, 14,162 were day cases, which had seen a 76% increase. This indicated that the trust had driven forward with their plans to increase their day cases by expanding the Ambulatory Care Unit to offer patients a streamlined diagnosis. This included patients being enabled to be sent home with ongoing clinical care, requiring no hospital admission.

Radiology had dedicated Ambulatory Care Unit slots for Doppler and computerised tomography pulmonary angiography/lead and ports being completed mostly within 1-2 hours. However, the department reported delays in Magnetic Resonance Imaging scanning and follow up.

Additionally the electronic discharge notice system was updated daily to identify known dementia, suspected dementia and delirium trust wide and was reported monthly. There were 775 dementia patients admitted trust wide in the last year.

Referrals were made to the diabetes team, electronically through the patient admission system. There was a facility on patient admission system which listed patients who had been identified as diabetic to be reviewed if they had been admitted to a ward. Patients could also be referred to the diabetic team at their request. Inpatients could self-assess to manage their own diabetes while in hospital.

Trust Level

For medical non-elective patients, the average length of stay was 8.4 days, which was higher than the England average of 6.6 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in General Medicine was higher than the England average.
- Average length of stay for non-elective patients in Geriatric Medicine was higher than the England average.
- Average length of stay for non-elective patients in Respiratory Medicine was higher than the England average.

Non-Elective Average Length of Stay – trust Level

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- Average length of stay for non-elective patients in Geriatric Medicine was higher than the England average
- Average length of stay for non-elective patients in Respiratory Medicine was higher than the England average

Non-Elective Average Length of Stay - Darent Valley Hospital

(Source: Hospital Episode Statistics)

The trust was operating at around 50% of day cases, 10% elective (5,994 elective admissions which was a 43% decrease in previous 12 months) and 40% of emergency spells with an average length of stay at 5.8 days which was a 26% increase on the previous 12 months. Of the top three specialties for elective admissions only General Medicine had a higher standard relative risk of readmission.

Medical care had 162 bed moves at night between July 2016 and June 2017 with the most occurring in Elm Court (30). In total, there were 473 delayed discharges in the same period (2% of the total discharges were delayed), with the most delays occurring in March 2017 (60).

There was a nationwide concern over delayed discharges with one of the most common being the required care package being available to allow patients to return home which could also attribute to the longer length of stay for non-elective patients. Although the average length of stay was worse than the national average we were told the department often experienced delays in discharging patients into community care settings. This was particularly hard when patients displayed aggressive or difficult behaviours.

Meeting people’s individual needs

The hospital did not always consider people's individual needs within the department. During our previous inspection in 2013 we found that there were mixed gender bays in use. We found that during our recent inspection there were still mixed sex breaches and bays in use.

We saw multiple breaches of mixed sex accommodation guidelines on both days of inspection. Staff reported it was a daily occurrence. We observed females in side rooms on male bays. These patients shared toilet and shower facilities with the male patients. On Palm ward we saw patients in side rooms (SW: 066, SW: 67, SW: 046 SW: 48) sharing showers and toilets. Staff told us these rooms could be allocated to both male and female patients meaning they would share toilets and showers. Patients had their dignity and privacy impacted on by having to share facilities with the
opposite sex and this was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10(2)(a) ensuring the privacy of the service user; People using services should not have to share sleeping accommodation with others of the opposite sex, and should have access to segregated bathroom and toilet facilities without passing through opposite-sex areas to reach their own facilities.

Staff told us mixed sex breaches were allowed because it was medical need. When questioned, the staff were not aware they were still required to make reasonable adjustments to segregate male and females. Therefore, staff were unable to fully explain the reasons for the breaches and we found they did not have a full understanding of the regulation.

The trust had one full time dementia specialist practitioner. We saw that a dementia bundle of policies and guidelines were available on the staff intranet. These included information on clinical and social assessment as well as support and discharge planning. However, staff we spoke with had generally not had specific dementia training. Although they verbally could describe what they would do to ensure dementia patients were cared for and their extra needs considered. For example staff in endoscopy had not had formal dementia training but were in regular contact with this patient group.

The trust had a Patient Engagement Strategy plan in place but at the time of inspection this had not been embedded into practice. Involvement of patients with any of the nine protected characteristic was being developed in line with the strategy. There was no data collected from patients with protected characteristic such as sexual orientation, civil partnership and gender reassignment. There was a Diversity Management Group and we were told they would be discussing how this data could be collected in the future.

There were arrangements to ensure when a patient required one-to-one care this was provided and additional staff were hired to provide this. We saw this in place on Ebony ward and in the Acute Medical Unit during our inspection.

The environment was not always well maintained for example we saw equipment in corridors. Areas were cluttered and disorganised. In the Acute Medical Unit we saw several items out in corridors including a mattress, a trolley with new stock, an oxygen cart, a linen trolley, wash bowls laying in a corridor as well as a recycling bin and clinical waste bin. We saw in most areas that there was equipment stored in corridors, items such as monitors, patient televisions and equipment trollies. The cluttered environment could be confusing for patients with dementia or special needs and could also cause a trip hazard for patients with limited mobility.

There was a register on the patient admission system to highlight a formal diagnosis of dementia. Through this system patients were also flagged as blind, deaf or deaf/blind, diabetic, have additional needs, learning difficulties and mental health problems.

Additionally the Electronic Discharge Notice system was updated daily to identify known dementia, suspected dementia and delirium trust wide and was reported monthly. There were 775 dementia patients admitted trust wide in the last year.

Teams were able to refer for an ageing health consultant review, dementia specialist review and frailty nurse review in complex cases.

A learning disability liaison nurse was available to offer advice and help with care plans. The safeguarding lead was also a registered learning disability nurse. Ward staff told us they would alert the learning disability nurse when patients were identified as having a learning disability. The learning disability liaison nurse was also able to make referrals to specialists who could confirm diagnosis for example, autism services and psychologists.
On the wards we saw staff did daily care rounds, these were documented in patients notes. They asked if the patient was comfortable, pain free or had any nutritional needs.

We saw suitable equipment for patients living with dementia and limited mobility. Bathrooms and toilets were suitable and there were adequate supplies of mobility aids and lifting equipment such as hoists to enable staff to care for patients. Ebony ward had coloured coded bays with pictorial signage, it also had a reminiscence room and ‘Rosemary café’ where they held bimonthly tea parties.

Ward areas displayed photo-boards of staff so patients and their relatives could identify them and their job role. We noted these were generally kept up to date.

Patients reported feeling supported during referral and transfer between services and discharge. We spoke with a patient who had been transferred from the Acute Medical Unit to the medical wards. They reported they were informed when and why the transfer was happening. We also witnessed several multidisciplinary discussions around discharge and the services complex patients would need once at home, for example the Hospital at home service, where teams would visit patients who required medical care such as Intravenous antibiotics, at home to aid discharge from hospital.

We saw key staff worked across services to coordinate people’s involvement with families and carers, particularly for those with multiple long-term conditions such as dementia. The Integrated Discharge Team worked with social services and local services to aid discharge to care homes or to patients’ homes with care packages in place.

We saw arrangements put into place that took account of patients’ individual needs when being discharged. This included patients with complex health and social care needs that required special considerations, for example older people with dementia or co-morbidities. The Integrated Discharge Team were present and accessible throughout the day across the department.

There were several means to aid communication with patients whom required it. These included easy read pictures that could be made into documents, easy read books on a number of conditions and hearing loops were available. Chaperones were offered for patients uncomfortable being seen by a medical professional of the opposite sex or if there were any concerns generally. The service offered both face-to-face and telephone interpreting. In the past financial year (April 2016 – March 2017) there were 797 bookings in total, of which 21 were unallocated. This means that 97.4% of interpreter bookings were fulfilled. Staff had access to relevant information for patients who had been flagged on the system as having a cognitive impairment or for those whose first language was not English. We heard that interpreters could be booked through this system for both face-to-face and telephone translations.

The department had a number of facilities to promote independence, for example large clocks trust wide to support orientation to time, black toilet seats trust wide to support differentiation of the facilities. The department also implemented red trays and water jugs to inform staff that these patients needed extra support with eating and drinking.

**Access and flow**

Every medical ward and area undertook board rounds which managed the flow of patients coming in and out of the hospital by identifying those patients that were ready for discharge in a timely manner. Board rounds determined which patients were to be discharged that day and these were transferred to the discharge lounge to free up beds. Additionally, the Acute Medical Unit and ambulatory care unit aimed to help in the prevention of unnecessary admission and avoid overnight stays.
Due to the lack of beds in medical wards, patients could be placed in other departments’ wards (usually surgical wards) and these patients were called medical outliers. From January 2017 to October 2017 there were 7688 medical outliers reported in medical care. This was a significant increase from the previous year when there were only 1433 reported. This could be explained in part by the increase in patients over the last year, and also by the changes in the service with some ward changes and patients being moved due to the reconfiguration of wards. We reviewed the care of these medical patients and we saw there was not an adverse effect on the quality of care for the medical outcomes of patients. Staff told us and records confirmed there was a designated consultant and their team for each outlier patient who visited each patient everyday by midday as part of their daily ward rounds. However, patients reported they felt they were “forgotten about.” This could be, in part, to do with medical rounds happening on the surgical wards which the medical outliers were not a part of. They would be waiting for the specialist consultant to visit them separately.

During our comprehensive inspection in 2013 the trust was told they must ensure that at all times patients are cared for in a safe environment that is designed to meet their needs. It needs to consider the use and management of escalation beds and the use of mixed sex accommodation. We felt placing people in window bay ‘escalation’ beds put them at risk of being treated in an environment that was not suitable, as these areas were not designed or equipped to be used for this purpose. People’s privacy, dignity and safety were compromised by the lack of facilities available to them. On this inspection, we found this practice was still in use. We saw ‘escalation’ beds in use on several on Chestnut, Linden and the Acute Medical Unit. The beds on Chestnut ward in particular are not fit for purpose and had no lighting, piped oxygen and are using doorbells to attract the nurse’s attention if needed. Staff told us these were used most weeks for medically fit patients only and that permission needed to be gained from the Medical Director.

There was no formal out of hours discharge policy that staff were aware of. However, we were told by staff on the Acute Medical Unit and several wards that staff would not discharge a patient after 9pm. If patients were not self-caring they would try to time discharge for when carers would be there to support. Within the hospital staff reported some late transfers from the Acute Medical Unit. The Matrons on wards went to the Acute Medical Unit in the morning to identify patients early so that this could be prevented. We also heard from staff in the discharge lounge that the senior staff member would visit wards in the morning to identify patients who were ready for the discharge lounge.
Between September 2016 and August 2017, the trust’s referral to treatment time for admitted pathways for Medicine for September 2016, showed 97% of this group of patients were treated within 18 weeks versus the England average of 90%. In the latest period, August 2017, the trust showed 87% of this group of patients were treated within 18 weeks versus the England average of 90%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for admitted referral to treatment time (percentage within 18 weeks).

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One specialty was below the England average for admitted referral to treatment time (percentage within 18 weeks).

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(Source: NHS England)

There were 25383 patients discharged from medical wards from 01/07/2016 to 30/06/2017, of these 473 were recorded as delayed discharges.

The trust had introduced Discharge to Access service for patients who were medically fit but still required additional support at home. Each patient was given a home assessment within two hours of their discharge. This included a personal care plan for their therapy, goals, carer provision and any equipment they required. The Discharge to Access was reported to have helped to ease the demand on hospital beds and staff and made better use of community services. We were told by staff that there could be delays in accessing the service, and we were also given an example where hospital transport delays had meant patients had missed the cut off point for discharge, to allow Discharge to Access to do a home visit. This was because all patients needed to be at home before 2pm.

There were three bed meetings every day to assist in the effective operational management of the hospital. We attended one meeting. We saw all the relevant stakeholders attended and we considered them well run and focused. Clinical navigators accompanied the post-take ward round to identify outliers and help with discharge delays.
We heard from the ward sister on the Acute Medical Unit that there were significant delays with referrals to Gastroenterology. We spoke with the senior sister on Oak ward (gastroenterology) who confirmed that there were currently only two senior registrars to deal with referrals. They also had commitments in endoscopy. This could have left the department short, particularly on nights or periods of annual leave.

A satellite dispensary had been set up in the Acute Medical Unit to reduce any waiting times for discharge medicines. There was no monitoring of this to ensure it was successful although staff reported it was.

Patient had access to an appointments telephone booking service and could also access appointments via the trust’s website. If patients did not attend appointments, the trust had access to the National Health Service Spine to track down patients who needed urgent contact. This enabled them to access updated contact and General Practitioner details.

The average waiting times for a follow up appointment within the medical care (including older people) from July 2016 to June 2017 was 26 weeks, the trust did not set a target for this. There was a small discharge lounge where a nurse and health care assistant were present at all times. They did not accept patients who were doubly incontinent. Regular hours were 8am to 8pm daily. On the night before our inspection a staff member had to stay until 9pm to wait for a patient to be collected. It was reported this was a regular occurrence.

Learning from complaints and concerns
The service treated concerns and complaints seriously, investigated them and learned lessons which were shared with all staff.

Between August 2016 and July 2017 there were 60 complaints about Medical Care (including Older People). The trust took an average of 46 working days to investigate and close complaints and seven complaints had not been closed. This was not in line with their complaints policy, which stated complaints should be responded to within 25 days.

There were between four and six complaints from each ward with a main theme of patients being unhappy with the level of care and treatment.

The trust had a central team of three staff to deal with complaints, with additional leadership from a senior nurse. There was also a Patient advice and liaison service officer who supported this work. The medical care directorate provided complaint responses with actions to the central team for logging and these were then reviewed by the Director of Nursing who was the executive lead for complaints. The Chief Executive Officer saw every complaint response and had overall sign off.

We saw and heard evidence to suggest good learning from complaints. We were given an example in endoscopy of a patient who reported being in pain during the procedure and claimed this was not recognised by the staff. The department reviewed the notes and saw there was no documentation to suggest this was the case. As a result they now document if patients report pain during the procedure or if they report being comfortable.

We saw information in all areas about how to complain and information leaflets on how to contact the Patient advice and liaison service office.

We saw evidence of complaint reports being reviewed at various committees for example the Quality & Safety Committee. Quality and Safety Committee sent reports to directorate meetings so that local teams could have sight of relevant learning as well as performance issues and any required actions.
Is the service well-led?

Leadership

The hospital had recently implemented a new model of care that brought the emergency care directorate and adult medicine into one directorate, this included all staff under one umbrella. There was a new lead nurse for governance and a Business Operations Manager in place since August 2017. This model also included streamlining the devolved leadership structure for medical workforce and charting the team under one management line. This new management structure was not fully embedded at the time of inspection.

Staff we spoke with were unclear of the new structure and showed limited knowledge of the impact it would have on the department.

There were several matrons across medical care; they managed wards sisters and managers who managed staff nurses and healthcare assistants. Matrons were in charge of several wards each and spent time between them during the day. Matrons reported directly to the Director of nursing who reported to the Medical Director and the Chief Executive Officer.

Staff across the directorate reported leadership up to matron level was clear and supportive. Staff knew their managers and felt free to contact them. They felt valued and that their opinions counted. All the ward managers and sisters we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their ward faced in delivering good care. However, this did not seem to pass between wards and there was little awareness of how other wards were doing from staff below matron level.

Staff we spoke with were aware of the whistleblowing policy and felt able to raise concerns with managers, sisters and the matron.

Staff had access to a mental health liaison team, 24 hours a day, seven days a week that covered the whole hospital. We saw examples where patients required an urgent referral and this was arranged via the mental health lead for medicine.

Vision and strategy

Apart from the senior staff there was not a clear vision and a set of values that staff recognised. We saw posters with the values displayed on wards, but staff could not repeat these to us and did not have a clear idea of any departmental plans for the future.

We were told the main focus of the directorate for the next 18 months was to review the specialty bed base and medical working model to ensure delivery of safe, high quality and effective inpatient care in adult medicine and improve the flow of the patient journey. We saw work had already started to make improvements and adjustments to the service, for example an increased numbers of junior doctors and the bleep 111 filtering. However, we did not see a timeline for completion of the new medical model and no clear outline of how this would be achieved.

The Dialysis unit on Redwood ward had a clear vision for the future, with a plan to introduce a seven day working pattern and was currently training new staff to achieve this.

Culture

Staff reported feeling valued and supported across the directorate. We spoke to several new starters as well as longer serving members of staff who said that it was a friendly and supportive working environment. We saw supportive interactions from staff throughout our inspection. Several staff from many different areas reported feeling proud to work for the organisation.
We saw a culture that included the needs and experience of people who use services. Handovers, record keeping and care and treatment plans included patients’ mental health and emotional wellbeing.

We were told that the culture encouraged openness and honesty at all levels within the organisation but we were given a few examples where this had not been the case. One example being when a lower band nurse had wanted to challenge a doctor’s practice and was apparently told it was not her place to question, as he was a doctor and she was “just” a nurse.

Leaders and staff demonstrated they understood the importance of staff being able to raise concerns without fear of retribution. We did witness open conversations in multidisciplinary team meetings and board rounds which included challenging care decisions. This was welcomed and we felt staff interactions were positive.

Appraisals were undertaken and staff development formed part of this process. Staff told us that development and training opportunities could be accessed, however there were barriers due to lack of staffing.

In the latest National Health Service England - National Health Service Staff Survey dated March 2017, staff reported ‘Communication between senior management and staff (%)’ was worse than the previous staff survey, with 38% of staff reporting communication was good compared to 41% last year.

The same survey revealed that Staff experiencing harassment, bullying or abuse from staff (%) was similar to the previous year with 25% of staff reporting they had experienced this behaviour.

**Governance**

The trust were told to improve on aspects of the medical care service they delivered during our previous inspection in 2013. These had not always been addressed and showed a lack of commitment by the leadership team to implement the recommendations. Examples included mix sex breaches, poor information governance and the use of inappropriate escalation beds.

Although there were effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services, these were not effectively reviewed to ensure safe practice. Several audits were undertaken on a weekly and monthly basis, but we saw these were not effective in reporting failings within departments, for example hand hygiene audits.

We saw examples where staff were not clear about their roles and staff did not always understand what they are accountable for, and to whom. For example we spoke to staff who were completing audits but were not sure what happened to them after completion, only that they had to be handed over to matrons. This could explain why we found audit results were inconsistent with what we found on inspection.

There was effective interaction with partners and other service providers which promoted coordinated and person-centred care.

**Management of risk, issues and performance**

During our comprehensive inspection in 2013 staffing was top of the risk register. During this inspection we saw staffing remained high on the risk register and the trust had a workforce strategy in place. A weekly meeting was held focusing on higher risk/vulnerable areas (mostly in medicine) with an improving picture. This remains a national challenge and the trust was working with other providers in Kent on European and international recruitment. The risk register was well established and monitored the risks in the department. Risks were scored between five and fifteen to determine the level of risk. Eleven risks were recorded on the risk register. A monthly report was fed up to the to the board outlining fill rates and more detailed reports went to the Workforce Committee which was a sub-committee of the board.
The trust had an antimicrobial stewardship group which included a representative from the medical directorate. They met every two months and reported to the Medicine Management Committee. They in turn reported to the Quality and Safety Committee. This was in line with National Institute for Health and Care Excellence, QS121 Statement 5: Individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber, team, organisation and commissioner level. Data on antimicrobial usage from 2013/14 up to and including Q1, Q2, Q3 and Q4 2016/17 had been submitted to Public Health England.

The trust had a Local Emergency Preparedness Resilience Policy dated July 2015, this was due for review in July 2019. It was a comprehensive document and included information on ‘Smart Triage’ cards and individual plans for critical incidents including mass casualty plan and an evacuation plan.

The trusts current Hospital Standardised Mortality Ratios is 96.2 and Summary Hospital-level Mortality Indicator (was 1.037 The Summary Hospital-level Mortality Indicator reports on mortality at trust level across the National Health Service in England using a standard and transparent methodology. These are both within the expected range. The trust had a number of alerts on Dr Foster data, Dr Foster exists to help healthcare organisations improve their performance through better use of data, we were told they were being monitored, addressed and reported monthly to the board quality and safety committee. The trust lead for mortality was the Medical Director who was responsible for this. The Medical Director also chaired the mortality review group which met before the trust’s patient safety committee and all mortality data was presented and challenged at this group, which included Clinical Commissioning Group representation. We requested meeting minutes for the morbidity and mortality meetings but were not provided with formal minutes to evidence attendance, regularity, and quality of the reviews and learning.

Unexpected deaths were raised by incident reporting and reported to the trust’s weekly incident declaration group where a decision was made whether to carry out a further investigation and proceed to manage any further actions through the patient safety committee. We saw all deaths were screened to determine whether they were potentially avoidable. Those raising concerns were reviewed and presented to the mortality review group which had the same membership as the patient safety committee, and included representation from the Clinical Commissioning Group. Following discussion and further investigation, some of these cases could go on to be declared as Serious Incidents for the trust and subject to a full investigation and declaration. Occasionally care with organisations outside the trust was questioned and this was then either handed to that organisation or jointly investigated. Complaints, Claims and Coroner’s hearings are monitored for any deaths that may later raise concerns.

There was a Service Transformation team, who helped implement a new care bundle on medical wards. This included the ‘red2green’ reporting and surveillance.

**Information management**

During our comprehensive inspection in 2013 we felt the trust should improve patients’ privacy and right to confidentiality should be respected at all times. Staff needed to be more careful in making sure that confidential information is not seen and heard by others. This had not improved during our recent visit. We observed a multidisciplinary board meeting which was held at the nurses’ station on Ebony ward. It was in the middle of the ward and visitors and patients, cleaners and porters were passing by throughout. This compromised the patients’ privacy and confidentiality as patients’ names and medical history, including mental health status were discussed.

During our inspection in 2013 we saw occasions when we saw that patients’ privacy was not always respected, with personal and confidential information on display. This had still not been addressed. During our recent inspection we saw several breaches of patient confidentiality during our recent inspection. This was not in line with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and
We witnessed several screens with patient identifiable information open in an area where members of the public could see. These included on Linden ward during a phlebotomy visit where two screens were left unlocked and unattended in public areas for more than five minutes. We also saw several screens open for view on the Acute Medical Unit, although two of these were behind the nurse's station, the open plan layout meant that patient information was clearly visible and left unattended. Another computer was left unlocked and unattended outside a patient bay, with patient details displayed. We also saw a handover sheet left on the reception desk on the Acute Medical Unit which could have been seen by patients and the public. This meant patients' personal and private details were compromised. Files could be accessed or changed while computers were logged in and unattended. Members of the public or other patients could see patient records which should remain personal and private.

Although there were clear and robust service performance measures in place we saw these were often not carried out in line with policy and that there was no check to see if practice was carried out as should be. For example we saw that maintenance of equipment was not well managed and staff did not seem to realise that they needed assurances that equipment was well maintained. Departments undertook routine weekly and monthly audits that were reported and monitored in monthly matrons meetings. These were then fed back to the Audit Leads Committee. The Audit Leads Committee had core members of staff from all directorates and included the senior governance manager and the medical director. The Audit Leads Committee fed into the Quality Safety Committee twice yearly, who fed directly to the trust board.

Staff had access though the trust's computer system to policy and practice guidelines. They could also access mandatory training information and training opportunities. Only certain staff had access to some meeting minutes and information on audits. This could mean staff were unable to challenge information as they were not able to access it.

**Engagement**

Staff were not actively engaged in the planning and delivery of services and in shaping the future development of the department.

A consultant was recently appointed as one of 20 national ‘diabetes clinical champions’. The role included meetings with stakeholders in developing a robust community Diabetes service; delivery of several education sessions and meet and greet sessions for local GPs to improve the competency, confidence and knowledge in managing patients with diabetes.

We saw positive and collaborative relationships with external partners to help with challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. For example consultants from a local National Health Service hospital coming to train staff members on Redwood ward.

Antimicrobial Pharmacists had a stall during a local Antibiotic Awareness Week. This took place in November 2017.

The trust had working relationships with local stakeholders such as the Local Authority Health Committee, Alzheimer’s and Dementia Society & Learning Disability Forum. Healthwatch representatives were also invited to, and sat on a number of patient focussed forums. The trust took part in the ‘Equality Delivery System 2 project’ and with local people and partners aimed to review and improve performance for people with characteristic protected by the Equality
Act 2010. However, we did not see any clear action plans in relation to this at the time of inspection.

Department newsletters included a section labelled ‘special mentions and thank you’ and ‘you're a star’. Staff were mentioned and thanked publicly in this section for their dedication and hard work. The trust also had an annual awards programme to recognise staff excellence and commitment. Examples of this included leadership, excellence, care and compassion awards.

**Learning, continuous improvement and innovation**

We saw all wards we visited had a ‘visborards’, by the nurse’s station. This board contained information about patients on the ward, such as name and where they were on the ward. Staff showed us a discrete symbol, which identified patients who had a HCAI. This meant all staff who were involved in the care or visited patients on the ward, were able to see this information. This was an improvement on our inspection in June 2016, where we found this practice was not consistent.

Departmental meetings were held monthly and all staff could attend. They covered incidents and any changes to practice/policy. Staff reported that if they were unable to attend that minutes were placed in staff rooms. We observed this on inspection. However, we didn’t see effective participation and learning from internal and external reviews was cascaded to all staff.

The trust launched a ‘Micro Guide’ in July 2016, this was available as an app and also via the Intranet for patients to learn about the hospital and treatments that it offered.

The trust had recently launched a nurse-led bleep filtering (111) to support junior doctors’ workload and streamline clinical resources to demand. It enabled triaging of bleeps and helped to ensure the most urgent patients got seen first.
Facts and data about this service

Surgical services at Dartford and Gravesham NHS trust provide emergency, elective and non-elective day stay and inpatient care across two sites. The specialities covered are general surgery, lower gastrointestinal (GI) cancer, benign and upper GI only, urology, orthopaedic and Ear, Nose and Throat (external provider).

There are dedicated surgical wards at the acute trust site. The trust has created a separate elective surgical unit at Queen Mary's Hospital to manage low risk patients for elective and some non-elective care where safe to do so.

(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)

The trust had 22,165 surgical admissions between July 2016 and June 2017. Emergency admissions accounted for 5,180 (23%), 12,036 (54%) were day case, and the remaining 4,949 (22%) were elective.

(Source: CQC Insight)

In their HR, training and appraisal data the trust coded all these wards to the core service that they currently belong to.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training figures had improved since our last inspection. However, they were still not meeting trust targets. The most recent mandatory training figures showed an overall compliance of 80% which was below the trust target. The lowest completion rates was in infection prevention level two which was 58%, which was below the trust target of 95%. This meant 42% of staff may not be aware of how to prevent or manage an infection and patients were at an increased risk of acquiring an infection in the hospital.

Completion rates for conflict resolution, equality and diversity, health and safety, adult basic life support and safeguarding children level two were equal to or better than the trust target of 85%. All of which had a completion rate of more than 85%.

The trust set a target of 85% for completion of mandatory training modules, apart from infection prevention level 2 where the target was 95%. Preventing radicalisation and emergency resilience training became a mandatory requirement from April 2017.

In their provider information request (PIR) the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and then by staff group.
Below is a breakdown of compliance for mandatory training modules between April 2016 and March 2017 for all staff in the surgery core service at the trust.

![Mandatory training completion rates graph]

The 85% training target was met for seven mandatory training modules. The target was not met for the remaining six modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust launched e learning in December 2016, and used the e-learning computer system.

In April 2017 all mandatory core skills monitoring and recording was centralised within each department. This enabled department or ward managers to have oversight of mandatory training compliance and address any issues. The trust had aligned incremental pay progression with completion of mandatory training from January 2017.

We spoke to 12 staff who told us that they could access mandatory training easily. The training was delivered face to face and via online modules. Staff told us they used the overlap time between the early and late shift to access the online modules. Staff reported this enabled them to complete their mandatory core skills at a time and place that was convenient with their work schedule.

We saw evidence in ward and department meeting minutes of discussions attendance at mandatory training and improved compliance. In addition, the requirement for mandatory training completion two weeks prior to their individual performance review was discussed.

**Safeguarding**

Staff we spoke to had good knowledge of the trust’s safeguarding policy and the contact information for the safeguarding leads within the trust and local safeguarding service. None had reported a safeguarding but could give examples of what and how they would report.

The contact details of the named safeguarding lead for adults and the named safeguarding lead for children were displayed on each ward and department we visited. However, not all staff had received the correct safeguarding training.
The trust held a safeguarding committee quarterly - adults and child safeguarding leads attended and submitted reports. The Director of Nursing and Quality attended the safeguarding boards and the adult and child safeguarding lead attended the sub groups.

The adult safeguarding lead attended the adult health leads meeting and both the adult and child safeguarding leads attended external safeguarding supervision.

Adult and child safeguarding leads had direct contact with the designated safeguarding leads in the local clinical commissioning groups and if required the Police and/or the Coroner.

The trust reported 92 adult safeguarding referrals in the twelve months prior to inspection. The data was not divided into speciality therefore; we did not know how many of the referrals related to surgery.

The trust reported 54 child-safeguarding referrals in the twelve months prior to inspection. The data was not divided into speciality therefore; we did not know how many of the referrals related to surgery.

**Safeguarding training completion rates**

Level one safeguarding adults training was mandatory for all staff. Level two was under development as an e-learning package, in line with draft intercollegiate document. Level three safeguarding adults training was currently being delivered to bands six, seven and eight professionally qualified staff.

The trust set a target of 85% for completion of safeguarding training. This was a lower target than many other trusts set themselves.

As noted above under mandatory training, in their provider information return the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and then by staff group.

We contacted the trust on 31 October 2017 and asked them to supply a breakdown by staff group for each core service.

The graph below is a breakdown of compliance for safeguarding training modules between April 2016 and March 2017 for all staff in the surgery core service at the trust.

**Trust wide**

![Safeguarding training completion rates (all staff)](image)
The trust reported that no staff in surgery were eligible for safeguarding children level three. However, young people under 18 years of age were treated on surgical wards and staff should have level three child safeguarding training in accordance with the intercollegiate guidance, Safeguarding children and young people: roles and competences for health care staff (2014). This meant not only were staff not trained to the correct level but also the trust had not identified this as an issue.

The 85% completion target was not met for safeguarding adults level one, but was met for safeguarding children levels one and two.

Darent Valley hospital

The 85% target was not met for any of the three safeguarding modules for which staff in surgery at Darent Valley hospital were eligible. This was already low target was not being met which meant the trust could not be assured that staff had sufficient safeguarding knowledge.

(Source: Trust Provider Information Request P18)

Cleanliness, infection control and hygiene

We undertook a focused inspection in June 2016, as there was a period of increased incidence of methicillin-resistant Staphylococcus aureus infection. We found staff did not consistently apply good infection prevention and control practice when working. For example, we found not all patients were screened for methicillin-resistant Staphylococcus aureus in line with national guidance, and staff did not always wear personal protective equipment correctly.

There were infection prevention and control policies and procedures readily available to staff on the trust’s intranet. These included, but were not limited to, hand hygiene policy, deep clean procedure, isolation policy, laundry guidelines, and mattress policy. In addition, there were policies relating to healthcare associated infections, such as methicillin-resistant Staphylococcus aureus, Clostridium difficile and norovirus. This was in line with the recommendations of The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance (the code) criterion 9; ‘Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections.’
We saw all wards we visited had a ‘visboard’, by the nurse’s station. This board contained information about patients on the ward, such as name and where they were on the ward. Staff showed us a discrete symbol, which identified patients who had a health care acquired infection. This meant all staff that were involved in the care or visited patients on the ward, were able to see this information and take the correct precautions. This was an improvement on our inspection in June 2016, where we found this practice was not consistent.

We checked 20 alcohol-based hand sanitising foam dispensers and found 19 were full and working. This meant staff and visitors had easy access to hand sanitising foam dispensers to clean their hands while in the hospital.

We saw inconsistent hand decontamination, which was not always carried out in line with the World Health Organisation five points of hand hygiene. There were posters displaying the World Health Organisation five points of hand hygiene throughout the area. This should have acted as a reminder to staff as to when to decontaminate their hands.

We saw staff were not compliant with infection prevention and control policies in the recovery unit. We saw multiple members of staff enter the recovery unit on different occasions accompanying patients and then left the department without washing their hands or using alcohol hand gel. This meant patients were at increased risk of infection.

During our inspection, we undertook a 20 minute hand hygiene audit of staff on Juniper ward cleaning their hands, during the 20 minutes; we saw there were nine times when hands should have been cleaned. We saw that on seven occasions staff cleaned their hand in line with trust policy. However, on two occasions staff did not clean their hands in line with policy.

Hand hygiene data provided to us by the trust was consistent with our findings during our inspection. Compliance varied between 63% (Maple ward August 2017) and 100% on several wards. The data showed 100% compliance with hand hygiene in the recovery unit, this was not consistent with our findings.

We observed a nurse disposing of dirty linen without wearing gloves or an apron. They did not clean their hands afterwards. This meant their uniform could have been contaminated by the dirty linen.

We informed the trust of our findings with regard to poor compliance with infection control and prevention policies. The trust told us that they would undertake a number of actions to address our concerns. These included but were not limited to; the theatre matron would identify staff members to undertake the role of infection control and prevention policies link practitioner. The infection control and prevention policies link practitioners would liaise with the infection control and prevention policies specialist nurse/ infection control and prevention policies sister in order to undertake hand hygiene competency assessments. Managers would ensure that 85% of clinical staff had completed infection control and prevention level two training. Posters would be developed to aid understanding regarding when/not to wear gloves and aprons. Each patient would be given their own supply of antibacterial hand wipes. The infection control and prevention policies team in conjunction with department managers would undertake training and education with staff regrading infection control and prevention policies and undertake regular audits to monitor compliance.

We observed all clinical staff within the multidisciplinary team were compliant with the ‘Bare below the Elbow’ policy.
The trusts *Meticillin Resistant Staphylococcus Aureus* policy version 9 (dated May 2016), stated all adult patients admitted to hospital (except maternity), should be washed in an antimicrobial body wash daily, during their stay.

On our previous specific inspection in June 2016, we found all bottles were individually labelled to ensure individual patient use only.

During our inspection, we spoke with staff who told us patients were given an individual bottle of the body wash. We checked ten patients on Juniper and Maple wards. We found four had a patient label attached; the remaining six bottles had patient’s names written in pen, which was wearing off with use. This meant the patients could not be sure they were using their own bottle and there was a risk of cross infection. Staff we spoke with were able to tell us how to use the antimicrobial body in line with policy. We informed the trust of this would told us they had taken action to address; an infection prevention and control action plan which included audits on the availability of body wash and an education programme for staff.

Patients admitted to the trust were swabbed on admission and then again at seven days for Meticillin-Resistant Staphylococcus Aureus. To test for Meticillin-Resistant Staphylococcus Aureus swabs were taken from nose and groin of all patients. If they had a wound, invasive device (such as an intravenous line) urinary catheter or had a productive cough, specimens were taken from these sites also.

All staff told us when patients should be swabbed for Meticillin-Resistant Staphylococcus Aureus and how often whilst in hospital; this was in line with the trust policy. We saw “Obs and Swabs” posters on notice boards, which reminded staff, which sites should be swabbed for Meticillin-Resistant Staphylococcus Aureus.

We saw surgery participated in monthly swabbing audits. Between April and September 2017, we saw results ranged between 72% and 100%, with an average of 98%. All wards submitted data and all scores except Cherry ward in September 2017, were 92% and above. Staff told us the infection control team rang through Meticillin-Resistant Staphylococcus Aureus results, which they would document in the notes and start the patient on the Meticillin-Resistant Staphylococcus Aureus pathway documentation. The pathway included their swabbing and treatment regime. During our inspection, we reviewed three Meticillin-Resistant Staphylococcus Aureus pathways and found them to be fully completed and up to date.

Staff told us a patient’s Meticillin-Resistant Staphylococcus Aureus result was discussed during handover, staff also showed us their hand over sheets, which confirmed this. This meant staff were aware of which patients needed treatment as per the Meticillin-Resistant Staphylococcus Aureus pathway.

Between April 2017 and October 2017 there were three Meticillin-Resistant Staphylococcus Aureus blood stream infections assigned to the trust, this meant they breached the NHS objective of no avoidable blood stream infections. We saw that one was in medicine and one in surgery, both were deemed avoidable. The third was a contaminated blood culture, this meant that the patient did not have a blood stream infection, but bacteria entered the blood culture, whilst it was being taken. The trust undertakes a post infection review of all Meticillin-Resistant Staphylococcus Aureus blood stream infections, to identify any themes or trends with outcomes and lessons learned shared with staff.

For example, we saw because of one Meticillin-Resistant Staphylococcus Aureus blood stream infection in surgery, a new nephrostomy pathway and guidelines had been implemented, in collaboration with the infection control team and urology specialist nurses. A nephrostomy is an
artificial opening created between the kidney and the skin which allows for the urinary diversion directly from the upper part of the urinary system.

A member of the infection prevention and control team reviewed all patients who were found to be Meticillin-Resistant Staphylococcus Aureus positive weekly during their stay. Staff told us they felt supported by the infection control team and valued their input in ensuring they were delivering good care.

We looked at the medical charts of two patients who were found to be Meticillin-Resistant Staphylococcus positive; we saw they had all had the correct medication to treat Meticillin-Resistant Staphylococcus Aureus. In addition, we saw there was a discrete box that could be ticked on drug chart to indicate if a person had Meticillin-Resistant Staphylococcus Aureus, this meant when medical staff were prescribing antimicrobial medicines for infection, they were able to consider the correct medication.

We saw an audit schedule for monitoring infections was in place across the hospital. For example, we saw peripheral intravenous lines, and urinary catheters, hand hygiene and compliance with Meticillin-Resistant Staphylococcus Aureus swabbing was undertaken monthly. Action plans were developed and implemented.

The trust had a ‘prevention of infections associated with peripheral venous catheters policy’ version 3 (dated June 2016), which included information on documentation, hand hygiene, skin cleaning and how often to review the device, in line with National Institute for Clinical Excellence QS61, statement five, vascular access devices.

We looked at eight sets of medical records for patients who had a peripheral intravenous line in place. A peripheral intravenous line is a tube that is inserted into a vein and used to administer fluids and medication.

We saw there were two types of documentation in use for the monitoring of peripheral lines. One required checks to be taken twice daily (day and night), for three days. The second required checks to be taken in 12-hourly intervals, up to 72 hours post insertion.

On the review of documentation that required twice-daily checks, we found multiple occasions where the checks had not been documented. We saw this was mainly checks to be undertaken at night. In addition, to missed night-time checks, we also saw there some days checks had not been documented. This meant the trust could not be confident that peripheral intravenous lines were being monitored in line with trust policy.

On review of the documentation with required checks to be taken at 12-hour intervals up to 72 hours post insertion, we saw there were some intervals when checks had not been documented. In addition, we saw checks that were recorded at 24-hourly intervals, resulting in the peripheral intravenous line being in place for longer than the trust policy of 72 hours.

For example, on Juniper ward we found a peripheral intravenous line inserted on 04 November 2017, there was no documented 12 hour check, 24 hour was undertaken on 05 November 2017 and 36 hour check on 6 November 2017. This meant staff were not aware if the insertion site was free from infection.

When informed about the trust two sets of documentation in use and inconsistencies with documented checks. The trust told us the Director of Infection Prevention and Control would re-issue communication to ward managers and procurement to ensure that the “old” colour Cannulation Insertion Charts were taken out of circulation. In addition, peripheral cannulas would be discussed at handover and during ward rounds and documentation completed.
We reviewed the care records of four patients who had a urinary catheter in place. A urinary catheter is a thin flexible tube used to drain urine from the bladder. We saw all patients had been commenced on a urinary catheter pathway. This pathway included information about catheter insertion, hand hygiene and maintenance in line with National Institute for Health and Care Excellence QS61, statement four, Urinary Catheters.

In addition, we saw the trust was introducing the HOUDINI nurse-led protocol. HOUDINI is an acronym where each letter represents a different reason why a urinary catheter should be inserted or removed. For example immobility or urology surgery. The HOUDINI nurse led protocol for urinary catheter insertion/removal is a useful tool in reducing the number of days of urinary catheter usage, thus reducing the associated risk of a catheter associated urinary tract infection.

We spoke with the lead for infection control and prevention, who told us this, was in the process of being rolled out across the trust. Urinary tract infections are the most common healthcare associated infection in acute hospitals. The risk of developing a catheter associated urinary tract infection increases the longer a urinary catheter remains in place.

Between April and September 2017, there were six cases of clostridium difficile the trust. This was below the reduction objective set by NHS Improvement, which required the trust to have no more than 24 cases of clostridium difficile between April 2017 and March 2018. Data supplied to us showed there were three cases in surgery on Rowan, Cherry, and Juniper Wards. Clostridium difficile is a type of bacteria, which can infect the bowel and cause diarrhoea.

The trust investigated each case to identify any specific themes. In addition, NHS Improvement requires, all Clostridium difficile infections were looked at to see if the case was associated with a ‘lapse of care’. A lapse of care indicates that policies and procedures were not followed.

During our inspection, we saw ‘stool specimen collection’ labels in patients notes, this showed when the stool sample was taken and why. Patients cared for in the side rooms due to diarrhoea had stool charts.

Data showed that between April 2017 and September 2017, there had been 30 Methicillin Sensitive Staphylococcus Aureus blood streams infections. However only five patients tested positive post 48 hours following admission and were attributable to the Trust. Twenty-five of the patients tested positive for Methicillin Sensitive Staphylococcus Aureus less than 48 hours following admission, this meant they did not contract Methicillin Sensitive Staphylococcus Aureus from the ward. There is currently no NHS improvement objective for Methicillin Sensitive Staphylococcus Aureus blood stream infections.

NHS Improvement requires all trusts to reduce gram-negative bacteria (such as Escherichia coli), by 50% by 2021. Data supplied to us showed that between April 2017 and September 2017, there had been 122 Escherichia coli blood stream infections. Twenty of the 122 patients tested positive post 48-hours following admission and were attributed to the trust. One hundred and two of the patients tested positive for Escherichia coli less than 48-hours following admission, this meant they did not contract Escherichia coli from the trust. All trusts have been ranked by Public Health England for post-48 hour cases of Escherichia coli for 2016 to 2017. This trust was ranked 73 out of 153 trusts.

We observed staff caring for patients requiring isolation. Signage was used to advise staff not to enter without protective clothing, and visitors to speak to a member of staff. However, not all rooms had the correct isolation signs in place. This meant staff would not take the correct precautions to protect themselves and patients and prevent the spread of infection.

Not all side rooms had en suite bathrooms in line with best practice. Not all patients in side rooms were in there for healthcare associated infections, some patients were looked after in side rooms...
due to a weak immune system, and this is called protective isolation. On Juniper ward the ward manager informed us one patient was in the side room for protective isolation, however when we asked other members of staff why the patient was in the side room they did not know and it was not included on their handover. This meant staff did not use the correct precautions and placed the patient at increased risk of developing an infection. We fed this back to the ward manager, who confirmed they would ensure this would be discussed at the next handover.

On our previous inspection in June 2016, we found sluice rooms were cluttered with items, such as mattresses. We required the trust to ensure sluice rooms were decluttered and there was consistent practice in place around the correct use of the room.

We looked at two dirty utilities in surgery; all were tidy and uncluttered, and had a separate dedicated hand hygiene sink with soap and paper hand towels available, a hopper for disposal of body fluids and a separate deep sink for cleaning equipment.

Patients told us they felt the hospital was clean, and that the cleaners came to the ward regularly. They told us that staff changed the bed linen daily.

The hospital had a designated Director of Infection Prevention and Control, in line with the recommendations of the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of Healthcare associated infections and related guidance.

The hospital had a designated infection prevention and control team, in line with the recommendation of criterion one of the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of Healthcare associated infections and related guidance. The team included the designated lead for infection control, qualified infection control nurses, and a consultant microbiologist with infection control responsibilities. The team worked across the trust, and coordinated with other healthcare professionals, patients, and visitors. The infection control and prevention team responsibilities included but were not limited to, giving advice, providing education and training (both formal and informal), monitoring infection rates, and auditing of the infection control and prevention practices.

The ‘Infection Prevention and Control Annual Report’ for April 2016 to March 2017, detailed activities to ensure the hospital met the requirements of the code. The report was mapped to the compliance of criteria set out within the code of practices and included systems to manage and monitor the prevention and control of infection, maintain a clean environment, ensure correct use of antimicrobials and ensure all staff were fully involved in the process of preventing and controlling infection.

Below is a table showing the cleaning audits for the previous 12 months prior to inspection.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of audits required in period</th>
<th>Actual audits undertaken</th>
<th>% compliance</th>
<th>Number of audits that achieved the required standard</th>
<th>Number of audits that did not achieve the required standard</th>
<th>% compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acer Unit</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>10</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Cherry</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>10</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Juniper</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>7</td>
<td>3</td>
<td>70%</td>
</tr>
<tr>
<td>Maple</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>5</td>
<td>5</td>
<td>50%</td>
</tr>
<tr>
<td>Redwood</td>
<td>10</td>
<td>9</td>
<td>90%</td>
<td>9</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Rowan</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>6</td>
<td>4</td>
<td>60%</td>
</tr>
</tbody>
</table>
Staff and visitors to the day surgery unit who had not changed into specific theatre attire were required to put plastic overshoes over their outdoor shoes before entering the theatre department. On two occasions, we saw staff remove their plastic overshoes without cleaning their hands afterwards. This meant germs on their shoes could then be transferred to other surfaces or people. We reported this to the trust who have now installed a hand foam sanitiser station in this area.

We observed a trolley being taken into theatre with the drawers labelled with dirty and curling sticky tape. In addition, in main theatres, we saw sticky tape was used to secure notices onto equipment. This meant germs could get stuck to the tape and poses an infection risk. We reported this to the trust who told us the sticky tape had been removed.

In the recovery area of theatres, next to the dedicated hand sink was a bin with a swing lid and not a foot pedal to open the bin. This meant staff were required to use their hands to open the bin to dispose of the paper towel they had used to dry their hands. There was a risk their hands could become contaminated with germs from the bin. We informed the trust who told us this bin had now been removed.

We saw staff in day surgery answering the phone in the staff area with the same gloves on that they had worn in theatre, which could contaminate the phone with germs.

The day surgery unit had a large amount of clutter in the corridor and staff base area; this could prevent effective cleaning. We raised this with the trust who told us they would undertake a review of storage within the day surgery unit. The carpet in the storeroom was visibly dirty, and sticky tape had been used to repair tears in the carpet. This meant this area could not be cleaned properly.

In theatres, we saw a single use item (syringe) was being used to deflate laryngeal airway cuffs multiple times against manufactures guidance. A laryngeal airway cuff is a device for maintaining a patent airway. We informed the trust who told us this practice had ceased and posters had been displayed reminding staff of the correct use of single use items.

The ward flooring was seamless and smooth, slip-resistant, easily cleaned.

The clinical treatment rooms contained posters on Aseptic Non Touch Technique and testing for Clostridium difficile, which acted as a reminder for the staff undertaking these procedures.

The hand washbasins in the ward areas were compliant with health building note HBN 00-09 - Infection control in the built environment. There were no plugs and no overflow. They had lever operated mixer taps.

We saw waste was not stored in the correct containers within the waste storage area of the Acer Unit; domestic and clinical waste was on the floor and not within the storage containers. This was not in line with The HTM 07-01 (The Safe Management of Healthcare Waste Memorandum). In addition, one bin containing sharps was not closed properly this could cause accidental injury and was against Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

We raised the issues regarding incorrect storage of clinical waste with the trust. The trust told us that additional storage containers would be ordered.

None of the yellow sharps bins we saw on the wards were temporarily closed when not in use. In addition, we saw yellow sharps bin, which was over flowing with contaminated waste. The ward sister rectified this when they were made aware. These findings were contrary to the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations).
However, in theatres four out of five yellow sharps bins had been correctly assembled and labelled. This was in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Each ward had a secure area to keep their yellow rubbish bags; tiger waste bags, sharps bins and soiled linen. The room had two doors; one for entry, which opened out on the ward, and one for exit, which could be accessed by the disposal team from the corridor. The room was locked from both sides.

On Juniper ward, there were areas where we found light dust, in particular on the television support arms, electrical conduit and windowsills, which would be consistent with the weekly high dusting regime. The October 2017 cleaning audit score was 96% and this was consistent with what we found on the day.

On Acer Unit, we saw completed records of daily, weekly and monthly cleaning. The audit scores for September and October 2017 on Maple ward were 100%, which was consistent with what we found on the day of inspection.

All chairs had a cleanable fabric cushion and the cushions could be removed to be cleaned both sides.

Each ward had a poster displaying the schedule for changing disposable privacy curtains. They had been changed 26 October 2017 and were due to be changed again on 26 April 2018.

Each ward had detergent cleaning wipes, antibacterial cleaning wipes and alcohol wipes available. We observed the staff using them to decontaminate equipment and to keep the patient bed area clean. The commodes were labelled and dated as clean. The commodes were visibly clean to the eye.

We saw posters on every ward showing the National Colour Coding System for hospital cleaning equipment and materials. National Colour Coding Scheme for cleaning materials ensures that these items are not used in multiple areas, therefore reducing the risk of cross-infection.

Each ward had a housekeeper on the ward between 7.30am and 3.30pm and had access to a housekeeper via a central telephone number outside these times.

The cleaning chemicals were stored in a cupboard on the ward. All wards we visited had this cupboard unlocked. This meant that there was open access to the chemical stored within and was not in line with the Guidance on the Control of Substances Hazardous to Health Regulations 2002.

The nurse in charge told us they signed to agree the cleaners work was completed and reported any issues to the contractor. This meant the nurse in charge had oversight of the standard of cleaning in the ward environment.

Environment and equipment

The Electrical and Biomedical Engineering department kept a register of all equipment with servicing and electrical testing dates. However, we found not all equipment was labelled with the date of the last electrical safety test. This meant staff could not be sure if the equipment was safe to use.

For example, an electrocardiograph machine on one of the wards had no indication of when the service date was due and when questioned by the inspection team the nurse said it would be safe to use once she saw it was working when she switched it on. A health care assistant overheard this conversation and immediately told the nurse to take the machine out of service. The health care assistant removed the machine and advised the nurse to try another ward. The ward sister
was informed of this incident and said they would attend to them immediately via the electronics and electrical engineering department.

Staff in theatres were able to demonstrate up to date records of servicing and testing of electrical equipment. We asked for details of two items which did not have stickers confirming when tests last undertaken and they produced records to show when they were undertaken. However, staff using the equipment did not know when the last tests were undertaken.

A full time technician supported the daily running of specialist equipment within theatres. Reusable theatre equipment was cleaned and sterilised on site.

We saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) was not adhered to. This guideline stated that records must be kept of each safety check of all anaesthetic machines in a logbook, which is kept with the machine. This meant there was no assurance that vital safety checks had been undertaken and the equipment was safe to use.

In theatres, there was an effective system to ensure the recording of medical implants used. This was in accordance with the Medical Devices Regulations 2002. A medical implant is a device intended to be either totally introduced into the body or to be partially introduced into the body through surgery and to remain there for at least 30 days.

Theatres had a difficult intubation (placing a breathing tube in the windpipe) trolley, which did not meet the Association of Anaesthetists of Great Britain and Ireland and Difficult Airway Society standard. This was because it was in a normal storage trolley and not in line with Association of Anaesthetists of Great Britain and Ireland guidelines. The difficult intubation trolley had no record of being checked on a regular basis. Staff told us there was an expectation stock would be replaced when used. This meant equipment might not be available if needed in an emergency.

Theatres were fitted with an uninterrupted power supply, which meant lifesaving equipment would continue to operate in the event of a power cut.

In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients’ operations. This ensured no items were left behind during surgery and was in line with the Association for Perioperative Practice guidelines.

In theatres, we saw that daily checks of emergency equipment were inconsistent with missing checks. This meant equipment may not be available and safe to use. We informed the trust of this who told us the checks and anaesthetic machine safety checks had been added to the agency staff induction record to ensure all agency staff undertook the checks.

The ward areas were generally tidy around the patient area and there was adequate storage. We observed untidy areas around the nurses’ base area in Cherry Ward and Juniper Ward. Surfaces were covered in paperwork making them difficult to clean. We observed shared storage areas in some wards that were untidy; this made it hard to find the equipment needed.

All patients had access to male or female toilets and washing facilities, which were accessed from their bay without having to pass by or through a bay occupied by patients of the opposite sex.

Each ward had a resuscitation trolley. The trolley had a partial check every day and a complete check once a week. We saw records that showed this was clearly documented and audited on a three monthly basis by the resuscitation service. Sealed drug boxes were in situ and we saw the sealed drug boxes were in date.

The day surgery ward had patient trolleys obstructing emergency equipment; this could delay access to them in the event of an emergency. We informed the trust of this who told us bays for
storage of trolleys would be marked on the floor for the safe storage of trolleys allowing access to emergency equipment.

Clinical rooms on the wards contained a medicine fridge, which displayed the temperature. The staff monitored the temperature of the fridge once a day and this was recorded in a folder, which also contained actions to take if the temperature was not within normal limits. It is important for some medicines to be kept at a particular temperature to maintain stability. We viewed the records and they were complete.

In four out of five wards that we visited the kitchen, doors were wedged open. These were labelled as fire doors. This was contrary to the Regulatory Reform (Fire Safety) Order 2005.

All fire extinguishers we examined had an annual maintenance record. All wards had visible fire action signs and exit signs in the event of an emergency. Fire exits were free from obstruction.

The day surgery unit only had one fire exit sign for the whole department. This meant in the event of a fire staff and visitors may not know the nearest exit out of the department.

Acer Unit had a fire door (FR60) which did not close properly which meant in the event of a fire the intumescent strips would be ineffective. Intumescent strips provide fire (and sometimes cold smoke) protection to the edges of fire doors, also known as fire resisting door sets. They are used to stop the passage of fire and smoke through a doorway between fire compartments in a building. We informed the trust of this who told us that the strips had been repaired and a new door had been ordered.

Juniper ward had two storerooms, 3E.357a and 3E.357, that had signs on stating these doors were fire doors and must be kept locked shut. On the day of the inspection they were both unlocked. This was a breach of trusts own fire safety procedures as the rooms clearly stated they should be locked shut.

We informed the trust of our findings regarding fire safety who told us that the trust fire safety officer would undertake a review of the areas and undertake any required action.

Within room number 3E.283 there were two cardboard boxes containing pulp products, for example disposable vomit bowls, stored on the floor. These products could become wet when the floor was cleaned. This potentially could contaminate the contents of the boxes.

Assessing and responding to patient risk

Although the trust policies provided guidance which was supported by a range of risk assessment tools for the staff to use to assess patient risk we found they were inconsistently used. This meant that patients risks were not identified and actions taken to mitigate the risks.

We looked at five sets of notes and records on the surgical wards and did not see consistent use of risk assessment tools across the surgical wards. The incomplete risk assessments included venous thromboembolism, Malnutrition Universal Screening Tool, pressure damage risk assessments and skin risk assessments.

Venous thromboembolism, is a condition where a blood clot forms in a vein, most commonly in a leg vein but a blood clot can travel to the lungs. Venous thromboembolism, risk assessments are undertaken to assess the risk of patients developing a venous thromboembolism, we reviewed five patients records, and four of these did not contain a fully completed venous thromboembolism, assessment. This meant the risk of patients developing a venous thromboembolism, was not correctly assessed placing them at an increased risk of a venous thromboembolism.
Data provided to us by the trust showed variable compliance with venous thromboembolism, assessment across the surgical wards between September 2016 and April 2017. Cherry ward achieved 86%, Juniper ward 68% and Rowan ward 67%. This was consistent with our findings that all patients were receiving a venous thromboembolism, assessment.

Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. We reviewed five patients records, three out of the five did not contain a completed Malnutrition Universal Screening Tool assessment. This meant patients that were malnourished or at risk of malnutrition would not be identified and treatment initiated.

The trust used the Braden Scale Assessment tool to assess patients who are at risk, as well as determining the degree of risk of developing a pressure ulcer/pressure damage. Braden Scale Assessment is made up of six elements of risk that contribute to pressure damage. The primary aim of this tool is to identify patients/clients who are at risk, as well as determining the degree of risk of developing a pressure ulcer. These are: sensory perception, moisture, activity, mobility, friction, and shear. Each item is scored between one and four, with each score accompanied by a descriptor. The lower the score, the greater the risk. We reviewed five patient records, of these two had a completed Braden Scale Assessment. This meant patients risk of developing pressure damage or a pressure ulcer were not identified.

Patients who had been identified as high risk of developing pressure ulcers after a Braden Scale Assessment needed a follow up skin assessment. We reviewed five patient records that required a skin assessment and three had a completed assessment. This meant preventative interventions were not undertaken to minimise the risk of developing a pressure ulcer. In addition, this was not in line with National Institute for Health and Care Excellence Quality standard [QS89] skin assessment.

The trust identified reducing the number of avoidable hospital acquired grade two pressure ulcers as a priority in their 2016/17 quality account. Despite the overall downward trend in hospital acquired avoidable grade two pressure ulcers over the last two years, and the number of grade two avoidable pressure ulcers decreasing in quarters one and two, there was an increase in the second half of the year. This priority was not achieved for 2016/17 and continued to be a concern for the trust. The trust created a pressure ulcer task force to take this improvement work forward.

We observed medical air mattresses in use for patients with reduced mobility and who were at risk of developing pressure ulcers.

The trust did not have a sepsis policy as per National Institute for Clinical Excellence NG51 Sepsis: recognition, diagnosis and early management. This meant patients in the early stages of sepsis might not receive immediate medical treatment.

Surgery services were effectively using a system to monitor acutely ill patients. The trust was using the National Early Warning Score system for the monitoring of vital signs in adult patients on wards to highlight early signs of deterioration of a patient’s conditions. The National Early Warning Score prompted staff to take further action, such as increasing the frequency of monitoring vital signs and informing medical staff so they could review patients and escalate treatment if required. We checked five patient records and saw all of the early warning score charts completed and used correctly.

Data provided to us by the trust showed in a vital signs audit undertaken in July 2017 good compliance in the 15 different elements audited, for example temperature, pulse and blood pressure monitoring. Compliance ranged between 96% and 98% across Cherry, Juniper and Rowan wards. In addition, another vital signs audit undertaken in October 2017 showed 100% of
patients across Cherry, Juniper and Rowan wards had the vital signs checked between 5am and 9am. This showed patients had their vital signs monitored regularly in order to highlight any change in their condition.

All patients undergoing planned surgery had a comprehensive health assessment in the pre-assessment department. We saw the completed assessment within the notes we reviewed. This meant patients’ needs were assessed in advance in order to ensure they could be met.

The American Society of Anaesthesiology classification grading of patients were clearly recorded on admission in the pre-assessment unit. The American Society of Anaesthesiology grading is a system for assessing the fitness of patients before surgery.

The trust had a falls prevention strategy. A leaflet was available for patients and relatives advising on how to reduce the risk of falls in hospital. We observed patients wearing non-slip socks to reduce the risk of falling when standing or walking which was in line with the trust strategy. We saw in patients’ records that patients had a weekly falls risk assessment this was in line with National Institute for Health and Care Excellence guideline CG161 Falls in older people: assessing risk and prevention.

The National Confidential Enquiry into Patient Outcome and Death was a National Confidential Enquiry into Perioperative Deaths undertaken in 1988. The National Confidential Enquiry into Patient Outcome and Death sets out categories of intervention of operations and when operations should be undertaken. The categories are immediate, urgent, expedited and elective. Staff in theatres told us that operations were not always undertaken in accordance with The National Confidential Enquiry into Patient Outcome and Death category guidance. Staff told us it depended on who the surgeon and anaesthetist was on call whether an operation was undertaken out of hours. This meant that the trust could not be assured patients were prioritised accordingly for operations or that operations were undertaken at the correct time.

Staff followed the National Patient Safety Agency five steps to safer surgery as part of the World Health Organisation surgical safety checklist in all operations we observed and in all records relating to patients’ surgery, we reviewed. The purpose of the checklist was to check all safety elements of a patient’s operation before proceeding. This included, for example, checking it was the correct patient, the correct operating site, and that all the staff were clear in their roles and responsibilities. We observed good engagement by all staff in the use of the checklists in theatres with no distractions.

Staff met for a team briefing at the start of each operating list in accordance with the World Health Organisation surgical safety checklist. We observed team briefings, which were comprehensive and discussed each patient to minimise any potential risk to patients. Pre-existing medical conditions and allergies were discussed to ensure the team was informed. Equipment requirements were also discussed and we witnessed surgeons checking the equipment was available. The briefings demonstrated that risks were discussed and any potential issues were highlighted.

Data provided to us by the trust showed variable compliance with the World Health Organisation surgical safety checklist. Between 04 January 2017 and 21 September 2017, compliance ranged between 64% (July 2017) and 100% (September 2017). The most common reason for non-compliance was incomplete team briefing.

Staff told us that since the most recent never event there had been a drive to improve compliance with the World Health Organisation surgical safety checklist.
We saw compliance with the WHO surgical safety checklist compliance was discussed at theatre staff meetings.

National Safety Standards for Invasive Procedures were not embedded in the theatres. National Safety Standards for Invasive Procedures provide a framework for the production of Local Safety Standards for Invasive Procedures. The theatre matron told us that one of the band seven’s in theatre was due to work on this.

Arrangements for handover and shift changes ensured people were kept safe. There were handover meetings, ward rounds and safety briefings involving the nurses each day. Handover procedures included information about all patients and highlighted any areas of concerns such as patients at risk of falls or patients living with dementia. We did not have the opportunity to observe any handovers during our inspection but saw this information was included on handover sheets.

Staff told us they checked the pregnancy status of female patients of potential childbearing age on the day of planned surgery by undertaking a pregnancy test. We saw the results of the test were documented on pre-operation checklist.

**Nurse staffing**

Surgical wards we visited were staffed to their agreed establishment during the inspection. Each ward had a white board, which identified the planned and actual numbers of trained and untrained nurses on each shift. The board was updated by the night shift for the day ahead. Staff told us that if the shifts were unfilled due to sickness or leave the wards tried to fill these with internal ward staff as the preferred option. If this was not possible, shifts were filled from hospital bank staff and then lastly agency nurses.

Trained bank or agency nurses were given a Clinical Bank / Agency Induction Booklet when working for the first time on each ward. It identified a checklist of their clinical skills, an induction checklist and important information such as adult / child safeguarding, cardiac arrest, documentation, fire alarms and incident reporting. This form was signed by the bank staff member and then countersigned by the nurse in charge of the shift. We did not see any bank or agency staff on duty so were unable to verify if this process was followed.

The orthopaedic service employed two frailty nurses and a care of the elderly nurse. This was in line with national standards outlined by the British Geriatric Society document Peri-operative Care for Older Patients Undergoing Surgery.

We saw staffing levels met the Association for Perioperative Practice guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list.

Theatres do not use any surgical agency staff but do use anaesthetic agency staff. We saw evidence of the relevant pre-employment checks were undertaken and reviewed by the theatre matron. Agency staff were doubled up for a period but did not have a specific structured induction. This meant agency staff might not be familiar with the processes and policies within the department. For example, the requirement to undertake daily safety checks of equipment we found this was inconsistent during our inspection.

There was a trust induction programme for new staff. All staff were expected to complete an induction programme and new staff were inducted on to the ward or department to ensure they had a good knowledge of the important aspects of working there, such as where to find the resuscitation trolley.
Darent Valley hospital reported its qualified nursing staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acer Unit</td>
<td>23.5</td>
<td>18.0</td>
</tr>
<tr>
<td>Admission Lounge</td>
<td>4.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Bridging Team Orthopaedics</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Cherry Ward</td>
<td>18.0</td>
<td>14.0</td>
</tr>
<tr>
<td>Day Care Unit Theatre</td>
<td>14.9</td>
<td>13.8</td>
</tr>
<tr>
<td>Juniper Ward</td>
<td>23.0</td>
<td>19.6</td>
</tr>
<tr>
<td>Main Operating Theatres</td>
<td>44.0</td>
<td>38.3</td>
</tr>
<tr>
<td>Maple Ward</td>
<td>21.0</td>
<td>18.5</td>
</tr>
<tr>
<td>Orthopaedic Directorate Management</td>
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</tr>
<tr>
<td>Plaster Room</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Poplar - Urology/Nephrology Out Patients</td>
<td>5.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Redwood</td>
<td>15.2</td>
<td>13.0</td>
</tr>
<tr>
<td>Rowan Ward</td>
<td>20.6</td>
<td>17.0</td>
</tr>
<tr>
<td>Surgery/Gynaecology - Bridging Team</td>
<td>3.2</td>
<td>0.8</td>
</tr>
<tr>
<td>Surgical Appliances</td>
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<td>1.0</td>
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<td>Surgical Directorate Admin</td>
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<td>1.0</td>
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<tr>
<td>Surgical Pre-Assessment Clinic</td>
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<td>6.3</td>
</tr>
<tr>
<td>Surgical Specialist Nurses</td>
<td>5.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Urology Specialist Nursing</td>
<td>3.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Urology/Nephrology Renal Unit</td>
<td>6.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Total</td>
<td>221.8</td>
<td>186.0</td>
</tr>
</tbody>
</table>

There were 13 wards/units at Darent Valley hospital, which were below establishment:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff</th>
<th>Number in post as of July 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Operating Theatres</td>
<td>44.0</td>
<td>38.3</td>
<td>5.7</td>
</tr>
<tr>
<td>Acer Unit</td>
<td>23.5</td>
<td>18.0</td>
<td>5.5</td>
</tr>
<tr>
<td>Cherry Ward</td>
<td>18.0</td>
<td>14.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Rowan Ward</td>
<td>20.6</td>
<td>17.0</td>
<td>3.6</td>
</tr>
<tr>
<td>Juniper Ward</td>
<td>23.0</td>
<td>19.6</td>
<td>3.4</td>
</tr>
<tr>
<td>Urology/Nephrology Renal Unit</td>
<td>6.0</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Maple Ward</td>
<td>21.0</td>
<td>18.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Surgery/Gynaecology - Bridging Team</td>
<td>3.2</td>
<td>0.8</td>
<td>2.4</td>
</tr>
<tr>
<td>Redwood</td>
<td>15.2</td>
<td>13.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Surgical Pre-Assessment Clinic</td>
<td>7.6</td>
<td>6.3</td>
<td>1.4</td>
</tr>
<tr>
<td>Urology Specialist Nursing</td>
<td>3.6</td>
<td>2.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Day Care Unit Theatre</td>
<td>14.9</td>
<td>13.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Admission Lounge</td>
<td>4.9</td>
<td>4.8</td>
<td>0.1</td>
</tr>
</tbody>
</table>
Vacancy rates
Between July 2016 and June 2017, the trust reported a vacancy rate of 12.3% for qualified nursing staff in Surgery. This did not meet the trust target of having a vacancy rate of 9% or lower. Darent Valley hospital had a vacancy rate of 13.7%

(Source: Routine Provider Information Request P17 Vacancies)

Turnover rates
Between July 2016 and June 2017, the trust reported a turnover rate of 8.5% for qualified nursing staff in Surgery. This did not meet the trust target of having a turnover rate of 9% or lower. Darent Valley hospital had a staff turnover rate of 7.2%

(Source: Routine Provider Information Request P18 Turnover)

Sickness rates
Between June 2016 and May 2017, the trust reported a sickness rate of 3.8% for qualified nursing staff in Surgery. This did not meet the trust target of having a sickness rate of 3.5% or lower. Darent Valley hospital had a sickness rate of 2.9%

(Source: Routine Provider Information Request P19 Sickness)

Bank and agency staff usage
Between August 2016 and July 2017, the trust reported bank usage of 2,665 shifts and agency usage of 3,501 shifts for qualified nurses in Surgery. Over the same period, there were 623 shifts that were not filled by bank or agency staff to cover sickness, absence or vacancies. The data supplied by the trust do not allow us to calculate usage rates.

- Darent Valley hospital:
  - Bank: 1,825 shifts
  - Agency: 2,010 shifts
  - Not filled: 590 shifts

(Source: Routine Provider Information Request P20 Nursing – Bank and Agency)

Medical staffing

Medical staff we spoke with said there was adequate consultant presence at the weekends within surgical services. Speciality consultants were on call throughout the weekend period as well as specialist registrars. Consultants on call led the ward rounds at weekends.

The junior doctors we spoke with felt well supported by the consultants. They said the consultants were approachable and could be contacted at any time when they needed support. Junior doctors were able to give us examples of when the consultant had come into the hospital to provide support.

Trainees said they felt well supported with good pastoral care and structured training. Junior staff also said they were given adequate time to attend teaching and to prepare for exams

Darent Valley hospital

Due to medical staff vacancies, there has been a higher use of middle career doctors. The higher use of middle career doctors and fewer consultants presents a risk that decisions about patient care were not being made at the right level. Less experienced doctors were making treatment decisions.
Darent Valley hospital reported its medical staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>28.7</td>
<td>35.5</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>22.9</td>
<td>22.9</td>
</tr>
<tr>
<td>Renal medicine</td>
<td>4.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Urology</td>
<td>14.6</td>
<td>14.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70.4</strong></td>
<td><strong>76.1</strong></td>
</tr>
</tbody>
</table>

**Vacancy rates**

Between July 2016 and June 2017, the trust reported a vacancy rate of 10.5% for medical staff in Surgery. This did not meet the trust target of having a vacancy rate of 9% or lower.

- Darent Valley hospital: a surplus of 9.2% above establishment

(Source: Routine Provider Information Request P17 Vacancies)

**Turnover rates**

Between July 2016 and June 2017, the trust reported a turnover rate of 38.3% for medical staff in Surgery. This did not meet the trust target of having a turnover rate of 9% or lower.

- Darent Valley hospital: 40.7%

(Source: Routine Provider Information Request P18 Turnover)

**Sickness rates**

Between June 2016 and May 2017, the trust reported a sickness rate of 0.9% for medical staff in Surgery. This met the trust target of having a sickness rate of 3.5% or lower.

- Darent Valley hospital: 0.9%

(Source: Routine Provider Information Request P19 Sickness)

**Bank and locum staff usage**

Between August 2016 and July 2017, the trust reported locum usage of shifts and agency usage of shifts for medical staff in Surgery. Over the same period, there were shifts that were not filled by locum or agency staff to cover sickness, absence or vacancies. The data supplied by the trust does not enable a calculation of proportionate use of bank and locum.

(Source: Routine Provider Information Request P21 Medical Locums)

**Staffing skill mix**

In June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff was...
similar to the England average.

**Staffing skill mix for the whole time equivalent staff working at Dartford and Gravesham NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>10%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

**Records**

The majority of patient notes we saw were not filed in chronological order, overfilled and not kept in a secure location when not being used by staff. This meant there was a risk of medical information not being found quickly when needed to make treatment decisions or in an emergency. Data supplied to us by the trust showed an audit undertaken in October 2017, on Juniper ward showed 50% of records were written in chronological order. This was consistent with our findings.

We reviewed ten sets of patient records across three wards. The five notes reviewed on Redwood ward contained neatly filed documents in chronological order. All risk assessments, activities of daily living assessments and care plans were completed.

The notes on Cherry and Juniper wards were untidy and overfilled. Four out of five notes had a completed assessment of activities of daily living assessment. Only two out of five notes had a completed care plan. None of the five notes had a completed nursing evaluation sheet. Data supplied to us by the trust showed an audit undertaken in October 2017, on Juniper ward only 50% of records had completed care plans. This was consistent with our findings.

Medical entries were completed in black ink, dated and signed but did not have the doctors name printed next to the entry.

Data supplied to us by the trust showed an audit undertaken in October 2017, on Juniper ward only 50% of entries in patient records had doctor's name and designation legibly printed. This was consistent with our findings.

We reviewed two patient records in theatres. Both notes were complete, legible and were signed documenting the designation of the documenter along with the date and time of the entry.

On the wards, we saw patient notes kept on shelves within the nurses’ base. The nurses’ base was centrally located and people could access the notes. In the pre-assessment area, we observed a set of notes in an unlocked notes trolley, which was in an unattended area. This meant confidential patient information could be accessed without permission.
The trust was in the process of converting to electronic notes and all paperwork within the notes was barcoded to enable it to be scanned into an electronic patient record.

The handover sheets, were updated at the change of shift and contained the following information: patients diagnosis, MUST / Braden score, social circumstances, Meticillin-Resistant Staphylococcus screen, estimated date of discharge, diet and last had bowels open, plan of care.

We saw some computers were left unattended and not locked in line with the Data Protection Act. This meant there was a risk that confidential patient information could be seen by others.

**Medicines**

The trust had a medicine policy, which was in date and referenced national guidance for example General Medical Council (2013), Good practice in prescribing and managing medical devices, and Nurse & Midwifery Council (2006), Standards for proficiency for nurse and midwife prescribers.

In the Day Surgery Unit, we saw oxygen and carbon dioxide cylinders, which were a mixture of empty and full cylinders were stored together on a wire rack. Under the Health and Safety at Work Act 1974 and HTM02 guidelines, it is the responsibility of employers to train their employees on the recommended safeguards relating to the handling of medical gases to ensure they understand and employ safe practices. The HTM02 guidelines state that the storage area must be large enough to allow for segregation of full and empty cylinders and permit separation of different medical gases within the storage area.

The guidance also states that warning notices prohibiting smoking and naked lights must be posted at the cylinder store that is clearly visible to all. These were not present in Day Surgery Unit. We spoke to one of the managers regarding this and they were unaware that empty, full and different types of gas cylinder should be kept separately. This meant they did not understand or had not received training in safe practices relating to medical gas storage and handling. We raised these issues with the trust who told us that empty cylinders had been removed and storage identified away from full cylinders. We also saw from Day Surgery Unit meeting minutes on 20/09/2017, this issue had been highlighted before. This meant the action taken to address the issue was not effective and there was not a process to monitor reoccurrences.

In main theatres, we inspected four medical gas cylinders, which were all correctly labelled and stored. All cylinders were in date. In the ward areas, each bed had piped oxygen next to it. The patients receiving oxygen had it prescribed on the drug chart.

In the Day Surgery Unit, we found there was no Control of Substances Hazardous to Health assessment, or procedure for safe use for use of Mitomycin C. Mitomycin C is an anti-cancer medication; the medication poses a risk to staff and patients, if not handled safely. We reported this to the trust who had since undertaken a Control of Substances Hazardous to Health assessment. In addition, a practice review of Mitomycin C use in theatres was to be completed and reported back to Quality and Safety Committee.

We reviewed ten medicine charts and people’s allergies were recorded on all ten charts. Data supplied to us showed that all patients in August, September October 2017 medicine charts had any allergies documented across three surgical wards. Patients body weight was not always recorded on medicine charts; body weight is sometimes needed to ensure both safe and effective prescribing of medicines.

Between November 2016 and October 2017 there was 46 medication incidents reported across Juniper, Cherry and Rowan wards. The most common incidents reported were medicine not administered (4), omitted medicine (4) and dispensing error in pharmacy (4). There were four
medicine incidents reported in theatres and recovery within the same time period all were different incidents.

Staff told us that pharmacist and pharmacy technician availability on wards was good. A pharmacist visited the ward on a daily basis during the week and checked the patient medicine charts, medicine stock levels and ensured drugs for the patients to take home were available. We observed a medicine chart where the pharmacist had documented a prescription query for the medical team three days prior but had not had a response. This meant the medicine had not been reviewed by a doctor regarding the continued need or dosage of medicine.

Medicines reminder charts were given to people upon discharge to help them take their medicines correctly at home. For example, they contained information regarding possible side effects and how often they should take the medicines.

Staff told us antimicrobial pharmacists attended wards to review antibiotic prescribing regularly.

Each ward had a clinical treatment room that was locked using a code lock. The code was only known to staff who required access and was not displayed anywhere near the door. Within the clinical treatment room, there were three locked medicine trolleys, which were kept locked to the wall.

We observed medicine administration rounds were completed safely. The nurse observed patients taking the medication before leaving the patient. The medicine trolley was never left unattended when unlocked. This was in line with the Nursing and Midwifery standards for medicines management.

All controlled drugs were kept in a double locked cupboard within a room that had a code lock to access. The keys to the controlled drug cupboard were kept with a trained nurse at all times. We checked controlled drugs stock levels against the records and found them correct. Controlled drugs are medicines liable for misuse that required special management.

In theatres, we checked two different controlled drugs stock levels. These matched with the register and the register was complete, with daily checks.

Overall trust performance for medicines reconciliation over the past year ranged between 73% to 89% at 24 hours post admission. Medication reconciliation is the process of comparing a patient's prescribed medicines to all of the medicines that the patient has been taking. This reconciliation is done to avoid medicine errors such as omissions, duplications, dosing errors, or drug interactions.

National Institute for Health and Care Excellence guidance relating to Technology Appraisals was discussed at the Medicines Management Committee. Technology appraisals are National Institute for Health and Care Excellence recommendations on the use of new and existing medicines and treatments within the NHS.

**Incidents**
The trust had an electronic incident reporting system to allow staff to report incidents. Staff spoke to could identify what incidents to report and how to report them. However, some staff told us they did not always have time to report incidents. This meant there was a risk of reoccurrence with potential harm to patients. There was a risk that themes or trends were not identified and the trust was using inaccurate data to plan services.

Surgical services across all sited reported 1767 clinical incidents in the twelve months prior to our inspection. It was not possible for us to breakdown the incidents into hospital or specific ward or department in the format provided to us. Of these incidents 76% resulted in no harm, 19% resulted in low harm, 4.5% in moderate and the remaining 0.5% resulted in severe harm or death. The top three themes of incidents reported were; grade three pressure ulcers (7% of all incidents
reported), patient found on floor (5% of all incidents reported) and fall from bed (3% of all incidents reported).

There were named governance leads across the specialities. The lessons learned from the review of incidents were distributed via a safety newsletter and on trust computer screen savers. We saw copies of the safety newsletter in staff rooms across the surgical service.

There was a weekly safety huddle including ward managers and matrons, the Director Of Nursing, Deputy Director Of Nursing and invited colleagues. Incidents and learning from incidents were discussed at these huddles.

One ward we visited aimed to meet monthly to discuss any incidents that had occurred in the previous month but told us they had not had a meeting for three months, as the team were too busy.

Staff we spoke with could not give us examples of learning from incidents in the area, which suggests not all staff, were aware of incidents reported and the learning from them to prevent a reoccurrence.

Whilst on a ward the inspector heard a telephone call from radiology to the ward informing them a patient from the ward had arrived without a name band on and the planned examination could not take place without the patient having identification. It took the staff twenty minutes to create a name band for the patient and take it to radiology. This was not reported as an incident at the time of the incident. This suggested not all staff were aware of which incidents need reporting.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between September 2016 and August 2017, the trust reported three incidents classified as never events for surgery. All three incidents were surgical/Invasive procedure incident meeting SI criteria.

September 2016: A  Patient had a left total knee replacement in July 2016: The patient was readmitted for management of post-operative infection in October 2016, which resulted in the need to remove the prosthesis. During surgery, the femoral component was found to be a right knee prosthesis.

July 2017 surgery undertaken conflicted with the consent form signed by the patient, which resulted in the patient’ ovaries being removed following a hysterectomy.

August 2017: A patient attended for an elective total hip replacement and during surgery, the hip joints were not fully matched to the needs of the patient.

There was learning from both serious and other incidents and change to practice. For example, we saw the prosthesis (medical implants) for joint replacements was well organised and labelled. This had been implemented since the Never Events. New whiteboards had also been ordered and prior to the operation the surgeon would document on the white board the specific prosthesis required for the operation, the implants would then be checked against this. The surgical care plan had also been changed to document the prosthesis used.

The theatre department had developed a video recording, which showed the correct procedure for checking prosthesis during surgery. This tool was used to educate staff following the Never Event. Staff we spoke with were aware of incidents that had occurred in other divisions and sites.
Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

We saw evidence that the duty of candour (DOC) regulation had been applied. The trust’s root cause analysis report contained a section for duty of candour. It included checks that the patient and/or relative had been given a verbal apology, they had received a trust letter and been given a point of contact as well as an offer to share the outcome of the investigation.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents (SIs) in Surgery, which met the reporting criteria set by NHS England between September 2016 and August 2017.

Of these, the most common type of incident reported was

- Pressure ulcer meeting SI criteria with 11 (58% of total incidents) (reference in responding to risk and how are they addressing it risk assessment and link to this
- Slips/trips/falls meeting SI criteria with four (21% of total incidents)
- Surgical/invasive procedure incident meeting SI criteria with three (16% of total incidents)
- HCAI/Infection control incident meeting SI criteria with one (5% of total incidents)
Incidents that were reported went to a weekly serious incident declaration group were they were reviewed to ascertain if they met the Serious Incident Framework. It was open to all staff and chaired by the Director of Nursing. The trust had a number of trained incident investigators. All serious investigations along with the root cause analysis and action plan were discussed by the monthly Patient Safety Committee. This group fed into the Quality and Safety Committee. The Clinical Commissioning Group attended the Quality and Safety Committee and this fed into the board. We reviewed completed root cause analyses and saw they followed a set template and were thorough, with actions, action dates and responsible person for actions.

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 23 new pressure ulcers, six falls with harm and four new catheter urinary tract infections between September 2016 and September 2017 for Surgery.

Staff collected safety information and shared it with staff, patients and visitors with results clearly displayed on each ward we visited.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Dartford and Gravesham NHS Trust**
Is the service effective?

Evidence-based care and treatment
Policies and guidelines were in place and reflected evidence based care and treatment. National Institute for Clinical Excellence guidance was circulated to the identified lead within each directorate or department together with a link to an on-line pro forma. The designated lead completed the pro forma to confirm it had been received. The Governance Department collated information that all areas had up to date National Institute for Health and Care Excellence guidance.

Quarterly reports were prepared for the Quality and Safety Committee (a subcommittee of the Trust Board) on the status of National Institute for Health and Care Excellence guidance. In addition, an annual report was prepared for the Quality and Safety Committee this giving the committee the opportunity to scrutinise the compliance status.

The trust entered all medical devices onto national registers such as the joint register. This ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects at national level. We observed this in practice during a hip replacement operation.

Care and treatment was based on the ‘enhanced recovery pathway’. These pathways ensure patients were encouraged to participate actively in their preparation and recovery by promoting early mobilisation, eating, and drinking normally. This helped to ensure a shorter recovery time.

To support patients to mobilise early following surgery, there were processes to review timely removal of catheters (HOUDINI stickers). This also reduced the risk of hospital-acquired infections associated with these devices.

There was a lead orthogeriatric consultant and team, which was in line with National Institute for Health and Care Excellence guideline: Hip fracture: Management CG124. This team supported the orthopaedic team in the management of patients with fractured hips.

The service participated in the National Hip Fracture Database (NHFD), which is part of the national falls and fragility fracture audit programme.

Staff followed the National Institute for Health and Care Excellence guidance on preparing and prevention of surgical site infection prior to surgery. We observed in theatre adherence to National Institute for Health and Care Excellence guideline CG74: Surgical site infections: prevention and treatment. For example, we saw antimicrobial skin preparation liquid was used prior to the start of the operation to minimise the risk of infection.
We saw patients observations such as temperature and pulse were recorded within their patient record. This was in line with National Institute for Health and Care Excellence guideline CG50: Acutely ill patients in unit- recognising and responding to deterioration.

We saw folders on the wards, which contained clinical care policies, and procedures that expired in 2014. This meant there was a risk that patients were not receiving the most up to date evidence based care if the staff were accessing information from an out of date policy. The staff showed us the hospital intranet, which contained current clinical policies and procedures. For example, staff showed us the catheter policy that could be accessed via the intranet. It was in date, fully referenced, contained learning tools and a care plan.

We observed posters and screen savers on the trust computer system promoting the awareness of acute kidney injury. This ensured that staff were informed of current practice and guidelines in relation to acute kidney injuries.

Each patient should have a nursing evaluation and care which should be evaluated twice daily by a trained nurse. We looked at ten sets of notes and found that only five sets of notes (all from one ward) contained twice-daily evaluation from a trained nurse. The other five sets of notes did not contain any evaluation at all. This meant patients were not undergoing regular assessments to monitor their progress and documentation was not complete and up to date.

We saw non-compliance with VTE assessment National Institute for Health and Care Excellence clinical guideline 92 ‘reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to surgery.

**Nutrition and hydration**

There was an effective process to ensure patients were correctly starved prior to undergoing a general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, this was in line with best practice.

The trust used a Malnutrition Universal Screening Tool scoring system to identify patients at risk of malnutrition. Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines, which could be used to develop a care plan. Patients admitted for longer than 24 hours following surgery should have had a Malnutrition Universal Screening Tool score.

We found the use of the Malnutrition Universal Screening Tool score was variable depending on which ward the patient was on which meant staff could not always know if the patient was a risk of malnutrition. If the risk was not identified then patients who were suffering from malnutrition did not receive the treatment they needed. Patients who required additional input to enhance their nutrition should have been referred to a dietician.

The staff we spoke to could give examples of what would trigger a referral to the dietician. Staff could refer patients to the Nutrition and Dietetics department. The dietician advised patients and staff on all aspects of diet and nutrition. None of the patients we reviewed had been referred to a dietician.

The communication about dietary needs of patients was inconsistent depending on which ward the patient was admitted onto. All wards discussed dietary needs with the handover but did not consistently communicate this with the support team assistant. The support team assistant took
menu choices, provided hot drinks and snacks and gave out meals. There was a risk of the patient receiving food not compatible with their needs. Some wards had the patients dietary needs displayed in the kitchen.

The wards all had protected mealtimes to ensure patients were not disturbed when eating. Patients needing assistance with eating were identified by a red tray. The red tray initiative allowed patients who required assistance to eat and drink to be easily identified to all relevant members of the team. No patients we reviewed were having their food intake monitored.

All patients we saw had drinks within reach. Staff were observed encouraging and assisting patients to drink.

**Pain relief**

The trust had an acute pain service. The acute pain service was consultant led, with a full time acute pain clinical nurse specialist. The acute pain service managed all patients with epidural (pain relief injection into the back), regional pain relief block, or patient controlled analgesia (pain relief) or continuous analgesic infusions. A patient controlled analgesia is a method of allowing a person in pain to administer their own pain relief. The acute pain service role included reviewing all patients referred experiencing acute pain, developing evidenced based education programs for nursing, medical and allied health staff, developing policies and procedures for analgesic therapy. The acute pain service team also collected and analysed acute pain service data to ensure the quality and safety of patient care.

The inspection team spoke to a patient who, had been reviewed by the acute pain service. The patient described a caring and compassionate service that reviewed their pain medication and ensured they were pain free after their operation.

We reviewed three sets of patient notes in theatre and all three had a completed pain score assessment. The service used a pain score of 0-10, zero meaning no pain and 10 the worst pain the patient had ever experienced. This meant the patients had their pain assessed and controlled. Patients on the ward told us they were given painkillers as needed.

In audit, data supplied to us by the trust, which was undated 80% of patients, said pain relief was discussed with them before their operation. The same audit also showed 92% of patients felt reassured with the information they were given regarding pain relief. Fifty-eight percent of patients said there was no delay getting pain relief on the ward and 27% said there was a little delay.

The trust supplied audit data regarding the effectiveness of epidural pain relief however, this was from audits undertaken in 2012 and 2013. The trust told us they were in the process of re-auditing epidural pain relief.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

Between June 2016 and May 2017:

- In total, patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- Urology patients at the trust had a slightly higher than expected risk of readmission for elective admissions when compared to the England average.
In total, patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

**Non-Elective Admissions – Trust Level**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/06/2016 - 31/05/2017))

**Hip Fracture Audit**

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 7.3%, which was within the expected range. The 2016 figure was 4.8%.

The proportion of patients having surgery on the day of or day after admission was 85.5%, which was similar to the national standard of 85%. The 2016 figure was 81.7%.

The perioperative medical assessment rate was 96.8%, which failed to meet the national standard of 100%. The 2016 figure was 89.5%.

The proportion of patients not developing pressure ulcers was 97.1%, which falls in the middle 50% of trusts. The 2016 figure was 97.4%.

The length of stay was 22.1 days, which falls in the middle 50% of trusts. The 2016 figure was 21 days.

(Source: National Hip Fracture Database 2016)

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 80.9% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate of
69%. The 2015 figure was 81.3%.

The risk-adjusted 90-day post-operative mortality rate was 4.9%, which was within expected range. The 2015 figure was 2%.

The risk-adjusted 2-year post-operative mortality rate was 36.2%, which was worse than expected. The 2015 figure was 21.1%.

The risk-adjusted 30-day unplanned readmission rate was 12.7%, which was within expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 41.2%, which was within expected range. The 2015 figure was 49.8%.

(Source: National Bowel Cancer Audit)

**National Vascular Registry**

The trust did not take part in the 2016 National Vascular Registry (NVR) audit.

(Source: National Vascular Registry)

**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 28.4%. This placed the trust within the bottom 25% of all trusts for this measure.

The 90-day post-operative mortality rate was not eligible.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 40%, which was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit 2016**

The time period covered by this audit was December 2014 to November 2015.

In the 2016 National Emergency Laparotomy Audit (NELA), 86.4% of cases at Darent Valley Hospital had a pre-operative documentation of risk of death. This resulted in the hospital achieving a green rating for this metric. This was based on 132 cases.

Eighty-one percent of cases at Darent Valley had access to theatres within correct time frames. This resulted in the hospital achieving a green rating for this metric. This was based on 75 cases.

The crude proportion of highest risk cases (>10% predicted mortality) with a consultant surgeon and anaesthetist present in the theatre was 91%. This resulted in the hospital achieving a green rating for this metric. This was based on 67 cases.

The crude proportion of highest risk cases admitted to critical care post-operatively was 93.8%. This resulted in the hospital achieving a green rating for this metric. This was based on 32 cases.
The risk-adjusted 30-day mortality for Darent Valley was 14.9%. This was within the expected range. This was based on 132 cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16, the proportion of patients undergoing surgery for groin hernias at the trust that reported an improvement was lower than the England average according to both the EQ VAS and EQ-5D indicators. However, the proportion of patients that reported a worsening of their condition was slightly lower than the England average according to EQ VAS, and similar according to EQ-5D.

For Varicose Veins, performance was better than the England average according to both indicators.

For hip replacements, performance was similar to the England average according to both indicators.

For Knee replacements, performance was similar to the England average according to both indicators.

(Source: NHS Digital)

**Competent staff**

**Appraisal rates**

Between July 2016 and June 2017, 82.2% of staff within Surgery at the trust had received an appraisal. The trust told us in their PIR that their completion target is 85%, though this only
applies to staff that have been employed for more than one year. The split by staff group at trust level and each site can be seen in the graphs below.

**Trust level**

There was only one qualified healthcare scientist in the whole Surgery core service.

**Darent Valley Hospital**

There were only three NHS infrastructure support staff, two of whom (66.6%) had completed an appraisal.

(Source: Routine Provider Information Request P43 Appraisals)

In theatres staff appraisals were completed between January and May each year.

Trust rates for appraisal were currently 78%.

The 2016 staff survey reported 86% of respondents had an appraisal in the last twelve months,
which was comparable with the national average of 86%.

The manager of the Day Surgery Unit could not provide evidence of staff undertaking recent laser safety training, the last documented training was in 2009. This meant staff may not have the skills and knowledge to operate the laser safely putting service users at an increased risk of harm.

In the Day Surgery Unit, we reviewed the Kings College Hospital laser policy, which was stored in a folder in the staff area. The policy stated all authorised users must sign below to acknowledge that they have read and signed the Local Rules and they have received the correct training. The authorised user list was blank this meant there was no assurances that staff had been trained in the use of laser and were safe to operate it.

We raised these concerns with the trust who took a number of actions to address our concerns. These included; consultants were asked to provide laser safety training certificates, which confirmed they had received training. The trust told us that all laser devices were listed on an inventory, which was held by the General Manager, and all users had signed the inventory. However, the manager of the Day Surgery Unit was unaware of these processes in place and therefore lacked oversight of laser safety.

Both Day Surgery Unit and main theatres undertook surgical procedures on children. Staff in recovery caring for children had not undertaken specific paediatric life support training. This was not in line with Resuscitation Council (UK) Quality standards for cardiopulmonary resuscitation practice and training. This meant the staff caring for children may not have the necessary skills and knowledge placing children at an increased risk of harm.

We raised this with the trust who told us basic paediatric life support training had been booked for theatre staff and paediatric resuscitation training would be included in all theatre resuscitation training. In addition, the trust told us they had arranged intermediate life support training to be delivered in-house.

The service did not ensure staff working within theatres were competent for their roles. Staff working in theatres completed a ‘green book’ competency book when they first started working in theatres. However, staff competency was not reviewed annually to ensure staff were still competent to perform their role.

We raised our concerns with trust who told us the ‘green book’ competency document had been removed and the trust will adopt the competency document trust wide, which was used at Queen Mary’s hospital.

Ward staff had training and opportunities for personal and professional development. These were discussed and reviewed during staff appraisal and we saw evidence of this within staff appraisals we reviewed. Competencies were also reviewed annually.

The trust had processes to ensure poor or variable performance was identified and managed, including providing support to staff. There was a process to review staff absence if they had repeated periods of absence over a short period of time. Support for staff was available such as referrals to occupational health.

**Multidisciplinary working**

All staff we spoke with described excellent multidisciplinary team working with good relationships between all disciplines. This was confirmed by the inspection team whilst in the ward areas.
Staff delivered and reviewed care in a coordinated way when different teams or services were involved. We saw many examples in notes of different healthcare professionals involved with managing patients’ conditions or discharge arrangements. Patients were seen by occupational therapists, specialist nurses, physiotherapists and other healthcare professionals specific to their needs.

All relevant staff were involved in assessing, planning and delivering care and treatment. There were daily board rounds on each inpatient ward, which was attended by medical staff, nursing staff and members of the allied healthcare professionals for example physiotherapists. We saw good communication about patients between staff of different disciplines.

We spoke to a ward pharmacist. They described an open and honest communication between themselves and the nurses and doctors on their allocated ward.

A multidisciplinary approach was adopted in all areas of surgery and all specialties were supported by physicians, endoscopy, intensive care, stoma therapy, dieticians and physiotherapists.

Staff told us that patients with social care needs were only discharged home within the day time and with the knowledge that ongoing care was in place. This was in line with National Institute for Health and Care Excellence NG27 Transition between inpatient settings and community or care home settings for adults with social care needs.

We attended a daily trauma meeting where patients who had presented the previous day with an orthopedic (bone) condition were reviewed and discussed by the orthopedic team. We saw the meeting was attended by different members of the multidisciplinary team. For example, a theatre representative and frailty nurses. We saw from meeting minutes referrals to other multidisciplinary teams were made correctly. This meant patients were provided with care from the correct specialist team.

**Seven-day services**

The trust was working towards NHS Services, Seven Days a Week. Priority Clinical Standard 2 which states all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital. This was outlined in their annual report.

Data supplied to us by the trust showed in March 2017, during the week, a consultant saw 73% of general surgery patients within 14 hours and 80% of urology (male and female urinary-tract system) patients were seen within 14 hours. The same data showed that at the weekend 50% of general and trauma and orthopaedic patients and 25% of urology patients were seen by a consultant within 14 hours.

This meant patients were not receiving a timely review by a consultant especially at the weekend, which may delay the correct care, and treatment a patient required.

We saw there was a reduction in services offered to patients out of hours.

The physiotherapy service offered a seven-day service to patients who had surgery to repair a fracture neck of femur (broken hip) and elective surgery to replace the knee or hip.

Pharmacy opened to provide medicines to take home between 10am and 3pm on Saturday and Sunday.

The inspection team spoke to junior doctors who described working a forty-eight hour shift over the weekend. The consultants came into the hospital to review post-operative patients and then
were available for advice via the telephone or could come into the hospital if required. The junior doctor covered three wards. The junior doctors told us they felt this was risk to patients as this shift was too long.

The ward teams were supported by a critical care outreach service out of normal working hours to care for acutely unwell patients. A critical care outreach team is a service that supports doctors and nurses on the ward who are caring for acutely ill patients.

There was emergency operating at the weekend in main theatres; Saturday had a mixed trauma operating list and general emergencies. On a Sunday, there was a dedicated list of each.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

Mental capacity and Deprivation of Liberty Safeguards policies were in place and in date. The consent policy had been updated taking into account recent changes resulting from a court case. Staff could refer directly to the lead or raise a concern via the electronic reporting system.

There were e-learning modules for both consent and mental capacity assessment, which were tracked through the clinical education department. All junior staff and staff on induction received training in consent processes including managing patients unable to consent. Staff we spoke to could describe an awareness of the mental capacity act and deprivation of liberty safeguards.

However, data supplied to us by the trust showed poor compliance with mental capacity act training amongst nurses. Overall across surgical services only 3% of staff were up to date with training. Rowan ward was the only ward where 100% (three) nurses were up to date with mental capacity act training. This meant nurses may not have up to date knowledge regarding patients who the mental capacity act may apply to.

Mental capacity act training compliance amongst doctors was 100% across surgical services.

Staff received dementia training, which was mandatory. The trust had a Clinical Lead for Dementia and Delirium (a doctor) and Dementia Specialist Practitioner who staff had access to. The trust had a dementia strategy and clinical guidelines.

The trust employed a Learning Disabilities Liaison Nurse who provided a link for people with learning disabilities. The nurse worked with the patient with learning disabilities to produce a patient passport, improve communication with ward staff, support with reasonable adjustments, support capacity assessments and be a link person.

Data supplied to us from an audit undertaken between 15 August and 22 September 2016 100% of patients had a consent form in their notes for the procedure that the patient is to undergo. The same audit showed that 98% of consent forms had the benefits of the operation documented and 96% had the potential risks documented.

The audit showed overall good compliance but highlighted areas for improvement for example documenting on the consent form if patient information leaflets had been given to the patient.

Consent was obtained in outpatients or at pre-assessment to avoid consenting on the day of surgery, where possible; consent was then confirmed on the day of surgery. Consent to treatment is the principle that a person must give permission before they receive any type of medical treatment, test or examination. Patients were encouraged to take a copy of their consent and written information was provided. Consent remains paper based due to the complexity of obtaining signatures on an electronic system.
We reviewed ten patient records and found that consent had been obtained from patients in line with NHS guidance, they were fully completed, legible and did not contain any abbreviations.

**Is the service caring?**

**Compassionate care**

We observed care and compassion in all interactions between staff and patients at all times. There were posters signposting patient and relatives on how to feedback on their experience on each ward area. We observed posters for the Care Quality Commission advertising the 2017 NHS inpatient survey.

In the Acer Unit, there was no dedicated recovery area for patients after their operation. Patients were recovered in the main entrance / exit of the department. This meant the patients did not receive the privacy and dignity they should expect following their operation.

Staff closed doors to patients’ rooms and drew the curtain to avoid people looking in through internal and external windows when supporting patients with personal hygiene activities, or when medical staff examined patients.

We spoke to ten patients across the surgical wards who commented the staff were very busy but they still felt cared for. They told us they would feel confident about raising any concerns they had with the ward staff. The main issues of concern were in relation to care and support after discharge from hospital.

Each ward we visited had a display of thank card, emails and feedback via the trusts twitter and Facebook page. All were positive comments about the caring of the staff and were dated within the last year.

**Friends and Family test performance**

The Friends and Family Test response rate for Surgery at Dartford and Gravesham NHS Trust was 16%, which was worse than the England average of 29% between September 2016 and August 2017. This meant that the trust could not be assured they were aware of how patients felt about being treated in the hospital.

As an initiative to improve the number of friends and family test responses, we were shown a new interactive tablet that could be used either by the nurses’ base or by the patient’s bedside. This would be used to obtain friends and family test information from the patient. The staff hoped this would increase the response rate to reflect a more accurate picture of the care they provided.

A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at Dartford and Gravesham NHS trust, by site**
(Source: NHS England Friends and Family Test)
### Emotional support

Staff recognised that emotional support extended beyond patients’ physical needs. Staff involved patients and those close to them in decisions about their care and treatment.

The Multi-Faith Chaplaincy, which included volunteer visitors, visited the wards offering a ministry of listening and support whether they practiced a formal religion or not.

For people of faith, they ensured their cultural, spiritual and religious needs were met and were happy to put patients in touch with the spiritual advisor of their choice.

The trust had an out of hours care service for deceased patients of the Muslim or Jewish faith. This included the completion of the Medical Certificate of Cause of Death (MCCD) documentation protocol. The service aimed to ensure that doctors treating any Muslim or Jewish patient likely to die out of hours could hand over to the on-call doctor. The on-call doctor then visited the patient to gain an understanding of their condition and treatment. In the event of the patient’s death out of hours they were then able to complete the MCCD, this meant the body could be released within 24 hours to Muslim or Jewish families for burial.

Patients with a diagnosis of cancer were able to access enhanced emotional support via their Clinical Nurse Specialist.

Staff could access other specialist nurses to provide emotional support for patients, for example, stoma specialist nurses.

The trust offered a friendship group who met for support following bereavement.

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

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Juniper and Linden wards reported the lowest overall scores (83% and 80% respectively). These two wards also reported the lowest monthly scores: Juniper scored 67% in June 2017 and Linden scored 67% in January 2017.

(Source: NHS England Friends and Family Test)
We spoke to ten patients across the surgical wards who felt the staff were friendly and listened carefully to their needs. Patients were given time to ask questions about their care and treatment and address any anxieties or fears. Patients were supported in making decisions about their own care and treatment.

Friends and relatives of patients were kept informed and involved with decisions. Relatives we spoke with reported they were given time to ask questions and that staff extended care to them as well. Relatives were provided with regular updates for example when the patient had reached the recovery unit.

Staff understood the importance of recognising each patient’s individual needs. Patients we spoke with reported that they were treated as individuals we observed staff recognised no one person was the same.

**Is the service responsive?**

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

Patients undergoing elective surgery were given appointments around their needs and requirements where possible. Patients attending for pre-assessment had a choice of the most convenient hospital to attend for the assessment. Staff reported they would factor in the needs of the patient wherever possible. Surgical lists also provided staggered admissions for patients as this reduced the anxiety and stress of patients waiting for long periods of time on the day of their procedure.

The EDN (electronic discharge notice) system was updated daily to identify known dementia, suspected dementia and delirium trust wide and was reported monthly. There were 775 dementia patients admitted trust wide in the 12 months prior to our inspection.

Referrals were made to the diabetes team, electronically through the PAS system. There was a facility on PAS, which listed patients who had been identified as diabetic to be reviewed if they had been admitted to a ward.
Average length of stay

**Trust Level – elective patients**

Between July 2016 and June 2017, the average length of stay for elective patients at the trust was 2.6 days, which was lower compared to the England average of 3.3 days.

For General Surgery elective patients the average length of stay at the trust was 2.5 days, which was lower compared to the England average of 3.3 days.

For Trauma & Orthopaedics elective patients the average length of stay at the trust was 3.2 days, which was as expected compared to the England average of 3.4 days.

For Urology, elective patients the average length of stay at the trust was 2.1 days, which was as expected compared to the England average of 2.0 days.

**Elective Average Length of Stay – Trust Level**

![Elective Average Length of Stay Graph](image)

(Source: Hospital Episode Statistics)

**Trust Level – non-elective patients**

The average length of stay for all non-elective patients at the trust was 6.5 days, which was higher compared to the England average of 5.1 days.

The average length of stay for General Surgery non-elective patients at the trust was 5.0 days, which was higher compared to the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics non-elective patients at the trust was 10.4 days, which was higher compared to the England average of 8.9 days.

The average length of stay for Urology non-elective patients at the trust was 3.9 days, which was higher compared to the England average of 3.0 days.

**Non-Elective Average Length of Stay – Trust Level**

![Non-Elective Average Length of Stay Graph](image)

(Source: Hospital Episode Statistics)
Darent Valley Hospital - elective patients

Between July 2016 and June 2017, the average length of stay for all elective patients at Darent Valley Hospital was 2.7 days, which was lower compared to the England average of 3.3 days.

The average length of stay for General Surgery elective patients at Darent Valley Hospital was 2.6 days, which was lower compared to the England average of 3.3 days.

The average length of stay for Urology elective patients at Darent Valley Hospital was 2.1 days, which was as expected compared to the England average of 2.0 days.

The average length of stay for Trauma & Orthopaedics elective patients at Darent Valley Hospital was 3.5 days, which was as expected compared to the England average of 3.4 days.

Elective Average Length of Stay - Darent Valley Hospital

(Source: Hospital Episode Statistics)

Darent Valley Hospital - non-elective patients

The average length of stay for all non-elective patients at Darent Valley Hospital was 6.5 days, which was higher compared to the England average of 5.1 days.

The average length of stay for General Surgery non-elective patients at Darent Valley Hospital was 5.0 days, which was higher compared to the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics non-elective patients at Darent Valley Hospital was 10.4 days, which was higher compared to the England average of 8.9 days.

The average length of stay for Urology non-elective patients at Darent Valley Hospital was 3.9 days, which was higher compared to the England average of 3.0 days.

Non-Elective Average Length of Stay - Darent Valley Hospital

(Source: Hospital Episode Statistics)
Meeting people's individual needs

We found reasonable adjustments were made to take into account the needs of different people for example on the grounds of religion, gender disability, or preference. The trust employed a Learning Disabilities Liaison Nurse who provided a link for people with learning disabilities. Any patient with a learning disability, who was known to the learning disability liaison nurse at the hospital, was ‘flagged up’ on the internal electronic systems and a hospital passport would be used. The hospital passport would include information on the patient’s medical history, who to contact as well as their likes and dislikes. This ensured that staff were aware and could make adjustments where required.

Staff sought accessible ways to communicate with people to meet their needs. Staff assessed patients’ communication needs to ensure effective communication. The trust used a hospital communication book this set out how to make sure people who had difficulties understanding and or communicating got an equal service in hospital. The book contained useful information about why people may have difficulties understanding or communicating. It had useful tips staff could use to improve communication, and pages of pictures that could be used to help staff communicate.

Patients with dementia and their families could access support from the Alzheimer’s and Dementia Support Services. It was an independent registered charity, which had developed a wide range of multicultural services to provide practical and emotional support to people with dementia, their carers, supporters and other relatives.

The Trust had one full time Dementia Specialist practitioner. We saw there was a variety of policies and guidelines in relation to caring for a patient with dementia available on the staff intranet. Staff could verbally describe what they would do to ensure dementia patients were cared for.

The trust offered a dementia buddy volunteer. The volunteer was specially trained and had a good understanding of dementia and knew how to engage positively with dementia patients. They promoted dignity and respect, provided social support whilst in an acute hospital setting, engaged in activities to help maintain cognitive capabilities and assisted patients at mealtimes.

We observed patients being assisted with washing and dressing. The patients were in clean clothes, looked cared for and had their dignity maintained.

Patients told us that staff respected their personal, cultural, social and religious needs. We saw nursing assessments within the patient notes that contained information about the patients personal, cultural, social and religious needs. This demonstrated that patients had these needs assessed.

The trust provided a translation service to use for patients who were did not speak English. Staff we spoke to said they preferred to use colleagues to translate for patients and actively encouraged families to translate to avoid the cost of employing a translator for the trust. The staff also used google translate services on their personal phones.

The use of family, friends or unqualified interpreters is strongly discouraged in national and international guidance and is not considered good practice.

Specific procedure patient information leaflets were available for patients in English but were available in other languages if requested at pre-assessment. This meant patient had enough information to give informed consent for their procedure.

Psychiatric support was available for all patients on wards with staff being able to refer patients to the psychiatric liaison nurse.
There was relevant equipment for bariatric surgery patients. This included equipment in theatres but also on wards.

The Trust had a Patient Engagement Strategy plan but at the time of inspection, this had not been embedded into practice. Involvement of patients with any of the nine protected characteristic was under development in line with the strategy.

The trust did not collect data from patients with protected characteristic such as sexual orientation, civil partnership and gender reassignment. A Diversity Management Group planned to collect this data in the future.

The environment was not always well maintained and suitable to meet the needs of patients. In the day surgery unit, Day Surgery Unit and we saw equipment in corridors and in incorrect places. The Day Surgery Unit main corridor was used to recover patients it was chaotic and disorganised. Patients recovered from their surgery in the main entrance and exit corridor to the department and adjacent to the staff base. This environment could be especially confusing or distressing for patients with dementia or special needs.

In main theatres, we saw patients waited for surgery in a bay located closely together and patients were mixed sexes. This meant patients individual needs were not considered whilst in the department.

Access and flow
Referral to treatment (percentage within 18 weeks)

Between September 2016 and August 2017 the trust’s referral to treatment time for admitted pathways for surgery has been worse than the England average and has followed a similar trend over time. In the latest period, August 2017 60% of this group of patients were treated within 18 weeks versus the England average of 70%.

Between September 2016 and August 2017 the trust’s referral to treatment time for incomplete pathways for surgery was similar to the England average and followed this trend over time. In the latest period, August 2017 92% was achieved.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Surgery broken down by specialty is below. All three surgical specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>65%</td>
<td>73%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>57%</td>
<td>62%</td>
</tr>
<tr>
<td>Urology</td>
<td>67%</td>
<td>77%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Dartford and Gravesham NHS Trust

Over the two years, the percentage of the trust’s patients whose operation was cancelled and were not treated within 28 days showed a trend of improvement. In Q3 and Q4 of 2016/17 and Q1 of 2017/18, all patients whose operation was cancelled were treated within 28 days. This was a considerable improvement from Q3 of 2015/16, when over 21% of such patients waited over 28 days. This took place against a background of more or less consistent performance against this metric at the national level.

Cancelled Operations as a percentage of elective admissions - Dartford and Gravesham NHS Trust
Over the two years between July 2015 and June 2017, cancelled operations at the trust varied considerably as a percentage of elective admissions. In every quarter except Q2 2016/17, the trust’s performance was better than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Patients were sometimes moved between wards at night. Bed moves at night are classified as any patient move that occurred between 10pm and 6am. This should be kept to a minimum as it can be disturbing and stressing for the patient being moved and the ward they are moved to and from. The data provided to us by the trust showed that between May 2017 and October 2017 98% of inpatient moves were undertaken between 10pm and 6am.

Services were planned in a way that ensured surgical patients were allocated a surgical bed. The service safely managed medical outliers in surgical beds. At the time of the inspection, there were no surgical outliers and staff reported that surgical outliers occurred only very rarely. Surgical outlier is a term used when there are not enough surgical beds meaning surgical patients use other specialty beds.

The data provided to us by the trust showed that between May 2017 and October 2017 only 0.37% of all patients were not cared for on a surgical ward. This meant patients had access to care and treatment that was suitable to their needs.

Data provided to us by the trust showed that between May 2017 and October 2017 1.85% of all surgical patients had a failed discharge. The term failed discharge means patients were discharged before they are clinically ready to leave hospital. This meant patients medical needs were correctly assessed to ensure they were fit to be discharged home.

There was a standard operating procedure in place which ensured operations were cancelled in a risk based way. Factors such as the reason for operation and if the patient had been cancelled before were considered before cancellation.

Referral to treatment times were discussed at weekly operational meetings, with each speciality providing an update on their current position and a plan to address and improve.

Theatres were monitored to determine reasons for delays. Weekly operational meetings were undertaken to review the forthcoming admissions for surgery. This ensured the correct capacity, equipment and specialist care was available.

Learning from complaints and concerns

The trust had a central team of three staff to deal with complaints, with additional leadership from a senior nurse. There was also a Patient Advice Liaison Service officer who supported this work. Surgical services provided complaint responses with actions to the central team for logging and these were then reviewed by the Director of Nursing who was the executive lead for complaints. The Chief Executive Officer saw every complaint response and had overall sign off.

We saw information in all areas about how to complain and information leaflets on how to contact the Patient Advice Liaison Service office.

We saw meeting minutes, which confirmed complaint reports being reviewed at various committees for example the Quality & Safety Committee. Quality and Safety Committee sent reports to individual directorate meetings this ensured local teams could have sight of relevant learning as well as performance issues and any required actions.
The inspection team spoke to band seven nurses who described meeting with patients and families who had complained about their service. The learning from complaints and concerns were displayed in the staff rooms for ward staff to read. There was no way of ensuring staff had read the learning which meant that staff could not be sure all staff were aware of the leaning from complaints.

The theatre and Day Surgery Unit meeting minutes showed the meetings did not follow a set agenda. We reviewed these meeting minutes and complaints were not discussed. This meant that managers did not have assurance that staff were learning from complaints or knew any actions resulting from complaints.

The trust had one complaint that was escalated to the parliamentary health ombudsman and this was upheld.

**Summary of complaints**

Between August 2016 and July 2017, there were 45 complaints about Surgery. The trust took an average of 43 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 25 days, or “up to 60” days for complex complaints. There were 13 complaints, which had not been closed.

The most received were on Juniper and Redwood wards with six complaints each. There was a main theme of patients being unhappy with level of treatment.

(Source: Routine Provider Information Request P61 Complaints)

**Is the service well-led?**

**Leadership**

The leadership in surgery required further development, resilience and oversight of clinical quality and the management of risk. The leadership team did not understand or act upon risks and therefore actions were not taken to address them.

Managers failed to take action to reduce risk. For example, we saw the issue in the Day Surgery Unit with mixed medical gas cylinders had been raised one month previously in a department meeting. This meant a risk had been identified but correct action not taken to mitigate the risk.

Although the matron for main theatres provided management oversight to the Day Surgery Unit there was a disconnect between the two departments. Both departments worked in silos to each other and this contributed to the issues we found in the Day Surgery Unit. The band six lead of the Day Surgery Unit had little management input or oversight into running the department and lacked insight into the issues we raised. For example, they were unable to provide us with evidence of laser safety training during the inspection. However, the trust were able to provide this to us when we raised this as a concern.

In main theatres poor practice had gone unnoticed by managers and there was an over reliance on audit findings to monitor practice. For example, poor hand hygiene practice within the recovery unit was not identified as audits showed good compliance (100% October 2017).

Staff working within the Day Surgery Unit and main recovery lacked any paediatric life support training despite caring for children. Managers were aware of this however had not escalated the risk it posed or taken any measures to mitigate the risk.
Young people under the age of 18 years old were cared for on surgical wards however, no staff member had received level three safeguarding training. Managers had not identified this and meant young people could not be safeguarded against harm.

In main theatres, managers could not be assured that staff were skilled and competent to undertake their role as there was not a process for the review of staff competencies.

Staff told us that patient relatives, staff and the internet were often used to translate for patients to save money on interpretation services. Managers had failed to recognise that this poor practice was being undertaken and take measures to address it.

The delivery of high quality care was not assured by the leadership, governance or culture in place. For example, we identified that patient risk assessments were not undertaken in line with trust policy to protect patients for harm. Non-compliance with Venous thromboembolism (VTE) and pressure area risk assessments had not been recognised and acted upon. This placed patients at an increased risk of harm. In addition, documentation within patient records was poor for example maintaining an accurate patient care pathway.

During our feedback to the trust, we highlighted our concerns we found within the Day Surgery Unit. We were informed that there had been a recent external review of the Day Surgery Unit and the findings were similar to the concerns we found. We requested a copy of this external review however to date the trust have not provided us with it. Failing to act on the concerns highlighted within the external review raised further concerns regarding the effectiveness of leadership.

Staff felt supported by junior sisters, ward managers and matrons. Matrons were visible on the ward every day during the week, junior sisters and ward managers worked alongside staff on most days. Staff told us that matrons, junior sisters and ward managers were approachable and supportive offering advice and training as required.

Leadership development in the trust was co-ordinated by the Clinical Education Department, through the Leadership Faculty. The new Consultant Development Programme consisted of six sessions over the year aimed to provide the consultants with a better understanding of the role of a consultant in the modern NHS. The Foundation Leadership Programme consisted of five sessions, which included leadership in multidisciplinary teams and service improvement.

There was a focus on the development of leadership skills for clinical staff. Programmes included Leadership Development Days that provided an introduction to the tools required to be an effective leader. For example, a band six nurse described the leadership training they had undergone when taking a leadership role within the trust. They had received training on being a role model in their practice, conflict resolution and management skills. We observed that each ward had a photo board with pictures of the senior management team of the trust. Each trust computer had a screensaver with the pictures of the senior management team of the trust. On each ward there was a poster identifying the meaning of each staff uniform. This ensured the patients could easily identify staff including the senior nurse on duty.

**Vision and strategy**

The trust described the purpose of the organisation as ‘Our Family, caring for yours’ This captured the approach taken by the teams which made the difference to the care that the patients and their families experienced as well as the value they had for their teams.

The trust had identified the following values:

Care with compassion - Delivering high quality care with compassion to every patient
Respect and dignity - Demonstrating respect and dignity for patients, their carers’ and our colleagues, patients, colleagues

Striving to excel in everything, we do

Professional standards - Sustaining the highest professional standards, showing honesty, openness and integrity in all our actions

Working together - to achieve the best outcomes for our patients

The staff had developed the values as a group. These values provided a set of standards for how they were expected to behave towards others and conduct themselves as professionals. We were given an example of a member of staff who was not maintaining expected behaviours. The manager used the behaviour standards as a tool to improve behaviour as part of the disciplinary procedure.

We saw posters with the values displayed on wards, and computer screen savers.

Culture

Staff reported feeling valued and supported across the directorate. Staff showed a commitment to the trust, its leadership team and the values and ethos of the organisation. Morale throughout the surgical services was generally good.

Junior medical staff felt well supported. This support included pastoral care, structured training programmes, excellent induction and they were given adequate time to attend regional teaching in preparation for exams. Additional support and development included a ‘journal club’ and attending monthly audit meetings. However, some junior doctors felt the shifts at weekends were too long.

We asked staff if they were aware of the Freedom to Speak up Guardian role. We had a mixed response, which may indicate staff were unaware of the role, its function or benefits.

Governance

There was a concerning disconnect between main theatres the Day Surgery Unit and Queen Mary’s hospital. This was exacerbated by silo working between main theatres and day surgery. This impacted upon shared practices, policies and procedures, as they were not consistent with each other. For example, Queen Mary’s hospital had a process, which ensured staff’s competency to undertake their role was regularly assessed. However, this had not be shared and implemented at Darent Valley hospital.

Ward managers in surgery attended monthly clinical governance meeting. There was a discussion of complaints, incidents, ward level audits and friends and family test performance. Staff from band seven upwards had an understanding of the governance issues and how the structure worked. This was not the same for staff for band six and below. The key learning messages were not reaching all staff.

The Director of Operations led the team brief to the senior management team every month. The board received a monthly quality report highlighting good practice as well as concerns. Data showed trends in areas such as tissue viability, falls and the safety thermometer which were discussed and action plans developed. Quality and Safety Committee (Q&S) presentations fed into the board on a monthly basis.

Non-executive members of the board had oversight of targeted areas such as infection prevention and control.

The board used responses to the friends and family survey, and other sources including complaints, to identify themes for action and to track progress. This was a concern because of the
low response rate of the friends and family survey meaning the board were not assured about the patients experience while in the trust.

Managers arranged ward or departmental unit meetings regularly to ensure staff were kept up-to-date with relevant information about the ward and the hospital. However, there was not a system which ensured staff who were unable to attend meetings received information from these meetings.

We reviewed the theatre, ward and Day Surgery Unit meeting minutes and saw formal agenda was not kept for consistency. We saw the same issues were raised at several meetings for example the use of mobile phones in theatres. This may indicate the meetings were ineffective. We did not see a record of learning from incidents and complaints, nor was there any mention of how the department could learn and improve from these. We did not see any evidence of trust wide learning from incidents, or complaints.

Management of risk, issues and performance

There was an inconstant approach to the way risk and performance was managed in the surgical services.

National Safety Standards for Invasive Procedures were not embedded in the organisation. National Safety Standards for Invasive Procedures provide a framework for the production of Local Safety Standards for Invasive Procedures and dedicated Local Safety Standards for Invasive Procedures checklists were also not in place for invasive procedures such as catheters, cardiac, central line insertion and tracheostomies. Trusts have responsibility to ensure Local Safety Standards for Invasive Procedures are created for all invasive procedures and are harmonised with National Safety Standards for Invasive Procedures. National Safety Standards for Invasive Procedures are a set of national safety standards to support NHS hospitals to provide safer surgical care.

National Safety Standards for Invasive Procedures were not in place therefore the trust was unable to audit and benchmark performance and share best practice.

Managers and surgeons talked to us about the recent never events within theatres and how ongoing improvements to the safety checklist were being made and audited. Theatre staff had made a video of the correct way of performing the World Health Organisation safer surgery checklist and this was due to viewed by all theatre staff. Although staff could give us examples and demonstrate changes as a result of never events, they were unable to give examples of learning from other incidents.

In main theatres, there was a lack of quality assurance processes in place. For example, compliance with the checking of emergency equipment was not monitored.

Staff told us that they often did not have time to complete clinical incident forms, which was of great concern. Staff did not demonstrate an understanding of what constituted a clinical incident. This indicated a positive reporting culture was not promoted and there may be under reporting of incidents. Leaders had failed to recognise that staff lacked time to complete incidents or the lack of knowledge regarding what constituted an incident. Learning from incidents was limited with staff unable to give us any examples.

Infection control practices were not effective and hand hygiene practices, placed an unacceptable risk to patient safety. There was no oversight of compliance with infection control practices and policies. We had previously raised concerns regarding infection control however, we saw practice was still not embedded. This placed patients at an increased risk of infection.
There was an established risk register to monitor the risks across surgical services at Darent Valley Hospital and at Queen Mary’s hospital. The electronic incident reporting tool was linked to the risk register, which provided an enhanced level of over sight of risk. Risks were scored between five and fifteen to determine the level of risk. Twenty-nine risks were recorded on the risk register. These included risks related to performance targets, the World Health Organisation safer surgery checklist, recruitment of qualified staff, lack of junior medical staff within orthopaedics, and slips, trips and falls. We noticed that some of the risks were old, the oldest was entered as a risk in January 2012 and still had not been closed. In addition, risks were repeated for example the World Health Organisation safer surgery checklist was on the risk registers four times. Eight risks on the register had not been reviewed within the last 12 months. The risks on the register did not reflect the risks we identified during our inspection.

We reviewed meeting minutes of the orthopaedic clinical governance meetings and saw that the risk register was discussed. For example, we saw in the July 2017 meeting the lack of junior medical staff was discussed and this was added to the risk register.

We saw discussion of the risk register was a standard agenda item on the surgical, urology and renal clinical governance and risk committee meetings.

We asked the trust to provide evidence of mortality and morbidity meetings. We were supplied with presentations regarding orthopaedic mortality and morbidity for two individual consultants that were presented at the orthopaedic clinical governance meetings. We did not see any discussion regarding mortality and morbidity in any other committee meetings. This surgical service was missing an opportunity to discuss errors and adverse events in an open manner, review care standards, and make changes if required.

Information management

We saw several breaches of patient confidentiality during recent inspection. For example, patients records were stored on wards insecurely and computer screen were not locked when left unattended. This was not in line with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; Be created, amended, stored and destroyed in line with current legislation and nationally recognised guidance. It states that patient information be kept secure at all times and only accessed, amended, or securely destroyed by authorised people. Both paper and electronic records can be held securely providing they meet the requirements of the Data Protection Act 1998.

Staff had access though the trust’s computer system to policy and practice guidelines. In addition, they could also access mandatory training information and training opportunities.

Engagement

A patient representative attended trust board meetings and patients were able to talk about their experience of care they had received. This enabled patients to give feedback regarding their experience to the board members to act upon.

There was a Patient Experience Committee, which discussed feedback from patients. Attendees at this meeting included Health Watch. The public were invited to the trust annual general meeting.

The Chief Executive attended the Heath Overview and Scrutiny Committee and had spoken at patient user groups such as the Speech and Language Group and Older People’s Forum.
Coffee mornings and other engagement events had taken place to obtain views on current
experiences. Engagement with the public was through social media and kept them informed of
developments such as the Accident and Emergency campaign.

Patients could leave feedback on social media and NHS choices website and all comments were
responded to by the trust. National patient surveys were undertaken regularly and the feedback
used to create an action plan.

The trust had not had to formally undertaken any public consultations over the past 12 months.
The Charitable Funds Manager spoke at community events, local schools, corporate businesses
and charitable committees. The trust were building relationships with their community provider to
try and improve the outreach and at home care schemes.

Staff were not actively engaged in the planning and delivery of services and in shaping the future
development of the service. Staff could not describe to us any way their views were taken notice of
at trust level. They told us about ideas they had that had implemented at ward level; for example a
monthly ward newsletter.

The trust had an annual awards programme to recognise staff excellence and commitment.
Awards included excellence, leadership care and compassion awards.

Staff were able to self-refer for physiotherapy services within the trust.

**Learning, continuous improvement and innovation**

The trust had completed the first phase of the THINK 2020 Programme, which involved
transforming the core services to work more efficiently and create the capacity to meet increasing
demand.

The trust had developed several performance dashboards including one for monitoring infection
control performance. They undertook a number of initiatives involving staff across the trust
including a Rapid Improvement Programme, which focused on improving the discharge planning
processes. This involved representatives from partner organisations across the local health
economy and was done in conjunction with NHS England and NHS Improvement. It has
contributed to a significant reduction in average length of stay on the core inpatient wards.

A new patient information leaflet had been developed to help manage patient expectation around
admission and discharge. The programme had been nominated for a Health Service Journal
award.

The trust had a Lean Thinking Transformation Programme, which empowered staff to make small
changes within their own areas with a view to improving patient care. They had implemented over
150 lean projects across the trust as a result. The programme formed part of their strategic
objectives. Staff we spoke to were unaware of the Lean Thinking Transformation Programme.

Wards we visited had a ‘visboards’, by the nurse’s station. This board contained information about
patients on the ward, such as name and where they were on the ward. Staff showed us a discrete
symbol, which identified patients who had an infection. This meant all staff who were involved in
the care or visited patients on the ward, were able to see this information.
Facts and data about this service

We last inspected the maternity services at Dartford and Gravesham NHS Trust in December 2013. We found the service good overall. The purpose of this inspection was to see if the performance of the maternity services had changed since its last inspection.

Dartford and Gravesham NHS Trust’s maternity services are delivered at Darent Valley Hospital in North West Kent.

Services consist of:

The delivery suite has 11 beds. This consists of eight labour rooms including a water pool facility. There is open visiting hours for a maximum of two nominated birthing partners. Grandparents can visit the delivery suite to meet their grandchild following birth. Following birth, women are transferred to a postnatal ward, either Aspen or Cedar ward, for continued care.

Aspen Ward has 14 transitional care beds. Aspen ward is a low to medium risk postnatal ward caring for mothers who have had normal births, instrumental deliveries and caesarean sections (CS). The majority of women are transferred to this ward from the delivery suite.

Cedar ward has 22 beds. Cedar ward is a mixed antenatal and postnatal ward. The ward accepts all antenatal admissions, planned and unplanned. The ward also accommodates the postnatal high risk women who require transfer from the delivery suite.

Tambootie Ward has four Maternity Assessment Unit (MAU) beds and two Fetal Assessment Unit (FAU) beds. The MAU provides a 24/7 telephone helpline for women to seek advice. The ward has a four bedded midwifery led triage area that will assess women who are in labour or have concerns with their pregnancy. Referrals can come directly from the woman or other areas within the trust. The FAU is a two-bedded area that provides midwifery led care from Monday to Friday. Care includes blood pressure checks, repeat cardiotocograph (CTG), fetal monitoring and ultrasound scans for presentation checks.

The birth centre has eight beds. The birth centre is located alongside Aspen Ward and consists of a four-bedded postnatal bay and four labour rooms, two of which have water birth facilities.

We carried out a comprehensive inspection and reviewed all areas in maternity where women receive care and treatment. These included the day assessment unit, the antenatal unit, the postnatal unit, the labour ward, theatres and recovery, and scanning areas. We spoke with staff from across maternity services including clinical leads, consultants, doctors, midwives and maternity support workers.

In the most recent four quarters, between April 2016 and March 2017, 4,755 women delivered their babies at the trust. Trends by quarter for the last two years are shown in the graph below.
Number of babies delivered at Dartford and Gravesham NHS Trust by quarter.

![Bar chart showing number of babies delivered by quarter from 2015/16 Q1 to 2016/17 Q4.](chart.png)

**SOURCE:** HES - Deliveries (01/04/2016 - 31/03/2017)

A comparison between the number of births at the trust and the national totals over the most recent 12 months is shown below.

Number of babies delivered at Dartford and Gravesham NHS Trust – Comparison with other trusts in England.
Is the service safe?

Mandatory training

The trust set a target of 85% for completion of mandatory training. Data provided by the trust demonstrated in September 2017, maternity services were meeting or were meeting the trust’s mandatory training target for equality and diversity (88%), health and safety (85%), infection prevention level 1 (100%), information governance (88%), moving and handling level 1 (100%), resuscitation (89%), safeguarding children level 2 (100%), safeguarding children level 3 (91%). The mandatory training data was worse than the trust target for: conflict resolution (80%), fire safety (78%), safeguarding adults (77%). Preventing radicalisation and emergency resilience training became a mandatory requirement from April 2017.

A breakdown of compliance for mandatory safeguarding courses between April 2016 and March 2017 for medical/dental and nursing/midwifery staff in maternity and gynaecology is shown below:

![Mandatory Training Completion (Medical and Dental Staff)](image)

Medical staff mandatory training figures were collated by the medical education department. Staff told us the clinical director was keen that maternity figures should be collated together for both medical and nursing staff, to improve the monitoring of compliance with mandatory training.
The lead midwife showed us a maternity specific database, which was used by the maternity education department. This was not aligned to the trust’s mandatory training spreadsheet. We saw that most maternity staff training was up to date on the maternity spreadsheet in November 2017, but that there were discrepancies with figures on the trust’s mandatory training spreadsheet.

Maternity education staff told us they did not have any oversight of the trust’s mandatory training database, and mandatory training sometimes did not register on the trust’s mandatory training database even though staff had completed the training. Maternity education staff kept their own records of when staff had completed their mandatory training and said they used this as evidence to ask the trust’s education department to amend the trust’s records.

Maternity staff said there was a six week delay between staff completing mandatory training and this showing on the trust’s mandatory training figures. Staff told us they had submitted an application for midwifery training data to be merged with the trust education department’s data. However, this had not been considered feasible due to the costs involved in merging databases. This was not identified on the service’s risk register. This meant there was a risk that staff training records were not the most up to date.

A breakdown of compliance for mandatory safeguarding courses between April 2016 and March 2017 for nursing and midwifery staff is shown below.

### Safeguarding

A breakdown of compliance for safeguarding courses between April 2016 and March 2017 for medical/dental and nursing/midwifery staff in Maternity and Gynaecology is shown below:
There was a band 7 specialist operational lead midwife for safeguarding and domestic abuse. There was also a band 8 specialist safeguarding midwife who covered both children’s and adults safeguarding.

Staff we spoke with were aware of which staff member to contact if they needed any support with safeguarding issues.

Figures showed that level three children’s safeguarding training had been completed by 91% of clinical staff against a target of 90%. Safeguarding adults at risk had been completed by 77% and safeguarding children level two had been completed by 100%.

We saw information was available at nursing stations that detailed the processes for staff reporting safeguarding concerns. The trust’s safeguarding policy was available to staff on the trust’s intranet.
Staff told us the service took a multidisciplinary approach to safeguarding, and described how maternity services liaised with the trust’s safeguarding team, other hospital departments, community services and the local authority’s safeguarding team. Staff told us they were informed during morning meetings of any safeguarding concerns, which may pose a risk to staff or patients.

We saw that women's records took into account the needs of both mothers and babies, and documented other agencies that were involved with women. For example, the local authority safeguarding team.

The antenatal clinic displayed the details of confidential domestic abuse services on the noticeboard in the waiting area. This meant women could take the contact details and contact services for themselves if they did not feel comfortable discussing domestic abuse with staff.

Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of women who have had Female Genital Mutilation (FGM) or who have a family history of FGM. In addition, where FGM is identified in NHS women, it is mandatory to record this in the patient’s health record. We saw a clear process was in place to facilitate the Female Genital Mutilation reporting requirement and clear guidelines were available to staff in recognising and supporting women who may have experienced FGM.

There was a flowchart in the trust’s Emergency Preparedness Plan (EPP) which gave staff guidance on what actions to take in the event of a child being abducted. We saw laminated printed copies of the flowchart on the wards. Staff told us this was to give staff easy access to the flowchart and avoid them having to trawl through the EPP. All staff we asked knew where the flowcharts were kept.

We viewed minutes from a live child abduction exercise carried out on 27 February 2017. The minutes identified issues from the exercise, but also reported that overall the services response was effective. The maternity risk register recorded on the 18 July 2017 that a live infant abduction exercise was being developed and the service were waiting for a response from the Police prior to scheduling the exercise.

**Cleanliness, infection control and hygiene**

The trust had a ‘strategic and operational cleaning plan’ in place with a private provider of cleaning services. We reviewed the plan and found this recorded the strategy for cleaning of the hospital in accordance with legislation and best practice guidance. The plan also determined the areas of responsibility for both privately commissioned cleaners and the trust’s own staff. However, the plan we received from the trust was ratified on 20 December 2012 and due for review in December 2016. This meant this version of the plan was out of date and overdue for review.

All departments within maternity were considered high risk or very high risk for infection control. The hospital was compliant with the Department of Health’s guidance, ‘Implementation of modified admission MRSA screening guidance,’ (2014). This recommends that, ‘all women admitted to high risk units and all women previously identified as colonised with or infected by MRSA, should be screened for MRSA. In addition, local risk assessment should be used to define other potential high MRSA risk.’ In line with the target of 0%, there were no reported cases of MRSA from September 2016 to August 2017 in maternity.

There were no cases of Clostridium Difficile (C Diff) in maternity between September 2016 and August 2017.
Cleaning schedules were displayed in the cleaning cupboards and checklists were completed daily. The schedule clearly identified the frequency of cleaning for separate areas of the maternity department. This ensured no areas were missed.

We observed all cleaners wearing disposable aprons and followed the correct procedures for preventing the unnecessary spread of germs.

Clinical staff were required to comply with the ‘Five moments for hand hygiene’, as set out by the World Health Organisation (2009) and the trust’s own hand hygiene policy which followed National Institute for Clinical Excellence (NICE) guidelines.

We saw alcohol based hand sanitizer available on the wards and units in maternity and gynaecology at the hospital. We saw clear signage for women and visitors. We observed staff using hand sanitizer appropriately in all areas we visited.

Personal protective equipment (PPE) was available in all clinical areas. Staff followed correct use of PPE, we saw staff members following trust policy and NICE guidance, QS61 statement 3: ‘People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.’

All staff we observed on inspection followed the trust’s ‘bare below the elbows’ policy. Staff with long hair had this tied back.

We saw sharps bins available in treatment areas where sharps may be used, the bins automatically shut when full to prevent overfilling. This was in line with Health and Safety Regulations 2013 (The Sharps Regulations), 5(1) d. This requires staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw labels on sharps bins had signatures of staff, which indicated the date it was constructed, by whom and on what date.

Specific hand washing sinks were available in all rooms and at the entrance to bays on wards. All sinks we saw were compliant with lever handles and taps positioned to cause the least amount of splash. Sinks also had hand washing technique posters displayed to advise staff used the correct technique. This was in accordance with Health Building Note, ‘Design for flooring, walls, ceilings, sanitary ware and windows’ (HBN 00-10).

Environment and equipment

Aspen ward had 14 low risk postnatal beds, supporting the care of women during the postnatal period who have previously been deemed as high risk. The birth centre had limited space in one birthing room, which had an inflatable pool. The presence of the pool in the room left limited space for women to move around and for partners. There was also limited space in the event of an emergency for staff and emergency equipment to gain access.

The obstetric theatres were on the delivery suite and easily accessible from the labour ward.

The neonatal unit was on Walnut ward with the Special Care Baby Unit (SCBU). This was located on the third floor, next door to the birth centre and delivery suite. This meant pre-term babies or babies requiring special care could be transferred in timely way from the labour ward.

The Head of Midwifery (HOM) told us the service was 17 years old and a lot of the equipment was dated and needed to be replaced. The HOM said the services were trying to get funding from the trust to replace equipment.
Overall, we found equipment including emergency and resuscitation equipment was checked on a daily basis and a report was given to senior staff by 9am. Staff had access to satisfactory amounts of equipment including fetal blood analysers and fetal heart rate monitors.

Eclampsia, (a condition in which one or more convulsions occur in a pregnant woman suffering from high blood pressure, often followed by coma and posing a threat to the health of mother and baby), kits were available to staff, this meant if a woman suffered convulsions, staff could provide care and treatment in a timely way.

Laboratory facilities were available for blood and blood products. A cardiotocograph (CTG) monitor was available in all delivery suites and additional monitors were available on the ward. Satisfactory numbers of neonatal resuscitaires were available; these were checked on a daily basis to ensure they were functioning correctly and were fully equipped.

However, we saw rusty drain covers and exposed wood on a bidet in room 164 on Aspen ward. This posed a risk to infection prevention. We also saw rust around the base of the toilet support in room 172, as well as sealant that was corroded on the shower. Staff told us they were not sure if these had been reported.

**Assessing and responding to patient risk**

There was a flowchart in the trust’s Emergency Preparedness Plan (EPP) which gave staff guidance on what actions to take in the event of a child being abducted. We saw laminated printed copies of the flowchart on the wards. Staff told us this was to give staff easy access to the flowchart and avoid them having to trawl through the EPP. All staff we asked knew where the flowcharts were kept.

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The October 2017 staff newsletter carried a message to staff to be vigilant of members of the public trying to tailgate through doors. However, there were no ‘tailgating’ notices on maternity wards from the main hospital corridor. This created a risk that unauthorised people could enter the maternity wards when authorised visitors were entering.

The service had audited the use of the ‘perineal repair page in women labour’ in February 2017. (these were tools which recorded post-natal repairs to women’s perineum). The audit highlighted that the suturing proforma was missing from most of the notes and should have been completed. As a result the service decided to re-audit in June 2017, with the main focus on the suturing proforma. Repairs completed in theatre were excluded from this audit. The June 2017 audit found 83% compliance with use of the suturing proforma or suturing page in women notes. As a result of the June 2017 audit, the service had added an appendix to the trust’s ‘perineal trauma guideline – intentional vaginal pack retention.’ This involved the midwife/scrub nurse agreeing with the surgeon that a vaginal pack would be left in place at the end of procedures, and the number of packs clearly recorded. The patient would have a luminous wristband attached for each pack in place, and a red card would be attached to patient notes. All wristbands were checked against the patient record before the red card could be removed from the patient notes, to minimize the risk of vaginal packs not being removed following suturing.
The trust had a specialist band 6 midwife lead and a consultant lead for risk. Women were risk assessed at every antenatal appointment and a plan of care was documented in their hand held records.

Risk assessments were carried out for women and risk management plans were developed in line with national guidance, (NICE QS22). Community staff was responsible for carrying out full assessments of women at their initial booking visit. These assessments included social and medical assessment and referral, as well as assessment of maternal mental health. Other assessments included smoking, drug use, family history and previous pregnancies.

Risk assessments were used to help women choose their preferred place of delivery, recommend further investigations and inform a plan of care. This included whether a patient should have midwife or consultant led care or be referred to other professionals within the multidisciplinary team. There were clear pathways in place based on National Institute for Health and Care Excellence (NICE) national guidelines.

The service used a maternity early warning tool, the modified maternity early warning system (MMEOWS) to enable staff to recognise acute illness and aid staff to escalate appropriately. The MMEOWS policy was up to date. We looked at four MMEOWS charts and found that they had been completed in accordance with the trust’s policy.

Paediatricians had undertaken paediatric immediate life support courses (PILS) and maternity staff had undertaken newborn life support (NLS) courses. This allowed staff to provide care to seriously ill babies. The neonatal intensive care unit and special care baby unit (SCBU) was also available to provide care to babies. The trust did not have a guideline for a deteriorating baby. However, the neonatal resuscitation (newborn life support) guidelines provided guidance to staff on when to obtain a paediatrician in an emergency.

There was a guideline for ‘severely ill pregnant women and high dependency care.’ High risk obstetric women were discussed daily at the labour ward handover.

Most staff across maternity had completed adult life support training; this meant staff could respond immediately to an adult that suffered a cardiac arrest or other immediate risk to life.

The maternity risk register recorded a risk due to an increase in the number of retained swabs within the maternity department. Existing controls included: daily staff briefings to all midwives during morning handovers; the introduction of a perineal count proforma for swab packs used within the delivery rooms; long term education via the maternity education programme and perineal repair study day; and regular bulletins throughout the year to illustrate the lessons learnt. The action plan included: a briefing paper being submitted to the trust’s SI declaration group; revision of perineal trauma guidelines; revision of labour notes to include a swab counting page; a never event workshop with mandatory training for all staff; the completion of a swab counting audit; and requirements for the directorate to fully participate in the application of the ‘National Safety Standards for Invasive Procedures’ (NatSSIP, September 2015). The risk register recorded on the 12 October 2017 that all actions from the action plan had been completed.

**Midwifery and nurse staffing**

The established number of maternity staff was 170 whole time equivalent (WTE), the actual WTE number of staff in post in September 2017 was 165. The vacancy rate was 3% this equated to five WTE staff vacancies in September 2017. The turnover rate from October 2016 to September 2017 was 8.5%, with 27 staff leaving the maternity service in the previous 12 months. The highest turnover of staff was with band 5 (8%) and band 6 (11%). The maternity sickness rate in September 2017 was 4.6%. This was in line with the average rate in England for the period April to June 2017 at 4.5%.
The midwife to birth ratio was 1:36, (this means there was 36 births to one midwife), this was identified on the trust’s risk register. The risk register recorded that maternity leave amongst the maternity service staff was high. The trust had a poor response to recruitment of band 5 midwives in September 2017, with only two posts being accepted. The risk register recorded that this was due to rates of pay. The trust were advertising vacancies for band 5 and band 6 staff. Staff told us recruitment was an on-going issue due to the hospital’s proximity to London hospitals, who offered enhanced payments.

“Following our inspection the trust informed us there were processes in place to mitigate the risk from the midwife staffing ratio. This included a board level discussion about the multi-professional skill mix and a review for staffing to provide assurance that the right staffing was in place; A strategic annual staffing review; A board review of midwifery staffing and establishment every six months. Staffing and service metrics monitoring via a monthly local dashboard which is reported to the Quality and Safety committee.; Within the midwifery staffing review there was an assurance that, safe staffing included women in established labour and some other women at high risk having one to one care; The occurrences of staffing red flags were recorded, and included in the staffing review process; In times of high activity and/or acuity there were escalation processes in place which allowed the inclusion of specialist midwives in the staffing ratios, where they had a caseload and additional consultant on-site at weekends.”

The trust did not use agency staff and used their own bank staff. The staff bank usage in September 2017 was nine WTE bank staff.

There was a lack of obstetric theatre nurses 24 hours a day seven days a week. There was one scrub nurse available on the delivery suite, Monday to Saturday 8am to 6pm. This had resulted in midwives scrubbing for theatres. This was on the maternity service risk register. The risk register identified a risk of harm to mothers or babies if midwives had to be redeployed away from designated areas and women. The risk register identified that an operating department practitioner (ODP), (these are staff that support operating theatre staff and provide care to women at all stages of an operation), was available, but did not provide 24 hour cover, seven days a week. The risk register identified that this could pose a risk if the second theatre needed to be opened as there was no ODP to support the anaesthetist.

In theatre two it was predominantly midwives scrubbing (86%), with most of these (77%) coming from the delivery suite. In 23% of cases, midwives had to be utilised from other ward areas. In six out of eight cases this was during normal workday times.

The trust had recruited a scrub nurse who was due to commence work in January 2018. However, this was contributory to potential understaffing on maternity wards. The delivery suite co-ordinator said the service it was ‘occasional’ that a midwife scrubbed. They would request bank if short staffed, but occasionally could not get a scrub nurse from the trust’s bank of staff. Staff also told us main theatres would not offer staff to assist with obstetric theatres.

Some staff told us they were of the opinion that staffing was more of an issue during the night, when there was less capacity to redeploy staff from the wards. Caesarean sections (CS) ‘out of hours’ were emergency CS. Staff told us midwives did not scrub for elective CS and only scrubbed in emergencies. There was one scrub nurse cover during the day and midwives always scrubbed out of hours. Staff said this sometimes resulted in midwives being taken away from patients, (sometimes a patient who was in labour), to scrub. Staff told us a CS involved two midwives, one to handle the baby and the other to scrub.

The service audited the 30-minute decision to delivery time interval for category 1 CS between April and September 2017. In four cases of the 55 cases audited, both theatres were in use with two midwives scrubbing in each. This review did not look at if the scrub midwife was caring for
another patient at the time of the CS and any impact on other patient’s care. However, the audit found there were no cases of CS being delayed due to staffing issues. Recommendations from the audit included a review of scrub midwife’s allocation at time of CS to determine any impact on patient care. The audit did not look at whether the ODP for the out of hour cases was assisting in main theatres. The audit recommended a review of ODP activity at the time of CS to determine any impact on patient care.

Health care assistants (HCA) rotated around all wards in maternity. Staff told us this was to enable HCA staffing to be responsive to demands within maternity services. HCA staff completed competencies across maternity to enable flexibility in the staff system.

**Medical staffing**

The trust sent us data relating to obstetrics and gynaecology in response to our request for data on medical staffing. The data did not specify which data related to obstetrics and which related to gynaecology. Hence, the following data is the combined data for both services. The established number of medical staff in September 2017 was 35 whole time equivalent (WTE), the actual WTE medical staff in post was 35.7. One member of the medical staff had left the service in the previous 12 months. The medical staff vacancy rate was -5%. The medical staff sickness rate was 2.9%.

The ‘staffing levels obstetricians’ guideline’ stated that maternity services at DVH employed 10 consultants providing 92 hours consultant presence a week on the delivery suite.

The maternity risk register identified consultant presence on the delivery suite. The risk register recorded a requirement of the Clinical Negligence Scheme for Trusts (CNST) and Royal College of Obstetricians and Gynaecologists (RCOG) ‘safer childbirth: minimum standards for the organisation and delivery of care in labour, 2007’ to provide 168 hours of consultant presence on the labour ward. The risk register recorded on the 12 October 2017, the trust had recruited two consultants, who were due to take up position in January 2018.

Consultant presence on the delivery suite was rostered via ‘hot weeks’ and resident on-call hours.

Following our inspection the trust reported that consultant cover Monday to Friday was 14 hours per day on site from 8.30am to 10.30pm. There was a consultant, on call from 10.30pm. There was one registrar on site during the day and two registrars on site at night. There was junior doctor cover on site 24 hours a day.

On Saturdays, Sundays and Bank Holidays a consultant was on site for 11 hours per day. There was additional junior doctor cover between 8:30am and 1pm on Saturday and Sunday for ward rounds, discharges and training.

A further consultant or senior registrar covered elective caesarean sections from Monday to Friday. A junior doctor also assisted.

The trust allocated evenings and weekend days on a rotational basis. During the weekend some of the on-call consultant hours had to be resident on the delivery suite. Staff told us medical cover during the day at the weekend could be an issue as the specific times when the consultant was present were not defined. We viewed the trust’s ‘staffing levels obstetricians’ guideline.’ This stated that from 5pm on Friday to 8am Monday consultant presence should be 27 hours minimum. The ‘guideline’ stated that these hours had to be reasonably spread over the two day period. Working more than 27 hours would be classed as ‘unpredictable on-call’. All consultants lived within 20 minutes’ drive of the hospital.
We noted, from the investigation report of an incident involving a retained swab, this had occurred at the weekend.

A consultant had taken a sabbatical for 12 months. A locum had filled their position. However, the consultant had recently told the trust they were not intending to return to the UK. Staff told us the locum obstetrician had also taken maternity leave. Staff told us they were advertising the consultant vacancy and filling the vacancy was a trust priority. On the 12 October 2017, the risk register recorded that the trust was recruiting another locum to cover the locum post.

**Staffing skill mix**

In June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior, foundation years one and two, staff was higher than the England average.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career</td>
<td>30%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>22%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior</td>
<td>11%</td>
<td>6%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

**Records**

Medical notes were paper based. Overall, we found women’s medical notes were complete and up to date. However, the trust was in the process of moving to electronic records. Women’s paper based notes were being scanned onto the electronic records system.

The maternity risk register recorded a risk of a lack of availability of archived electronic health records (EHR) for clinic and debriefing sessions. The action plan included timely scanning of previous obstetric health records into the EHR. However, staff told us there were issues with the scanning process and records sometimes went missing for up to two weeks during transit to scanning.

Women held their own paper maternity records. Women used these throughout the pregnancy and recorded information from appointments. These were in addition to the hospital recording system. These included information about their pregnancy, screening, pain relief and birth choices. Staff gave women a ‘red book’ on discharge to keep records of their baby’s growth, development and for use in the community and transfer between services. We saw midwives check with women prior to discharge that they had this book before they left.

Staff completed a variety of different forms of information prior to discharge, including information sent to the community midwives, social workers, and GP surgeries. This ensured that the care of women continued after discharge.
Records were stored securely both within offices and on the wards. We reviewed eight sets of patient notes and saw they were comprehensive and well documented and included diagnosis, management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with patient and families. They were generally compliant with guidance issued by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), the professional regulatory bodies for doctors and nurses. Patient records were easily accessible to those who needed them.

All women had a named consultant (for high-risk pregnancies) or a named midwife (for low risk pregnancies). We saw staff completed appropriate risk assessments.

**Medicines**

The clinical governance manager told us the maternity service had addressed issues in 2016 related to women receiving medicines at the correct time. The manager had addressed this with staff and the service had seen improvements as a result.

We looked at the arrangements for storing medication on the postnatal ward. We found that they followed best practice and had a locked controlled drug cupboard, inside another cupboard, and all the drugs we looked at were in date.

Medicines that needed to be stored in fridges were also in date. Staff checked the drug fridge temperatures daily and recorded the minimum (2°) and maximum temperatures (8°). Staff signed upon completion and we saw a protocol, which staff should follow if the fridges were not within the correct limits. This is in line with best practice guidelines. However, we found a fridge on the labour ward, which was used for storing emergency drugs where the temperature exceeded the maximum limit. We saw the fridge on two occasions at 10 degrees and 11 degrees. We discussed this with the labour ward coordinator who told us there had been no action taken to address this as the fridge had returned to 8 degrees by the time it was checked and recorded.

Staff told us the pharmacist visited daily and checked drugs and administration charts.

We looked at controlled drugs (CD’s). CDs are medicines liable to be misused and requiring special management. Staff completed checks of controlled drugs daily.

In theatres, the theatre practitioner held the keys to the drug cupboards to ensure they were safely stored.

**Incidents**

Between September 2016 and August 2017, there had been 1443 reported incidents in maternity services at Darent Valley hospital. Most incidents, 171 or 12%, were in the category of unexpected readmission or attendance, with 132 or 77% of these incidents reported by Cedar ward.

In accordance with the Serious Incident Framework 2015, maternity reported six serious incidents (SI) which met the reporting criteria set by NHS England between September 2016 and August 2017. We reviewed SI reports relating to a gauze ball event in August 2016, which indicated the trust held multidisciplinary meetings and reviewed cases at several staff meetings. A root cause analysis (RCA) had been undertaken.

In the same period, the trust reported one ‘never event’ for maternity at Darent Valley hospital. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
The maternity services never event involved a retained swab in October 2016. This followed a previous incident in August 2016 which was downgraded from a never event to an SI. The August 2016 incident involved a retained gauze ball. In response to the retained swab incident in October 2016 the trust had rolled out a comprehensive programme of learning. This included regular bulletins throughout the year to illustrate the lessons learnt, revision of local guidelines to reflect National Safety Standards for Invasive Procedures (NatSSIPs) and documentation changes. Never event forms were also included as part of new staff induction process for all health care professionals. Furthermore, all maternity and obstetric staff had attended a never event workshop. The trust had also introduced ‘swab logs’ and a process of wristbands for each swab in use. Following our inspection, the trust informed us that the principles of the gauze ball incident were covered in ‘never event workshops’ which were attended by 100% of all staff. The trust added that an action plan from the gauze ball SI was in the process of being implemented at the time of the retained swab event. Actions the trust were taking in response to the gauze ball incident should have raised staff awareness of the risk of posed by retained items. Never event workshops had included discussions about the gauze ball incident, and the trust reported “a sustained implementation of change."

Staff discussed incidents at handovers and morning meetings. We also saw incidents had been minuted in ward meetings. For example, there were bi-monthly meetings, which had a standard agenda, between the maternity governance team, gynaecology lead consultant and gynaecology matron to discuss SIs or any incidents, which had resulted in harm to women or babies.

The severity of an incident was graded using the National Patient Safety Agency framework, these were no harm, low harm, moderate harm, severe harm and catastrophic harm. The clinical governance midwifery manager reviewed all incidents. The clinical governance midwifery leads were the only members of staff that could close incidents.

All low or no harm incidents were reviewed and logged for trend analysis by the clinical governance midwifery manager and actions were taken locally to rectify shortfalls. If it was decided after review by the clinical governance midwifery manager that an incident was classified as a serious incident (SI) then it was passed onto the governance team and a RCA investigation was conducted. Once the RCA report has been completed, and approved by the trust corporate team, it was sent to the Clinical Commissioning Groups (CCG) for approval.

The maternity governance leads emailed monthly incident reports to community maternity leads, Medical Director and hospital general manager. The governance lead midwife reviewed all incident reports daily. Staff told us they received feedback about incidents they submitted and felt that the incident reporting culture in maternity was positive.

All staff we spoke to were aware of their responsibilities relating to Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify women (or other relevant persons) of “certain notifiable safety incidents” and provide them with reasonable support.

Duty of candour was included in induction training for new starters across maternity services. We reviewed incident data for the service and actions staff took following incidents and saw evidence that, showed staff applied DoC appropriately.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between September 2016 and August 2017, the trust reported one incident which was classified as a never events within maternity. This was recorded as “Maternity/Obstetric incident meeting SI criteria: mother only.”
The occurrence of never events within the obstetric department was added to the maternity risk register on 24 October 2017. This included the potential for a never event to occur in obstetrics, partially related to high risk procedures involving swabs. Controls in place were identified as compulsory use of the World Health Organisation (WHO) checklist for all women attending obstetric theatre; the NATSSIPs proforma with adapted WHO checklist to be used for all surgical procedures outside obstetric theatres; regular bulletins throughout the year to illustrate the lessons learnt; revision of local guidelines to reflect NATSSIPs and documentation changes; all staff had attended a never event workshop; the duty of candour being observed in cases of retained swabs and full RCA investigations being completed.

The action plan included a documentation audit to ensure compliance with the new proforma; never events forming part of staff induction processes for all staff; and monitoring of swab incidents via the trust’s electronic incident reporting systems. We saw that some of the actions had been implemented prior to the risk being added to the risk register. The action plan was due for review on 30 November 2017.

(Source: Strategic Executive Information System (STEIS))

### Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in maternity and gynaecology which met the reporting criteria set by NHS England between September 2016 and August 2017.

Of these, the most common type of incident reported was

Pressure ulcer meeting SI criteria with 3 (50% of total incidents)

Maternity/Obstetric incident meeting SI criteria: mother only with 1 (17% of total incidents)

Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with 1 (17% of total incidents)

Slips/trips/falls meeting SI criteria with 1 (17% of total incidents)
Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. The trust collected data monthly.

The maternity safety thermometer focused on perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. From September 2016 to October 2017, Cedar and Aspen wards regularly scored over 80% harm free care. The safety thermometer trend was also improving.

The trust recorded birth information on the maternity dashboard. This covered organisational performance indicators, such as closures, activity, workforce and clinical indicators. This was reviewed regularly by the clinical governance midwifery manager and head of midwifery (HOM).

Is the service effective?

Evidence-based care and treatment

We found from discussions with staff and women as well as our observations that care was being provided in line with the National Institute for Health and Care Excellence (NICE) quality standard 22. This standard covers the care of all women up to 42 weeks of pregnancy. It covers all areas of antenatal care including community and hospital settings.

Women, who needed a caesarean section (CS), whether planned or emergency, also received care in-line with the NICE recommendations (Quality Standard (QS) 32. For example, Quality statement 1: Vaginal birth after a caesarean section (VBAC).

There was evidence to indicate that NICE QS 37 was being met in post-natal care. Examples included women discharged with appropriate checks and with correct medicines. All women we spoke with told us staff had provided them with breastfeeding advice and support.

The trust were meeting NICE QS 190: Intrapartum care. Staff offered women a choice of birthing locations and a choice of care throughout labour. For example, a patient told us staff had discussed their preferred birthing location. Staff told us they always tried to accommodate women's specific choices of birthing locations, dependent upon the availability of the women’s preferences.

The maternity service used a customised assessment of birthweight and fetal growth via the Gestation Related Optimal Weight (GROW) programme. This enabled staff to accurately define...
each pregnancy's growth potential through the use of customised charts. All staff had received training in the use of the GROW charts. The programme was on-going and due for review in April 2018 to enable the service in benchmarking its performance.

We reviewed six policies and all were within their review date, with the exception of the strategic and operational cleaning plan. We saw evidence that most guidance and policies within maternity services had been reviewed and were based upon current guidance.

The trust education department, obstetricians, would disseminate new guidance from NICE and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines or maternity education leads.

We saw areas of evidence-based antenatal practice. For example, the trust offered fetal anomaly screening in accordance with current UK National Screening Committee programmes. This was in line with NICE quality standard QS22: Antenatal care.

The maternity education team produced a monthly newsletter, ‘From Here to Maternity.’ We viewed the October 2017 edition of the newsletter. This contained information for staff on guidance updates, for example, in October there were updates to the female genital mutilation (FGM) guidelines, home birth guidelines, and cell salvage guidelines.

The trust had achieved level two UNICEF Baby Friendly accreditation and was working towards level three. The Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care. Following our inspection the trust informed us that they had achieved level 3 Baby Friendly accreditation in January 2018.

**Nutrition and hydration**

Breastfeeding initiation rates at Darent Valley hospital did not meet the trust’s targets. The target was 85%. We viewed the maternity services dashboard and found the target had not been met between September 2016 and October 2017. The highest rate achieved in the previous 12 months was 72% in January 2017. The lowest rate was 64% in December 2016.

The post-natal wards had introduced the ‘11 o’clock stop’ initiative to promote breastfeeding. This involved staff on the wards engaging parents in conversation about feeding at 11am every day.

Patient information of breastfeeding support was seen throughout the department. All women we spoke to said they had received support to breastfeed soon after birth, and that this had continued on the post-natal ward.

The department offered a breastfeeding room and had a specialist breastfeeding midwife to support women. There was a breastfeeding room for women to use with a fridge to store breastmilk and if women wished to bottle feed sterilisers were readily available. Support workers were trained to support women with feeding their babies.

Women were offered a choice of menu options and dietary requirements were taken into consideration. Women we spoke with reported the food was good and a variety of options were available. Women had access to tea and toast 24 hours a day. Hot drinks were available for women at all times.

**Pain relief**
The maternity service annual report 2016 to 2017 recorded that 26% of women used some form of alternative pain relief during labour, including the birthing pool, hypno-birthing, aromatherapy, reflexology and yoga or meditation.

Results from a questionnaire in October 2016 to understand women’s views and experiences on their elective caesarean section found 84% of women rated their discharge pain relief was either ‘sufficient’ or ‘extremely sufficient.’

Women had access to a range of pain relief methods following NICE guidance CG190. This included entonox (gas and air) and pethidine (a morphine-based injection) for medical pain relief during labour.

Epidurals were available 24 hours seven days a week. Women generally received epidurals within 30 minutes of request.

We spoke to several women during our inspection and all reported their pain was managed well. However, one woman told us she felt staff had not believed her when she told them she was in pain and there had been a delay before she was offered pethidine.

Patient outcomes

Maternity services had a dashboard to monitor Key Performance Indicators (KPI). The dashboard was ‘red, amber, green’ (RAG) rated. For example, the dashboard recorded the rate of third and fourth degree perineal tears during labour. A perineal tear is a laceration of the skin and other soft tissue structures that, in women, separate the vagina from the anus. The threshold for a red rating on the dashboard was 5%. The dashboard for the rate of third and fourth degree tears was consistently RAG rated ‘green’ between November 2016 and October 2017. This meant the incidence of third and fourth degree tears were similar to that seen across the UK. The RCOG guidelines, ‘Third- and Fourth-degree Perineal Tears, Management (Green-top Guideline No. 29), 2015,’ state the “overall incidence in the UK is 2.9%.” We found the trust were consistently lower than this rate during the period November 2016 to October 2017, with the exception of January 2017 when the rate was 3%.

The maternity dashboard recorded that between October 2016 and October 2017 an average of 97% of women received one to one care from a midwife during labour. This was slightly worse than, but close to, the trust target of 100%.

National Neonatal Audit Programme

In 2016, the National Neonatal Audit for Darent Valley hospital showed the following:

Do all babies of less than 28 weeks gestation have their temperature taken within an hour of birth? There were 28 babies born at less than 32 weeks gestation included in this audit measure. 100% of these babies had their temperature measured within an hour of birth; this was above the national average of 96%.

Are all mothers who deliver babies between 24 and 34 weeks gestation inclusive, given any dose of antenatal steroids? There were 108 eligible mothers identified for inclusion in this audit measure. 84% of these mothers received at least one dose of antenatal steroids of antenatal steroids; this was slightly below the national average of 86%.

What proportion of babies less than 33 weeks gestation at birth were receiving any of their own mother’s milk at discharge to home from a neonatal unit? There were 20 babies born at less than 33 weeks who met the criteria for inclusion in the unit. 70% of these babies were receiving mother’s milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit; this was above the national average of 59%.
Standardised Caesarean section rates and modes of delivery

Between April 2016 and March 2017, the total number of caesarean sections (CS) was similar to the England average. The standardised CS rates for elective sections as expected and rates for emergency sections were as expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>Dartford and Gravesham NHS Trust (RN7)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesarean rate</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>11.0%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.4%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.4%</td>
<td>29.7%</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

In relation to other modes of delivery between April 2016 and March 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Dartford and Gravesham NHS Trust (RN7)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections</td>
<td>1,411</td>
<td>29.7%</td>
</tr>
<tr>
<td>Instrumental deliveries</td>
<td>595</td>
<td>12.5%</td>
</tr>
<tr>
<td>Non-interventional deliveries</td>
<td>2,747</td>
<td>57.8%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>4,755</td>
<td>100%</td>
</tr>
</tbody>
</table>

All delivery rates were about the same as the England average.

(Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 5.2. The comparator group was 5.2.

(Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

Competent staff

There were comprehensive training and education opportunities available to staff. We saw that staff views were being sought for a maternity ‘clinical education strategy’ that was in development.
The strategy development included a drop in for staff in November 2017 to feedback on maternity education and training.

New midwives joining the trust completed a comprehensive preceptorship programme. This included completing a midwife core competencies handbook. There were trust wide competencies for bands five to seven. Health care assistants’ (HCA) band two and three had a separate booklet setting out their core competencies. Staff supervisors signed off core competencies when staff had provided evidence of competence.

Matrons supported band seven nurses clinical competencies these included a comprehensive list of competencies such as administration of oral medication, administration of intravenous (IV) medication, epidural infusions, bereavement care, maternal resuscitation and cardiotocography (CTG) interpretation. CTG is a means of recording the fetal heartbeat and the uterine contractions during pregnancy.

We spoke with two maternity support workers who had recently joined the trust. Both told us they felt welcomed and had completed a month’s induction and orientation when they had first taken up their roles. A HCA told us, “They don’t throw you in at the deep end. You are always supported.”

The trust employed two dedicated maternity education lead midwives. One acted as the maternity education lead and the other took the lead with preceptorships and practice development. The education leads met with midwives throughout their employment. They were also involved in the professional development of students and newly qualified midwives.

The midwifery education team produced an annual training report. We reviewed the 2017 report which included the education opportunities that were available to staff. For example, suturing skills refresher workshops, CTG masterclasses, and bespoke training projects including, epidural masterclasses, cannulation skills, and aseptic non-touch technique (ANTT).

The midwifery education team provided a ‘support worker month.’ This was to enhance support workers skills and knowledge. For example, support worker staff told us about a workshop in ‘saving babies lives’ which was held during ‘support worker month.’ Staff told us they had also attended workshops provided by the ultrasound department, as well as visiting the catheterisation laboratories as part of the ‘support worker month’ initiative.

A range of drop in sessions were available to staff. This was to enable staff to access training without booking. For example, there had been monthly fire safety sessions and regular drop in sessions for cannulation updates training between February and November 2017. There were also regular quarterly suturing workshops.

Eight members of staff had attended human factors in healthcare, train the trainer courses in April 2017. This enabled staff to become skilled in delivering human factors training across the service.

Support worker staff told us they received regular refresher mornings to maintain support workers skills across maternity in response to rotational working.

Staff told us they received information on available training with their payslips, to encourage staff to book training.

Staff told us nurses and midwives had protected time for revalidation to ensure they had appropriate support in maintaining their professional nursing registrations with the Nursing and Midwifery Council (NMC).

A comprehensive programme of training and support was available from the maternity education department. For example, midwives had two days set aside every year to complete the trust’s mandatory training. Staff also had days allocated annually for midwifery specific training. For
example, one day for fetal monitoring and another day for breastfeeding. Midwives also had access to a range of study days.

Education lead midwives told us they advertised training courses to staff three months in advance by email and maternity newsletters. However, maternity staff also told us some courses were not full and ran at 60% attendance. Staff told us this was due to operational demands on staff and staff being unable to attend scheduled training. Maternity education leads told us they always followed up staff non-attendance at training to ensure there was a valid reason.

The trust had employed an audit midwife in 2017. Staff told us in the six months the audit midwife had been in post, the audit midwife’s focus had been audits of the service.

Maternity education leads told us they recognised that simulation training was an area for improvement in maternity education. Staff said this was due to the lack of an obstetrics lead consultant and education staff not having someone to liaise with to identify opportunities in terms of staffs’ simulation training needs.

In response to the December 2016 ‘never event’ the service had introduced a long term programme of training and awareness for all obstetric and midwifery staff via the ‘Maternity Educational Programme and Perineal Repair Study day.’ Staff told us they had also attended a ‘retained swabs’ workshop in February 2017.

Maternity services had introduced a new model of midwifery supervision. All supervisors of midwives were transferring to the professional maternity advocate (PMA) role. PMA are experienced practising midwives trained to support and guide midwives to deliver care developed nationally and locally. PMAs also support women by listening and advocating on concerns they may have about their midwifery care.

Mother and infant mental health service (MIMHS) were in the process of providing staff with a rolling programme of education in mental health awareness. We saw the dates of these sessions advertised in the antenatal training area and staff had signed a form to register their attendance.

**Appraisal rates**
The trust managed consultant appraisals centrally. All consultant appraisals were up to date. Consultants or associated specialist in other specialities appraised obstetric staff.

Between July 2016 and June 2017, 66% of staff within maternity at the trust had received an appraisal compared to a trust target of 85%. Nursing and midwifery staff had an improved appraisal rate in October 2017 with an 87% appraisal completion rate. Obstetrics had an appraisal rate of 87% in September 2017. This was better than the trust target of 85%.

A split by staff group of the July 2016 to June 2017 figures are shown in the graph below:
Multidisciplinary working

In accordance with RGOG safer childbirth guidelines there were daily meetings following handover on the post-natal, antenatal wards and the labour ward. These involved multidisciplinary staff members including anaesthetists, junior doctors, senior midwives and clinical leads.

There were monthly meetings between ultrasound staff and the fetal medicine consultant, screening midwife, senior midwifery staff and community midwives on Tambootie ward to review women’s antenatal imaging.

The band seven specialist lead midwife for mental health told us they had an effective working relationship with the community mental health team.

Medical staff told us doctors from other specialisms in the hospital were supportive. For example, staff told us microbiology and radiology staff would do tests on the same day upon request.

Seven-day services

All women could report to the hospital in an emergency through the accident and emergency (A&E) department.

The delivery suite, birth centre, Cedar and Aspen ward operated 24 hours a day, 7 days a week service.

Community midwifery care and clinics ran between 8.30am and 5pm hours, seven days a week, outside of these hours an on call service was provided.

The maternity unit had ultrasound scanners available that could be used out of hours if necessary.

There were two dedicated obstetric theatres that offered 24-hour caesarean sections (CS).

Health promotion
The public health midwifery team, led by the assistant head of midwifery, took the lead on substance misuse; high-risk women in pregnancy, for example diabetes and sexual health; antenatal and newborn screening; breastfeeding; and the Fetal Assessment Unit (FAU).

At antenatal booking appointments women had a carbon monoxide exposure test and where appropriate referral to the smoking cessation service, in accordance with National Institute for Health and Care Excellence (NICE) 26, ‘smoking: stopping in pregnancy and after childbirth.’

The October 2017 antenatal ‘open day’ had a ‘Movember’ session, to raise awareness of men’s health issues, such as prostate cancer, testicular cancer, and men’s suicide.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
We saw staff gained verbal consent before commencing any treatment.

Staff demonstrated awareness of what actions to take in the event of a patient lacking the capacity to consent. The training department provided compulsory annual Mental Capacity Act 2005 study days.

Staff were aware and followed the trusts Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) policies. Staff demonstrated how they could access these policies through the trust intranet.

Staff understood the use of ‘Gillick competencies’ in relation to children. This is a legal ruling whereby parents cannot overrule a child’s consent when the child is judged as competent to make the decision. The understanding required for different interventions will vary considerably and therefore a child under 16 may have the capacity to consent to some interventions but not to others.

Is the service caring?

Compassionate care
Overall, the women and relatives we spoke with all reported that they received good-quality care and all staff were kind to them. They felt staff listened to them. We observed woman-centred care and saw staff responding compassionately when a woman needed help. This was in accordance with NICE QS15 Statement 1.

Staff maintained women’s privacy and dignity by drawing curtains around women before undertaking examinations or providing care. Typical comments about staff included: “They’ve been great. All of them.” Another patient commented, “They have been very nice.”

Friends and Family test performance
Between June 2017 and August 2017, the trust’s Maternity Friends and Family Test (antenatal) performance was generally similar to the England average.

Friends and family test performance (antenatal), Dartford and Gravesham NHS Trust
Between September 2016 and August 2017, the trust’s Maternity Friends and Family Test (birth) performance was generally similar to the England average. In the latest period, August 2017 the trust’s performance for antenatal was 100% compared to the England average of 96%.

Friends and family test performance (birth), Dartford and Gravesham NHS Trust

Between September 2016 and August 2017, the trust’s Maternity Friends and Family Test (postnatal ward) performance was generally similar to the England average. In August 2017, performance for birth was 97% compared to the England average of 96%.

Friends and family test performance (postnatal ward), Dartford and Gravesham NHS Trust

Between September 2016 and August 2017, the trust’s Maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. In July 2017 performance for postnatal wards was 100% compared to the England average of 94%.

CQC Survey of women’s experiences of Maternity services 2015

The trust performed similar other trusts for 14 out of 16 questions in the CQC Maternity survey 2015. Please note that RAG on the following table relates to a red, amber green (RAG) rating.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>9.09</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and</td>
<td>About the</td>
<td>7.62</td>
</tr>
<tr>
<td></td>
<td>do you feel that you were given the opportunity to wash and</td>
<td>same</td>
<td></td>
</tr>
<tr>
<td></td>
<td>change your clothes?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20180126 Dartford and Gravesham inspection – Evidence appendix
Choose the position that made you most comfortable?  

If your partner or someone close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?  

Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?  

Staff during labour and birth

Did the staff treating and examining you introduce themselves?  

Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?  

If you raised a concern during labour and birth, did you feel that it was taken seriously?  

Thinking about your care during labour and birth, were you spoken to in a way you could understand?  

If you used the call button how long did it usually take before you got the help you needed?  

Thinking about your care during labour and birth, were you involved enough in decisions about your care?  

Thinking about your care during labour and birth, were you treated with respect and dignity?  

Did you have confidence and trust in the staff caring for you during your labour and birth?  

Care in hospital after the birth

Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?  

Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?  

Thinking about your stay in hospital, how clean was the hospital room or ward you were in?  

Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?  

Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?

“Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?” scored in the best performing trusts and there was no score for “If you used the call button how long did it usually take before you got the help you needed?”  

(Source: CQC Survey of Women’s Experiences of Maternity Services 2015)

We saw staff introducing themselves to women and explaining their roles within the department. This was in-line with NICE guideline QS15, statement 3: ‘Women are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare ‘team’.

Emotional support

The antenatal clinic offered open days. We saw an open day in November 2017 offering prospective parents an ‘emotional and wellbeing workshop,’ as well as practical sessions on parenting.

Maternity services had recently been allocated a consultant psychiatrist for one day a week. The service also had a lead mental health midwife. The midwife was a qualified counsellor and worked with ‘Rape Crisis’ services. The midwife told us they could signpost women or their partners to...
‘talking therapies’ with MIND and a local counselling service. They also told us they had referred women for cognitive behavioural therapy (CBT). The community midwives assessed women for any extra care needed they may require at booking. This included an assessment for post-natal anxiety and depression.

The trust had a team of bereavement midwives who supported women and their families following stillbirth or neonatal death. Bereaved parents would receive 1:1 care from a bereavement midwife. A local charity provided families with bereavement boxes to enable parents in keeping mementoes of their baby. The community bereavement midwives provided on-going support to families following discharge. The maternity service also offered an annual remembrance service at Christmas, with poems, music, art and craft activities for other children in the families. Babies’ names were read out. The service also provided Christmas decorations, which parents could put on a tree in memory of their baby.

Understanding and involvement of women and those close to them
We saw photographs of all staff displayed within the department. This helped women to identify staff members during their stay.

The antenatal unit was midwife led. Staff were committed to providing and promoting normal birth. Staff offered women a choice of birthing options and if women requested no consultant presence, this was adhered to as long as it was safe to do so.

Most women we spoke with said nurses and midwifery staff involved them in decisions about their care and they were involved in their care planning. We spoke with 11 women, partners and relatives during our inspection. Most of them told us they were satisfied with the information and advice they had been given; leading up to and during labour; following the birth of their baby; or whilst receiving care and treatment. However, one parent told us their baby had been taken to the Special Care Baby Unit (SCBU) during the night and they had not been informed of the reason. Staff returned the baby to the parent in the morning. However, the parent said they had not received a satisfactory explanation.

Women always had a named midwife who was responsible for their care. Women we spoke with confirmed they had a named midwife. When asked, women were mostly able to tell us the midwife that was in charge of their care.

Staff demonstrated good communication skills during the examination of women.

Across the maternity services women, their partners, friends and relatives had access to a variety of information leaflets. For example, the birthplace had a leaflet on ‘infant security on the maternity unit.’ This gave advice on how parents could be involved in ensuring the security of the maternity unit.

Mothers we spoke with told us they received breastfeeding support immediately following delivery and that this continued once on the ward.

Is the service responsive?

Service delivery to meet the needs of local people
Dartford and Gravesham NHS Trust, is one of the main acute healthcare providers in the West Kent area. It offers maternity provision to high risk and low risk pregnant women in three models of care: traditional community care with a home birth service, co-located midwifery led birthing unit; low and high risk traditional hospital care. In the most recent four quarters, between April 2016 and March 2017, 4,755 women delivered their babies at the trust.

Dartford and Gravesham NHS Trust maternity care was provided in Darent Valley hospital with women choosing delivery booked under the care of the midwife/ shared care or with the consultant
obstetrician. Delivery was planned via the hospital teams, which offered the facilities of a home birth, co-located midwifery led unit (birth centre), delivery suite, and obstetric theatres.

Darent Valley hospital is a single site hospital that has the maternity unit based in the west wing. The facilities available on Level three included delivery suite with eight en-suite delivery rooms, this included a high dependency room, two bedded recovery area, two obstetric theatres and a bereavement suite. It provided intrapartum care, this relates to care provided during the act of birth, to high and low risk women. We found there were capacity issues on the delivery suite. Two rooms on the delivery suite had two beds. In mitigation staff said women would only use the rooms if the post-natal ward was full, and would transfer as soon as a bed became available on the post-natal ward.

A 20 bedded maternity ward (Cedar Ward) provided care to high risk antenatal and postnatal women, 24 hours a day, seven days a week.

The fetal assessment unit (Tambootie Ward) had two couches and two chairs that provided high risk, day care surveillance to antenatal women. This was a seven and a half hours a day, five days a week service.

The maternity triage facility (Tambootie Ward), had two cubicles, two couches and two chairs providing triage, assessment, advice and a plan of care to women, 24 hours a day, seven days a week.

The co-located midwifery led unit, birth centre, had four birthing rooms. The centre provided intrapartum and immediate postnatal care to low risk women. Staff told us there had been discussions about the ‘children’s resource centre’ being converted to a new birth centre. However, staff said this had not been taken forward by the trust.

The antenatal clinic and the ultrasound department were based on level two. Consultant and midwifery led services were held in this facility. Services were provided seven and a half hours a day, five days a week. This service does also flex to provide some evening and weekend sessions as required for the level of bookings.

The neonatal unit provided care for newborn babies who were either preterm or required a higher level of medical and nursing care following birth. Walnut ward, the Special Care Baby Unit (SCBU) had 22 cots including three high dependency cots. There were also facilities for parents to stay with their babies before discharge. Community midwifery care and clinics were held in a variety of settings including Children’s Centres, GP surgeries and women’s homes. Services ran between 08.30am and 5pm (seven days a week), outside of these hours, an on call service was provided.

There were two obstetric theatres within the maternity department, which were available 24 hours. Theatre one was the main obstetric theatre. Theatre two was the emergency obstetric theatre, which was used when theatre one was occupied. The service audited the use of theatre two between February and October 2017. The audit found theatre two had been open 58 times in the period, with 46 of these being for caesarean sections (CS): 83% of cases were during normal working hours in the week; 10% were out of hours in the evening or at night; 7% were at weekends.

Bed Occupancy
Between January 2016 and June 2017, the bed occupancy levels for maternity were generally higher than the England average, with the trust having the highest levels of bed occupancy in Q1 2017/18 (90%), compared to the England average of 60%.

The chart below shows the occupancy levels compared to the England average over the period.
Meeting people's individual needs
Most women choose to stay between six to 12 hours following the birth of their baby. There were facilities for partners to stay with women during the period including access to tea and coffee on the postnatal ward.

The trust had a specialist lead midwife for mental health. There was also an obstetric consultant who led on perinatal mental health. The October 2017 maternity newsletter informed staff of a new pathway for the mother and infant mental health service (MIMHS) and gave staff guidance on how to refer to the service.

We viewed the mental health pathway and found this provided comprehensive guidance for staff on assessment, resources available to staff and information on different types of mental health conditions. The lead mental health midwife worked closely with the psychiatric liaison team, who would respond to referrals within 48 hours or four hours for urgent referrals. The lead midwife told us the psychiatric liaison team were responsive and usually met their referral to treatment targets. We viewed a standard operating procedure (SOP) which was being drafted for women with learning disabilities. This provided staff with a flowchart on the patient pathway through maternity services and the support available. For example, women would receive 1:1 parent craft sessions and a 1:1 tour of the maternity unit.

Staff showed us a copy of the MENCAP ‘getting it right’ charter in the antenatal clinic. This provided staff with information on providing services for people with a learning disability.

We saw the antenatal liaison officer asking the antenatal reception staff to book a telephone interpreting service for a patient who did not have English as a first language.

Maternity services had a bereavement team. These were midwifery staff that received further training in loss and bereavement. There was a bereavement room, ‘Serenity,’ which was available to parents who had sufered the loss of a baby. The bereavement room was en-suite and separate from other maternity areas. The room provided a TV, DVDs and tea and coffee making facilities.

(Source: NHS England)
**Access and flow**

Staff told us the maternity dashboard recorded that there had been no maternity unit closures between September 2016 and October 2017. The maternity dashboard recorded two transfers of women ‘in utero’, before birth, outside the organisation and no women transferred within the organisation during this period.

The 10 week deadline, (in accordance with NICE QS 22 statement 1), for offering antenatal screening for thalassemia and sickle cell was on the services risk register. Thalassemia and sick cell are inherited blood disorders. The risk register recorded on 21 August 2017, this was due to low rates of women booking screening prior to 10 weeks of their pregnancies. There was an action plan in place, which included early booking appointments being offered, and early screening opportunities. Community phlebotomy clinics were offering antenatal bookings before 10 weeks gestation.

Community midwives provided care in children’s centers, GP practices and the home. They provided antenatal and, postnatal care from the first pregnancy appointment until discharge, usually around 10 days after birth, when they transferred babies to the health visiting service.

The maternity services annual report 2016 to 2017 found 60% of bookings were at the children’s centre, 16% were booked by the GP, and 16% were via the antenatal clinic.

We spoke with four women in the antenatal clinic that had used the self-referral online service. All told us the online form was accessible and easy to use.

Women had 24-hour access to the triage phone line for advice. The triage system for all women went through a dedicated triage midwife and depending on the women’s needs they were bought into the day assessment unit, triage room or directly to labour ward.

Caesarian Section rates were on the trust’s risk register. This was due to the CS rate, planned and unplanned, remaining amber to red on the maternity dashboard. The maternity dashboard target was 23%. However, the rate from September 2016 to October 2017 was consistently above the target. The lowest rate was in April 2017 at 24.7%, this was the only time the risk was amber on the dashboard during the period. The rate was red for all other months in the period, peaking at 32.5% in February 2017. There was an action plan in place, which included: all vaginal births after CS, (vaginal birth after caesarean section, VBAC); women seeing the VBAC midwife; and elective CS over 39 weeks embedded into practice; women having debriefings after their CS if VBAC was considered appropriate in their next pregnancy.

The maternity services annual report 2016 to 2017 reported that 8% of CS were category one emergency, 32% were category two urgent, 14% were category three scheduled, 46% were category four elective.

The service audited the 30 minute decision to delivery time interval for category one CS between April and September 2017. This found 56% of category one CS were due to pathological cardiotocograph (CTG). CTG is used to monitor the fetal heart and contractions of the uterus. The audit found 93% were performed within the 30 minute timeframe; 49% were performed out of hours during the week; 25% were performed at the weekends. Recommendations from the audit were the implementation of category one prompt card to ensure smooth communication pathway; continue reviewing CS that fell outside the 30-minute time limit, listing reasons for the delay and any remedial action taken; and to ascertain midwifery views on scrubbing.

The maternity risk register recorded on 26 November 2013 a risk of normal vaginal delivery rates being below the national average. The normal vaginal delivery rate remained amber to red on the maternity dashboard. The maternity dashboard target was 70%. The risk register recorded that the rate was 54% to 58% in the previous six months. An action plan was in place; this included the
choice of birth needs being discussed at 36 weeks gestation; the introduction of a birth choices team; community midwives offering home triage assessments to increase the homebirth rate, to enable women who were booked for a homebirth to be assessed without having to visit the hospital. We saw that the risk was on the risk register from 2013 and update regularly. The risk register recorded an update to the risk on the 12 October 2017 that birth planning was working well. However, the home birth rate was down by 1%. An action plan was being requested by the service from the community midwifery manager to improve this.

Breast feeding rates were identified on the maternity risk register. Breast feeding rates were also red on the maternity dashboard for the previous 12 months, with the exception of May and July 2017. The trust target was 85%. Between December 2016 and September 2017, the highest rate was 72.3% in July 2017 and the lowest rate was 64.3% in December 2016.

Women were discharged with contact details for the maternity service to enable them to contact the service for advice or if they experienced any issues once they had been discharged We saw staff discussing women’s discharge planning with them on post-natal wards. For example, we saw staff giving women advice on cot death risks, including sleeping positions for babies.

The fetal anomalies obstetric sonographer worked in line with accepted authorities in this field and followed Antenatal Reproductive Choices (ARC). The service had relevant accreditation and audit in line with the National Screening Committee guidance for screening for detection of fetal anomaly. Sonographers told us 100% of women attended their 20-week ultrasound scan. Staff told us women not being seen at 20 weeks was “extremely rare” and usually due to women not attending the allocated appointment. Staff told us there were six appointments a day, which were allocated for urgent scans.

Bereaved parents were offered a ‘kid glove’ appointment six to eight weeks after discharge to discuss post-mortem results and implications for future pregnancies. The midwifery staff who had provided care at the time of delivery would accompany parents at the meetings, as far as possible.

**Learning from complaints and concerns**

Women and families we spoke with knew how to raise concerns or make a complaint.

Between October 2016 and October 2017, there were 13 complaints to maternity services. All complaints were responded to and closed in less than 25 workdays. Six of these complaints were about care, three complaints were about clinical treatment and diagnosis, two were clinical treatment operative procedure, there was one complaint each for treatment and care information and breach of confidentiality.

We saw evidence of appropriate responses to complaints, including apologising to women and meeting with them to review their notes and offer explanations.

Complaints were discussed as part of the weekly risk meetings. We asked several staff members if they could give us examples of any learning from complaints. We were told complaints were fed back to staff but staff on the wards could not give us any specific examples of changes to practice as a result of a complaint.

The Head of Midwifery and ward managers told us women complaints were dealt with immediately on the wards. Where possible the service would try to resolve any issues directly with the woman involved. If this was not possible, the woman was signposted to the patient advice and liaison service (PALS). The complaints department handled all formal complaints.

Complaints were standard agenda items at monthly maternity and gynaecology risk meetings.
We saw information on making complaints and the hospital PALS service was available across maternity services.

**Is the service well-led?**

**Leadership**

Maternity services had a clearly defined accountability structure. The clinical director told us the trust’s medical director was approachable. The clinical director met monthly with the Chief Executive Officer (CEO). However, we were told the meeting was not minuted.

Maternity staff told us the board did ‘walk arounds’ the hospital and were visible. However, sonographers in ultrasound told us they did not see the board and had not seen the new CEO.

During the inspection, we were told by staff that over 90% of decisions for caesarean sections were made by registrars. However, an audit of elective lower segment caesarean section (LSCS) in June 2017 found 82% of decisions were discussed with a consultant. Staff also told us consultants were not always visible on the labour ward.

We viewed a flowchart for maternity services dated October 2017. This demonstrated how leadership of maternity services was structured from the ward to the Head of Midwifery (HOM). The Head of Midwifery (HOM) reported to the director of nursing, who was the board lead for midwifery. The Head of Midwifery (HOM) presented a ‘safe staffing’ report twice a year to the board.

All the staff we spoke with told us the Head of Midwifery (HOM) was accessible and visible. For example, a health care assistant (HCA) told us, “You do see them around all the time, we have their telephone number. We can contact them.” A band seven midwife told us, “Head of Midwifery is hands on. She is very good at developing particular midwives. She has an office on Aspen ward and the door is always open.” The HOM told us staff had 24 hour access to their telephone.

The Head of Midwifery (HOM) had an assistant Head of Midwifery (HOM), who had oversight of the clinical governance midwifery manager, senior outpatient midwifery manager, senior inpatient midwifery manager and specialist midwifery teams. Staff told us the assistant Head of Midwifery (HOM) was approachable and supportive.

Staff at the antenatal clinic told us the matron was visible and approachable. The maternity service had a range of lead midwives; these were midwives whose specific job role was related to the areas they led on. Lead midwives were not included on staffing rotas for antenatal care or the delivery suite. For example, there were lead midwives for education, safeguarding, diabetes, sexual health, mental health, parent education, and learning disability.

**Vision and strategy**

The trust’s values were displayed on noticeboards on all the wards and clinics we visited. The values were, “Respect and dignity; striving to excel; professional standards; working together; care with compassion.” Most staff told us they were aware of the trust’s values as these were linked to staff professional development and annual appraisals. The service also had the NHS England ‘six C’s’, these were values that were to underpin practice. The ‘six C’s” were “care, compassion, competence, communication, courage, commitment.”

The trust had produced a ‘maternity safety improvement plan’, dated March 2017. The improvement plan was in response to the Department of Health’s (DOH) publication ‘safer maternity care’ dated October 2016. The plan included the introduction of a human factors sub-group in November 2016. The sub-group’s objective was to examine the role of people in the delivery of safe care and treatment.
Culture

We found a positive culture in maternity services. Staff reported that they felt supported by their immediate line management and that they had good working relationships with other specialties in the hospital. New members of staff said that they were made welcome and everyone was willing to help out.

Staff we spoke with were positive about the culture of team working in maternity services. For example, a member of staff in antenatal clinic told us, “It's a lovely place to work. The culture is really good. When it's busy everyone chips in.” A staff member on the delivery suite told us, “It's busy, but, it's manageable. We are a supportive team.”

The Head of Midwifery (HOM) was a ‘Freedom to Speak Up Guardian.’ These are employees in healthcare who provide challenge, learning and support to the healthcare system as a whole by reviewing trusts' speaking up culture and the handling of concerns where they have not followed good practice. Staff told us managers encouraged staff to raise concerns.

Governance

There were a range of governance meetings to ensure information flowed from board to ward. For example, the directorate sat within the women and children's directorate. The Head of Midwifery (HOM) attended monthly directorate business meetings where finance and performance across the directorate were discussed.

The services strategic goals were monitored via the directorate risk and governance meeting. The meeting looked at maternity key performance indicators’ (KPI) and decided strategy to meet or improve the KPIs.

Maternity had a dashboard, which was used to monitor KPIs. The dashboard was reviewed at monthly maternity and gynaecology risk governance meetings. There were also monthly managers meetings; these were attended by the maternity ward managers.

We saw schedules of monthly maternity meetings displayed on noticeboards across maternity services. For example, meetings included departmental audit meetings, labour ward forum, stillbirth review meetings, maternity medicines management group. The schedule included the time, date and venues of the meetings from January to December 2017.

Maternity services had a specialist maternity governance team. The team consisted of a band eight clinical governance manager, band six lead governance midwife and consultant lead. The maternity clinical governance manager told us they met on a bi-monthly basis with the maternity governance consultant lead.

The maternity governance meeting fed into the maternity monthly risk meeting. These were meetings where incident trends and near misses were discussed.

Following our inspection the trust informed us that there were regular six monthly workforce committee and board reviews of maternity workforce requirements.

Midwifery related practice issues were discussed at monthly professional midwifery advocate meetings. Drug and medicine related incidents were discussed at the maternity medicine management group.

Management of risk, issues and performance

There were monthly maternity and gynaecology risk meetings. The Head of Midwifery (HOM), clinical director, assistant Head of Midwifery (HOM), midwifery manager, consultant obstetrician
and complaints manager attended the meetings. Incidents, complaints, and the risk register were regular agenda items for the meeting.

The risk register contained 15 items relating to maternity services. However, these did not contain timescales for when identified actions should be completed.

Staff told us the Head of Midwifery (HOM), clinical director and maternity governance lead reviewed the risk register quarterly. The risk register was also reviewed monthly at the managers meeting and at the directorate monthly risk meeting.

The risk register highlighted a staffing ratio of 1:36 in October 2017. The Head of Midwifery (HOM) kept tight control on the monitoring of staffing numbers. The Head of Midwifery (HOM) told us the staffing ratio meant the trust would not ask maternity to make cost savings on staffing.

An audit of the 30-minute decision to delivery time interval for category one caesarean sections (CS) between April and September 2017 recommended a review of scrub midwife’s allocation at time of CS to determine any impact on patient care. The audit also recommended a review of ODP activity at time of CS to determine any impact on patient care. However, obstetric theatre staff told us actions following the recommendations had not been implemented and were unsure about when these would be implemented.

The staffing ratio was on the trust’s risk register. The risk register recorded the trust’s intentions were to fund and maintain a retrospective ratio of 1:34 in 2016/17 as defined via safe staffing reviews. Birthrate Plus recommends 1:28 low risk, 1:34 higher risk. The risk register acknowledged the midwife to patient ratio was not at the agreed level according to Birthrate Plus. The rate of women in labour receiving one to one care was 82.4%, this was lower that the trust’s 90% target. In mitigation the trust had put controls in place including regular and ongoing workforce planning; maternity safe staffing review; business cases produced to support increased activity across ‘sliding scale mechanisms’; 1:34 funding secured for 5100 women; all students who qualified as midwives with the trust being offered fixed term contract; short term workforce contingency planning in place; staff working flexibly across hospital and community settings; and monthly meetings with ward managers to ensure staffing levels were adequate for each area.

However, the risk register also recorded that increasing case complexity and a high midwife to birth ratio increased risks to women and babies; the risk register also recorded that only one part time scrub nurse was available on the delivery suite, this posed a risk to the elective list being delayed during the undertaking of unplanned theatre cases. Furthermore, the risk register had been updated on the 12 October 2017 and recorded that the ratio had increased to 1:36.

The risk register did not have dates for action plans and did not contain timescales for the completion on actions.

In response to the NHS England ‘saving babies lives’ (2016) care bundle the maternity service had completed actions to meet the requirements of the ‘saving babies lives’ care bundle, with the aim of reducing stillbirths, neonatal deaths, and intrapartum brain injuries.

**Information management**

Staff told us there was good access to information at the trust. The Head of Midwifery (HOM) told us they received an updated maternity dashboard every month from the maternity governance midwife. The maternity IT manager also sent weekly statistics. For example, the IT manager updated the Head of Midwifery (HOM) weekly on the delivery rate at the birth centre.

The maternity IT manager produced the annual maternity report; this was based upon hospital demographic and performance data. We saw copies of the 2017 report were available to women and staff across maternity services.

**Engagement**
There was a range of methods for engaging the public. For example, the maternity service had a ‘women’s experience’ lead that was also a parent education co-ordinator. The ‘women’s experience’ lead midwife co-ordinated the friends and family test (FFT). (Please see the caring section of this report for FFT results).

Staff had the opportunity to provide feedback daily at handover meetings as well as at ward meetings.

The antenatal department produced a monthly ‘antenatal and new-born screening’ letter for staff and prospective parents. The clinic also offered open days, for example, we saw a November 2017, ‘preparing for parenthood’ open day that was advertised in the antenatal clinic.

The maternity services liaison committee (MSLC), (these gather insights into how well maternity services are working locally by talking to new parents and their families), had 30% patient representatives on the committee.

The trust had introduced bi-monthly Schwartz rounds for staff. These reflective practice forums provided an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. Staff who had attended a Schwartz round told us they had found them useful. However, we also spoke to two members of staff who told us they were unable to attend the forums due to work commitments.

Staff had access to an independent counselling service. The Head of Midwifery (HOM) told us some staff had received support from the counselling service to resolve workplace conflict.

Learning, continuous improvement and innovation

Staff told us funding was unavailable for innovation and improvement. For example, the maternity education department had submitted a business case for funding to merge the trusts and maternity training data and this had been declined due to costs.

Maternity services had employed an audit midwife. The audit midwife was involved in the Phoenix trail, the trial was looking at whether delivery in women with pre-eclampsia between 34 and 36 weeks of gestation reduced maternal complications without short and long term detriment to the infant compared to expectant management and delivery at 37 weeks of gestation.

The delivery suite was involved in the safety culture, quality improvement and realistic evaluation (SCQUIRE) project in 2016 and 2017. This was a project developed by the Kent, Surrey and Sussex Academic Health Sciences Network. The project was an evaluation study to identify effective strategies of working in particular settings. Work was still in progress on the project at the time of inspection.
Surgical services at Dartford and Gravesham trust provide elective day-stay and inpatient care. The specialities covered are general surgery, gynaecology, orthopaedic and ear nose and throat (external provider). Only low risk patients have operations on this site as there are no support services.

There is a dedicated surgical ward, day surgery unit and pre-assessment unit which undertakes pre-assessment for both Queen Mary’s hospital and Darent Valley hospital.

We inspected the surgical admission lounge, theatre suite and Avery Hill Ward at Queen Mary’s hospital.

(Source: Routine Provider Information Return—“Sites-Acute” tab)

The trust had 22,165 surgical admissions between July 2016 and June 2017. Emergency admissions accounted for 5,180 (23%), 12,036 (54%) were day case, and the remaining 4,949 (22%) were elective.

(Source: CQC Insight)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The trust had a mandatory core skills training policy. This was due to be updated in September 2017. The mandatory training programme was delivered either face to face and via online modules.

The trust launched e learning in December 2016, and used the e-learning computer system.

In April 2017 all mandatory core skills monitoring and recording was centralised within each department. This enabled department or ward managers to have oversight of mandatory training compliance and address any issues. We reviewed two mandatory training records for staff and saw it was easy to check the status of mandatory training. The trust had aligned incremental pay progression with completion of mandatory training from January 2017.

We saw evidence in the ward and theatre meeting minutes of discussions attendance at mandatory training and improved compliance. In addition, the requirement for mandatory training completion two weeks prior to their individual performance review was discussed. Managers were proud of the improvement made in mandatory training compliance.

The trust set a target of 85% for completion of mandatory training modules, apart from infection prevention level 2 where the target was 95%. In their provider information request the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and then by staff group.
Overall, mandatory training compliance was 90 per cent, which was better than the trust target of eighty-five per cent.

Below is a breakdown of compliance for mandatory training modules between April 2016 and March 2017 for all staff in the surgery core service at the trust.

The 85% training target was met for seven mandatory training modules. The target was not met for the remaining six modules.

(Source: Routine Provider Information Request P40 – Statutory and Mandatory Training)

Safeguarding

Safeguarding training completion rates

The trust held a safeguarding committee quarterly - Adults and Child Safeguarding Leads attended and submitted reports. The Director of Nursing and Quality attended the safeguarding Boards and the adult and child safeguarding lead attended the sub groups.

The adult safeguarding lead attended the adult health leads meeting and both the adult and child safeguarding leads attended external safeguarding supervision.

Adult and child safeguarding lead had direct contact with the designated safeguarding leads in the local clinical commissioning groups and the Police and/or the Coroner if required.

The contact details of the named safeguarding lead for adults and the named safeguarding lead for children were displayed on each ward and department we visited.

One of the matrons was the adult and children safeguarding lead for Queen Mary's hospital and had level three adult safeguarding and level two children safeguarding training.

Queen Mary's hospital did not treat patients under the age of 18 years old, therefore only level two child safeguarding was required to be undertaken by staff.

We spoke to staff who knew the process for reporting safeguarding. None had reported a safeguarding concern but could give examples of what and how they would report. The trust made 92 safeguarding referrals in the 12 months before the inspection. This information was not broken down by hospital site therefore, it was not clear if any were from Queen Mary's hospital surgical services.

The trust set a target of 85% for completion of safeguarding training. This was achieved within Queen Mary's hospital.
As noted above under mandatory training, in their PIR the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and then by staff group.

We contacted the trust on 31 October 2017 and asked them to supply a breakdown by staff group for each core service.

The below is a breakdown of compliance for safeguarding training modules between April 2016 and March 2017 for all staff in the surgery core service at the trust.

**Trust wide**

The trust reported that no staff in surgery were eligible for safeguarding children level 3.

The 85% completion target was not met for safeguarding adults level 1, but was met for safeguarding children levels 1 and 2.

**Queen Mary’s Hospital**

The 85% target was met for all three safeguarding modules for which staff at Queen Mary’s hospital were eligible.

(Source: Trust Provider Information Request P18)
Cleanliness, infection control and hygiene

There were infection prevention and control policies and procedures readily available to staff on the trust’s intranet, as well as the public via the trust’s main website. These included, but were not limited to, hand hygiene policy, deep clean procedure, isolation policy, laundry guidelines, and mattress policy. In addition, there were policies relating to healthcare associated infections, such as Methicillin resistant staphylococcus aureus and Clostridium difficile and norovirus. This was in line with the recommendations of The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance (the code) criterion 9; ‘Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections.’

We saw staff adhered to the infection prevention and control policies and demonstrated good hand hygiene in line with best practice. Data supplied to us showed 100% hand hygiene compliance between August 2017 and October 2017 on Avery Hill ward and recovery. This was consistent with our observations during the inspection. All staff we saw were compliant with the ‘bare below the elbow’ policy in clinical areas.

Each department we visited was visibly clean and tidy. An external cleaning company provided cleaning services. This was inspected on a weekly basis by the cleaning supervisor and matron. This provided assurance that there was oversight of the effectiveness of the cleaning. Staff were able to give us an example of communicating with the external company regarding cobwebs within the pre-assessment department.

All patients attending the hospital for pre-assessment prior to admission for a procedure were swabbed for Methicillin resistant staphylococcus aureus. Swabs were taken from nose and groin of all patients. Rarely were patients admitted for long enough for repeat Methicillin resistant staphylococcus aureus swabbing seven days after admission.

The trust had a designated infection prevention and control team, in line with the recommendation of criterion one of the code. The team included the designated lead for infection control, qualified infection control nurses, and a consultant microbiologist with infection control responsibilities. The team worked across the trust, and coordinated with other healthcare professionals, patients, and visitors. The infection prevention and control team responsibilities included but were not limited to, giving advice, providing education and training (both formal and informal), monitoring infection rates, and auditing of infection prevention and control practices. We saw posters with the name and contact details of the Director of Infection Prevention and Control displayed within the departments.

The ‘Infection Prevention and Control Annual Report’ for April 2016 to March 2017, detailed activities to ensure the hospital met the requirements of the code. The report was mapped to the compliance of criteria set out within the code of practices and included systems to manage and monitor the prevention and control of infection, maintain a clean environment, ensure correct use of antimicrobials and ensure all staff were fully involved in the process of preventing and controlling infection.

Personal protective equipment was available and used correctly by staff while we were within the department. Personal protective equipment refers to protective clothing such as aprons and gloves designed to protect the wearer's body from injury or infection.

The trust had a ‘prevention of infections associated with peripheral venous catheters policy’ version 3 (dated June 2016), which included information on documentation, hand hygiene, skin
cleaning and how often to review the device, in line with National Institute for Clinical Excellence QS61, statement five, vascular access devices. We reviewed three patient records and found the policy had been adhered and was documented correctly.

The ward flooring was seamless and smooth, slip-resistant, easily cleaned. All chairs had a cleanable fabric cushion and the cushions could be removed to be cleaned both sides.

Each area had detergent cleaning wipes, antibacterial cleaning wipes and we saw staff using these correctly. For example, wiping down the trolley after every use in the pre-assessment unit.

We saw posters showing the National Colour Coding System for hospital cleaning equipment and materials. The National Reporting and Learning Service developed a National Colour Coding Scheme for cleaning materials thus ensuring that these items are not used in multiple areas, therefore reducing the risk of cross-infection. We saw completed records of daily, weekly and monthly cleaning.

An audit undertaken in October 2017 showed 98% compliance with cleaning standards within theatres, this was consistent with our findings.

We saw waste was stored and segregated in line The HTM 07-01 (The Safe Management of Healthcare Waste Memorandum).

We inspected seven yellow sharps disposal bins in theatres and the ward and found them to be correctly assembled and labelled. This was in line with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The hand washbasins in all areas were compliant with health building note HBN 00-09 Infection control in the built environment. There were no plugs and no overflow. They had lever operated mixer taps.

The cleaning chemicals were stored in a locked cupboard on the ward. This was in line with the Guidance on the Control of Substances Hazardous to Health Regulations 2002.

Environment and equipment

On the day of inspection, we visited the pre-assessment unit, day surgery unit, Avery Hill ward, theatres and recovery. All patients were admitted to the day surgery ward if they were having a local or general anaesthetic procedure. From here, they went to theatre, then recovery and back to the day surgery ward if they were going home on the same day and to Avery Hill ward if staying overnight.

The day surgery unit had nine day-case trolleys in the morning and eight in the afternoon, Avery Hill ward had 15 beds and eight trolleys, side rooms were available.

There were computers on wheels, which were useful to take to the patient’s bedside, for example to show the patient their x-ray.

We inspected eight pieces of electrical equipment and found all of them had undergone electrical safety checks within the last 12 months.

We saw that the Association of Anaesthetists of Great Britain and Ireland safety guidelines ‘Safe Management of Anaesthetic Related Equipment’ (2009) was not adhered to. This guideline stated that records must be kept of each safety check of all anaesthetic machines in a logbook, which is kept with the machine. This meant there was no assurance that vital safety checks had been undertaken and the equipment was safe to use.
In theatres, there was an effective system to ensure the recording of medical implants used. This was in accordance with the Medical Devices Regulations 2002. A medical implant is a device intended to be either totally introduced into the body or to be partially introduced into the body through surgery and to remain there for at least 30 days.

We inspected the theatre resuscitation trolley. All items were in date. We looked at two months of records and saw that the trolley had been checked daily. We inspected the resuscitation trolley on Avery Hill ward. We checked 15 items and all were in date. We saw records of checks for the previous two months and they were complete. This meant there was a system, which ensured emergency equipment was safe and available for use.

We inspected the resuscitation trolley on the day-surgery unit. We checked 17 items and there were five adrenaline pre-prepared syringes, which expired in October 2017 despite recent records to say all items checked an in date. This meant that the system for ensuring that medicines used for resuscitation were safe to use was not effective. We highlighted this to the ward manager who immediately arranged a replacement and told us they would follow up with the staff member who undertook the checks. We saw records of checks for the previous two months and saw that they were complete.

All fire extinguishers we examined had an annual maintenance record. All wards had visible fire action signs and exit signs in the event of an emergency. Fire exits were free from obstruction.

Theatres had a difficult intubation (placing a breathing tube in the windpipe) trolley, which meet the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Difficult Airway Society standard. The difficult intubation trolley had completed records to show it was checked on a regular basis and safe to use.

Theatres were fitted with an uninterrupted power supply which meant lifesaving equipment would continue to operate in the event of a power cut.

In theatres, we observed staff checked all surgical instruments and gauze swabs before, during and at the end of patients’ operations. This ensured no items were left behind during surgery and was in line with the Association for Perioperative Practice guidelines.

The clinical room on Avery Hill ward contained a medicine fridge, which displayed the temperature. The staff monitored the temperature of the fridge once a day and this was recorded in a folder, which also contained actions to take if the temperature was not within normal limits. It is important for some medicines to be kept at a particular temperature to maintain stability. We viewed the records and they were complete.

**Assessing and responding to patient risk**

The trust policies provided guidance, which was supported by a range of risk assessment tools for the staff to use to assess patient risk. These were available to all staff via the intranet and used to ensure the staff were aware of them and how they could mitigate avoidable patient risk.

Comprehensive risk assessments were carried out for patients in line with national guidance. These were carried out both pre-operatively and post-operatively to highlight those who may need additional support. We reviewed three care records, which showed risk assessments and actions taken. This included those patients at risk of falls, blood clots and pressure area damage.

Crash call arrangements were in place and staff had good knowledge of what to do in the event of a patient deteriorating and gave an example of when a situation had gone well.
The pre-assessment clinic was led by nurses and supported by health care assistants and had a dedicated lead. If staff felt the patient required a medical review they were referred for an anaesthetist review. Anaesthetists ran clinics every week and patients were reviewed and referred to other healthcare staff if required. Patient pre-assessments were undertaken in line with routine preoperative tests for elective surgery The National Institute for Health and Care Excellence guideline NG45 and this was demonstrated within the patient’s records.

Health care assistants did the initial screening and blood tests, then the trained nurse did a full assessment. If a patient did not meet the criteria for surgery at Queen Mary’s hospital their procedure was undertaken at Darent Valley hospital.

The American Society of Anaesthesiology classification grading of patients were clearly recorded on admission in the surgical assessment unit. The American Society of Anaesthesiology grading is a system for assessing the fitness of patients before surgery. Of the three records we looked at, all had a clear American Society of Anaesthesiology grading recorded. Generally, only American Society of Anaesthesiology 1 and American Society of Anaesthesiology 2 patients had surgery at Queen Mary’s hospital as these were considered low risk and their needs could be met.

Arrangements for handover and shift changes ensured people were kept safe. There were handover meetings and ward rounds. Handover procedures included information about all patients and highlighted any areas of concern such as patients at risk of falls or patients developing pressure areas.

Venous thromboembolism is a condition where a blood clot forms in a vein, most commonly in a leg vein but a blood clot can travel to the lungs. Venous thromboembolism risk assessments are undertaken to assess the risk of patients developing a Venous thromboembolism. We reviewed three patients records; two of these contained a fully completed venous thromboembolism assessment. The resident surgical officer told us it was the responsibility of the anaesthetist to undertake the initial venous thromboembolism assessment prior to their procedure and theirs to review it 24 hours later. The patient with the missing venous thromboembolism assessment had it completed immediately.

Data provided to us by the trust showed 100% compliance with venous thromboembolism assessments between September 2016 and April 2017 on Avery Hill ward.

Staff told us they checked the pregnancy status of female patients of potential childbearing age on the morning of planned surgery by undertaking a pregnancy test. We saw the results of the test were documented on pre-operation checklist. Two people were required to verify and document the result.

A system was in place to support patients when they were discharged. On discharge; patients were given the ward’s telephone number and could contact the ward 24 hours a day seven days a week.

Staff followed the National Patient Safety Agency five steps to safer surgery as part of the World Health Organisation surgical safety checklist in all operations we observed. The purpose of the checklist was to check all safety elements of a patient’s operation before proceeding. This included, for example, checking it was the correct patient, the correct operating site, and that all the staff were clear in their roles and responsibilities. Although we observed good practice in the use of the checklists in theatres, the documentation of the checklists was poor. We reviewed 10 World Health Organisation surgical safety checklist and nine were incomplete. All nine were missing information, which included: staff present during the operation, patient details and completion of the ‘time out stage’. This meant the trust could not be assured that the safety checks had been undertaken correctly and there was accurate records kept of the operation.
We raised our concerns with regard to the World Health Organisation surgical safety checklist documentation with the trust. The trust said they had taken a number of actions to address our concerns which included that patients did not leave the theatre until the checklist was fully completed, a member of staff could sign to confirm the time out stage had been completed on behalf of the surgeon. In addition, the World Health Organisation surgical safety checklists would be audited daily to ensure compliance. Audit findings would be discussed at surgical governance meeting and the theatre users group, which met monthly.

Compliance with World Health Organisation surgical safety checklist was varied. Data supplied to us showed compliance ranged between 76% (July 2016) and 100% (October 2016). This meant the trust could not be assured that the World Health Organisation surgical safety checklists were undertaken consistently.

All qualified members of staff were required to complete intermediate life support training. The matrons and resident surgical officers were required to complete advanced life support training. If a patient became acutely unwell during admission, the staff would stabilise the patient and then call an emergency ambulance to transfer the patient to Darent Valley hospital. Darent Valley hospital was the centre for treating acutely unwell patients. There was a policy in place, which allocated staff roles when an acutely unwell patient required rapid transfer.

Staff gave us an example of a patient who had a cardiac arrest within the ward who was successfully resuscitated and transferred to Darent Valley hospital for intensive care. Staff were proud with their response to the emergency.

Staff participated in a monthly ‘hot scenario training’. Staff told us the last scenario was about a collapsing patient. This meant staff had the opportunity to practice the skills needed in an emergency. All staff were familiar with the emergency patient transfer kit bag.

Surgery services were effectively using a system to monitor acutely ill patients. The trust was using the National Early Warning Score system for the monitoring of vital signs in adult patients on the ward to highlight early signs of deterioration of patients’ conditions. The National Early Warning Score prompted staff to take further action, such as increasing the frequency of monitoring vital signs and informing medical staff so they could review patients and escalate treatment if required. In three patient records, we saw the early warning score charts completed and used correctly.

The trust undertook monthly audits to ensure compliance. Data supplied to us showed 100% compliance with monitoring of vital signs on Avery Hill ward between January and July 2017. We reviewed three patient records, which all showed, evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient’s health post-surgery. This was in line with National Institute for Health and Care Excellence guideline CG50: Acutely ill patients in unit- recognising and responding to deterioration.

**Nurse staffing**

The day surgery unit and Avery Hill ward were staffed to their agreed establishment during the inspection. Planned versus actual staffing levels were displayed on the wards for patients and members of the public to see. The unit was in the process of reviewing their staffing establishment to enable the trust to review the staffing versus their activity.

Staff rotated through the day surgery unit and Avery Hill ward on a three monthly basis. This ensured all members of staff had up to date skills to work in each area as needed.
The trust temporary workforce provided staff for any shifts that needed covering in theatres. However, there were no assurances that agency staff had the qualifications, competence, skills and experience to safely undertake their role. The trust temporary workforce department were responsible for undertaking all the relevant checks for agency staff. Although staff were confident that planned long-term agency had the checks undertaken they were not assured that last minute agency staff had the checks undertaken. We raised this issue with the trust who told us they had taken a number of actions. No agency worker would be set up on the health roster system until the required documents were received by temporary staffing. Where there was a replacement ad-hoc agency staff member the theatre co-ordinator made a call to the staff bank department to ensure that the correct documents had been received, the staff member would not be allowed to start work until this was confirmed. Theatres had also spoken to the two agencies utilised to request that the coordinators are included in the documents sent to staff bank, so that a dossier was maintained on site.

Agency staff were not used in the day surgery unit or Avery Hill ward. Vacant shifts were covered internally by permanent staff.

Trained bank or agency nurses were given a Clinical Bank / Agency Induction Booklet when working for the first time on each ward. It identified a checklist of their clinical skills, an induction checklist and important information such as adult / child safeguarding, cardiac arrest, documentation, fire alarms and incident reporting. This form was signed by the bank staff member and then countersigned by the nurse in charge of the shift. We did not see any bank or agency staff on duty so were unable to verify if this process was followed.

We saw staffing levels met the Association for Perioperative Practice guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list.

There was a trust induction programme for new staff. All staff were expected to complete an induction programme and new staff were inducted on to the ward or department to ensure they had a good knowledge of the important aspects of working there, such as where to find the resuscitation trolley.

**Queen Mary’s Hospital**

Queen Mary’s hospital reported its qualified nursing staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Patient Ward - Avery Hill</td>
<td>24.3</td>
<td>24.3</td>
</tr>
<tr>
<td>Main Theatres</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>Pre-Assessment</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50.3</strong></td>
<td><strong>47.8</strong></td>
</tr>
</tbody>
</table>

The main theatres were the only reporting unit to report vacancies.

(Source: Routine Provider Information Request – P16 Total numbers – Planned vs actual tab)
Vacancy rates

Between July 2016 and June 2017, the trust reported a vacancy rate of 12.3% for qualified nursing staff in Surgery. This did not meet the trust target of having a vacancy rate of 9% or lower. The staffing vacancy rate at this hospital was 5.8%

(Source: Routine Provider Information Request P17 Vacancies)

Turnover rates

- Between July 2016 and June 2017, the trust reported a turnover rate of 8.5% for qualified nursing staff in Surgery. This did not meet the trust target of having a turnover rate of 9% or lower. The staff turnover rate at Queen Mary’s hospital was 13.8%.

(Source: Routine Provider Information Request P18 Turnover)

Sickness rates

- Between June 2016 and May 2017, the trust reported a sickness rate of 3.8% for qualified nursing staff in Surgery. This did not meet the trust target of having a sickness rate of 3.5% or lower. The staff sickness rate at Queen Mary’s hospital was 7.5%.

(Source: Routine Provider Information Request P19 Sickness)

Bank and agency staff usage

Between August 2016 and July 2017, the trust reported bank usage of 2,665 shifts and agency usage of 3,501 shifts for qualified nurses in Surgery. Over the same period there were 623 shifts that were not filled by bank or agency staff to cover sickness, absence or vacancies. The data supplied by the trust don’t allow us to calculate usage rates.

- Queen Mary’s’ hospital:
  - Bank: 840 shifts
  - Agency: 1,491 shifts
  - Not filled: 33 shifts

(Source: Routine Provider Information Request P20 Nursing – Bank and Agency)

Medical staffing

Medical cover for the ward was provided by a team of three resident surgical officers working a variety of shifts. A resident surgical officers is a junior doctor in training. The resident surgical officers we spoke to felt well supported by the consultants. They said the consultants were approachable and were easily contactable. The medical team at Darent Valley hospital provided medical advice via the telephone out of hours.
Queen Mary’s hospital reported its medical staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics</td>
<td>6.3</td>
<td>2</td>
<td>4.3</td>
</tr>
<tr>
<td>General Surgery</td>
<td>9.2</td>
<td>5</td>
<td>4.2</td>
</tr>
<tr>
<td>Renal</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Site RSO Team</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25.5</strong></td>
<td><strong>10</strong></td>
<td><strong>15.5</strong></td>
</tr>
</tbody>
</table>

These were high vacancy rates reported; 4.3 of the 6.3 anaesthetist posts, 4.2 of the 9.2 general surgeon posts, the one renal post and all four trauma and orthopaedic surgeon posts. The overall vacancy rate for medical staff was 64.7%.

(Source: Routine Provider Information Request – P16 Total numbers – Planned vs actual tab)

Vacancy rates

Between July 2016 and June 2017, the trust reported a vacancy rate of 10.5% for medical staff in Surgery. This did not meet the trust target of having a vacancy rate of 9% or lower. The vacancy rate at Queen Mary’s hospital was 64.7%. This is much higher than the trust target and is a risk to patient safety.

(Source: Routine Provider Information Request P17 Vacancies)

Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 38.3% for medical staff in Surgery. This did not meet the trust target of having a turnover rate of 9% or lower. The turnover rates at Queen Mary’s hospital were 20.0%. This higher than the trust target and may be a reflection of the culture of the organisation.

(Source: Routine Provider Information Request P18 Turnover)

Sickness rates

Between June 2016 and May 2017, the trust reported a sickness rate of 0.9% for medical staff in Surgery. This met the trust target of having a sickness rate of 3.5% or lower. The sickness rate at Queen Mary’s hospital was 1.4%.

(Source: Routine Provider Information Request P19 Sickness)

Bank and locum staff usage

Between August 2016 and July 2017, the trust reported locum usage of shifts and agency usage
of shifts for medical staff in Surgery. Over the same period there were shifts that were not filled by locum or agency staff to cover sickness, absence or vacancies. The data supplied by the trust does not enable a calculation of proportionate use of bank and locum.

(Source: Routine Provider Information Request P21 Medical Locums)

Staffing skill mix

In June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff was similar to the England average.

Staffing skill mix for the whole time equivalent staff working at Dartford and Gravesham NHS Trust

![Staffing skill mix chart]

(Source: NHS Digital Workforce Statistics)

Records

Patient records were a mixture of paper records and electronic records. The trust was in the process of converting to electronic notes and all paperwork within the notes was barcoded to enable it to be scanned into an electronic patient record.

The handover sheets, were updated at the change of shift and contained the following information: patients diagnosis, score, social circumstances, Methicillin resistant staphylococcus aureus screen, estimated date of discharge, diet and last had bowels open, plan of care.

Patients’ records were kept securely in line with the Data Protection Act. A courier was used to transfer records between hospital sites. Records were kept within the pre-assessment department once the patients were pre-assessed and deemed fit for surgery. If the patient was not suitable for surgery at Queen Mary’s hospital, the notes were transferred securely via a courier to Darent Valley hospital.

We reviewed three sets of patient notes. In all three the entries where legible, completed in black ink, were signed with the designation, dated and timed. All paper records were scanned into the
Medicines

The trust had a medicine policy, which was in date and referenced national guidance for example General Medical Council (2013), Good practice in prescribing and managing medical devices, and Nurse and Midwifery Council (2006), Standards for proficiency for nurse and midwife prescribers.

We inspected five medical gas cylinders in theatres. We found all of them to be correctly stored, labelled and within date. The wards had piped oxygen.

All controlled drugs were kept in a double locked cupboard within a room that had code lock to access. The keys to the controlled drug cupboard were kept with a trained nurse at all times. The controlled drug register showed records were fully completed. We checked two controlled drug stock levels against the records and found them correct. Controlled drugs are medicines liable for misuse that required special management.

We reviewed three medicine charts. They were legible, had drug allergies documented, had no missed doses, had the patient weight recorded and were signed. One chart did not have a venous thromboembolism assessment completed. This was rectified immediately when we raised it with the ward manager.

Both on the wards and theatres intravenous fluids were stored in locked room. We checked intravenous fluids and found them to be in date and intact. An audit on administration of intravenous fluids on Avery Hill wards showed 100% compliance in August 2017, 97% in September 2017 and 99% compliance in October 2017. This showed compliance with National Institute for Health and Care Excellence clinical guidance CG174 Intravenous fluid therapy in adults in hospital.

We saw ten blank prescriptions, which were kept in a locked cupboard. These were occasionally given to patients on discharge to obtain medicines. An effective process ensured these were tracked and monitored correctly. This was in line with NHS Protect security of forms guidance prescription.

Avery Hill ward had a clinical treatment room that was locked using a code lock. The code was only known to staff who required access and was not displayed anywhere near the door. Within the clinical treatment room, there were locked medicine trolleys, which were kept locked to the wall.

Medicines reminder charts were given to people upon discharge to help them take their medicines correctly at home. For example, they contained information regarding possible side effects and how often they should take the medicines.

National Institute for Health and Care Excellence guidance relating to Technology Appraisals was discussed at the Medicines Management Committee. Technology appraisals are National Institute for Health and Care Excellence recommendations on the use of new and existing medicines and treatments within the NHS.

Staff told us that pharmacist and pharmacy technician availability on Avery Hill ward was good. A pharmacy technician and pharmacist visited the ward on a daily basis during the week and checked the patient medicine charts, medicine stock levels and ensured drugs for the patients to
take home were available. Medicines advice was available out of hours via telephone to the pharmacist at Darent Valley hospital.

Overall trust performance for medicines reconciliation over the past year ranged between 73% to 89% at 24 hours post admission. Medication reconciliation is the process of comparing a patient's prescribed medicines to all of the medicines that the patient has been taking. This reconciliation is done to avoid medicine errors such as omissions, duplications, dosing errors, or drug interactions.

Between November 2016 and October 2017, there was 10 medication incidents reported across Avery Hill ward, day surgery unit and theatres. Four occurred on Avery Hill ward, four within theatres and two within the day surgery unit. Reasons for the incidents varied for example problem dispensing take home medicines and delay in administration of medicines. We did not identify any themes in relation to medicine incidents.

**Incidents**

The trust had an electronic incident reporting system to allow staff to report incidents. Staff we spoke to could identify what incidents to report and how to report them. Staff were able to give us examples of learning from incidents. This was different to Darent Valley hospital were staff said they did not always have time to report incidents and could not give examples of changes from incidents.

Surgical services across all sites reported 1767 clinical incidents in the twelve months prior to our inspection. It was not possible for us to breakdown the incidents into hospital or specific ward or department in the format provided to us. Of these incidents 76% resulted in no harm, 19% resulted in low harm, 4.5% in moderate and the remaining 0.5% resulted in severe harm or death. The top three themes of incidents reported were; grade three pressure ulcers (7% of all incidents reported), patient found on floor (5% of all incidents reported) and fall from bed (3% of all incidents reported). The most commonly reported incident across surgery at Queen Mary’s hospital was equipment not available (15 incidents) the second most commonly report incident was patient fall (9 incidents).

There were named governance leads across the specialities. The lessons learned from the review of incidents were distributed via a safety newsletter and on trust computer screen savers. We saw copies of the safety newsletter in staff rooms across the surgical service. Staff were positive about the trust intranet site and told us it contained lots of useful information and blogs with learning from incidents.

The trust had a number of trained investigators. All serious investigations were discussed along with the root cause analysis and action plan were discussed at the monthly Patient Safety Committee. This group fed into the quality and safety committee. The Clinical Commissioning Group attended the Quality and Safety Committee and this fed into the board.

All staff we spoke to were aware of how to report an incident via the electronic reporting system. A ward pharmacist gave an example of how they reported an incident about an incorrectly prescribed medication on a prescription chart. They received an updated with any outcome of incidents they reported either via email or in person

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to
cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between September 2016 and August 2017, the trust reported three incidents classified as never events for surgery. All three incidents were surgical/Invasive procedure incident meeting Serious Incident criteria.

September 2016: A patient had a left total knee replacement in July 2016: The patient was readmitted for management of post-operative infection in October 2016, which resulted in the need to remove the prosthesis. During surgery, the femoral component was found to be a right knee prosthesis.

July 2017 surgery undertaken conflicted with the consent form signed by the patient, which resulted in the patient’s ovaries being removed following a hysterectomy.

August 2017: A patient attended for an elective total hip replacement and during surgery, the hip joints were not fully matched to the needs of the patient.

There was learning from both serious and other incidents and change to practice. For example, we saw the prosthesis (medical implants) for joint replacements was well organised and labelled. This had been implemented since the never events. New whiteboards had installed within theatres and prior to the operation the surgeon would document on the white board the specific prosthesis required for the operation, the implants would then be checked against this. The surgical care plan had also been changed to document the prosthesis used.

We saw the prosthesis (medical implants) for joint replacements was well organised and labelled. This had been implemented since the never events.

All patients who suffered a never event were allocated a senior member of staff as their “never event advocate”. The matron explained how they were a “never event advocate” and explained how she telephoned the patient weekly to offer advice and support and update them on the progress of the investigation. This provided support for the patient after discharge home.

Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.
We saw evidence that the duty of candour regulation had been applied. The trust's root cause analysis report contained a section for duty of candour. It included checks that the patient and/or relative had been given a verbal apology, they had received a trust letter and been given a point of contact as well as an offer to share the outcome of the investigation.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents in Surgery which met the reporting criteria set by NHS England between September 2016 and August 2017. Of these, the most common type of incident reported was

- Pressure ulcer meeting serious incidents criteria with 11 (58% of total incidents)
- Slips/trips/falls meeting serious incidents criteria with four (21% of total incidents)
- Surgical/invasive procedure incident meeting serious incidents criteria with three (16% of total incidents)
- HCAI/Infection control incident meeting serious incidents criteria with one (5% of total incidents)

(Source: Strategic Executive Information System (STEIS))

The trust did not breakdown the 19 serious incidents therefore; it was not possible to know how many occurred at Queen Mary’s hospital.
Incidents that were reported went to a weekly serious incident declaration group where they were reviewed to ascertain if they met the Serious Incident Framework. It was open to all staff and chaired by the Director of Nursing. The trust had a number of trained incident investigators. All serious investigations along with the root cause analysis and action plan were discussed by the monthly Patient Safety Committee. This group fed into the Quality and Safety Committee. The Clinical Commissioning Group attended the Quality and Safety Committee and this fed into the board. We reviewed completed root cause analyses and saw they followed a set template and were thorough, with actions, action dates and responsible person for actions.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 23 new pressure ulcers, six falls with harm and four new catheter urinary tract infections between September 2016 and September 2017 for Surgery.

Staff collected safety information and shared it with staff, patients and visitors with results clearly displayed on each ward we visited.

There were no new pressure ulcers, falls with harm or new catheter urinary tract infections between September 2016 and September 2017 for Surgery at Queen Mary’s hospital.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Dartford and Gravesham NHS Trust

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(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The surgery services had processes to ensure care and treatment was aligned with current evidence-based practice.

Policies and guidelines were in place and reflected evidence based care and treatment. National Institute for Clinical Excellence guidance was circulated to the identified lead within each directorate or department together with a link to an on-line pro forma. The designated lead completed the pro forma to confirm it had been received. The Governance Department collated information that all areas had up to date National Institute for Health and Care Excellence guidance.

Quarterly reports were prepared for the Quality and Safety Committee (a subcommittee of the trust Board) on the status of National Institute for Health and Care Excellence guidance. In addition, an annual report was prepared for the Quality and Safety Committee this giving the committee the opportunity to scrutinise the compliance status.

The trust entered all medical devices onto national registers such as the joint register. This ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects at national level.
Care and treatment was based on the ‘enhanced recovery pathway’. These pathways ensure patients were encouraged to participate actively in their preparation and recovery by promoting early mobilisation, eating, and drinking normally. For example, hip and knee replacements. This helped to ensure a shorter recovery time. We saw the discharge process started during the pre-assessment appointment. This meant any support a patient may require was organised in advance.

To support patients to mobilise early following surgery, there were processes to review timely removal of catheters. This also reduced the risk of hospital-acquired infections associated with these devices.

In addition, National Institute for Health and Care Excellence guidance relating to Technology Appraisals was discussed at the Medicines Management Committee. When required the medicine was added to the formulary within three months of publication of the guidance.

Staff followed the National Institute for Health and Care Excellence guidance on preparing and prevention of surgical site infection prior to surgery. We observed in theatre adherence to National Institute for Health and Care Excellence guideline CG74: Surgical site infections: prevention and treatment. For example, we saw during pre-assessment patients undergoing joint replacements were advised patients to shower or have a bath using soap, either the day before, or on the day of, surgery.

We saw patients observations such as temperature a pulse were recorded correctly within their patient record. This was in line with National Institute for Health and Care Excellence guideline CG50: Acutely ill patients in unit- recognising and responding to deterioration.

We observed posters and screen savers on the trust computer system promoting the awareness of acute kidney injury. This ensured that staff were informed of current practice and guidelines in relation to acute kidney injuries.

Staff assessed patients’ physical, mental health and social needs in a holistic manner, this started at the pre-assessment stage. For example, staff obtained information about patients living accommodation to help discharge planning.

**Nutrition and hydration**

There was an effective process to ensure patients were starved correctly prior to undergoing a general anaesthetic, each patient was asked to confirm when they last ate and drank during the checking process on arrival to theatre. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum, patients were allowed to drink clear fluids up to two hours prior to their operation and patients having operations in the afternoon had an early breakfast, this was in line with best practice.

Patients undergoing joint replacement surgery were given high calories to drink the day before and on the morning of their operation. The drinks are specifically formulated to ensure patients are adequately hydrated and help the body cope with the stress of surgery.

The trust used a Malnutrition Universal Screening Tool scoring system to identify patients at risk of malnutrition. Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines, which could be used to develop a care plan. Patients admitted for longer than 24 hours following surgery should have had a Malnutrition Universal Screening Tool score.
We found the use of the Malnutrition Universal Screening Tool score was consistent we reviewed three patient records and all had a complete Malnutrition Universal Screening Tool assessment. This was undertaken at pre-assessment so that patients who required additional input to enhance their nutrition were referred to a dietitian.

Staff could refer patients to the Nutrition and Dietetics department at Darent Valley hospital. The dietician advised patients and staff on all aspects of diet and nutrition. None of the patients we reviewed had been referred to a dietician.

We saw special dietary needs were written on the board next to the patients for example if the patient was vegetarian. If a patient had a specific dietary need it would be highlighted at pre-assessment to ensure arrangements were made.

All patients we saw had drinks within reach. Staff were observed encouraging and assisting patients to drink.

Patients undergoing a day stay operation were offered light refreshments of a sandwich and drinks prior to discharge.

**Pain relief**

The department used the one – three pain score on rest and on activity. One being no pain and three being extreme pain. Patients scored their pain when they were resting and when they were moving. We reviewed three sets of patient notes and found evidence of completed pain assessments in all of the notes.

The staff told us they had good access to advice to manage patient’s pain following surgery. There was a dedicated anaesthetist during the daytime. Out of hours, the staff made contact with the anaesthetist in Darent Valley Hospital to support them with patient pain control.

The medicine charts contained pre-printed stickers for pain relief after surgery for example powerful pain relief if required in recovery. This meant powerful pain relief could be administered quickly if required. The medicine charts also contained anti-sickness regime to be followed if patients experienced sickness.

In audit, data supplied to us by the trust, which was undated 80% of patients, said pain relief was discussed with them before their operation. The same audit also showed 92% of patients felt reassured with the information they were given regarding pain relief. Fifty-eight percent of patients said there was no delay getting pain relief on the ward and 27% said there was a little delay.

Different types of pain relief were discussed with patients during pre-assessment. For example, epidural (pain relief injection into the back), regional pain relief block, or patient controlled analgesia (pain relief) or continuous analgesic infusions. A patient controlled analgesia is a method of allowing a person in pain to administer their own pain relief.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

Between June 2016 and May 2017:

- In total, patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
Urology patients at the trust had a slightly higher than expected risk of readmission for elective admissions when compared to the England average.

In total, patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Elective Admissions Graph](Image)

*by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity (Source: HES - Readmissions (01/06/2016 - 31/05/2017))*

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.
In 2015/16 the proportion of patients undergoing surgery for groin hernias at the trust that reported an improvement was lower than the England average according to both the EQ VAS and EQ-5D indicators. However the proportion of patients that reported a worsening of their condition was slightly lower than the England average according to EQ VAS, and similar according to EQ-5D.

For Varicose Veins, performance was better than the England average according to both indicators.

For hip replacements, performance was similar to the England average according to both indicators.

For Knee replacements, performance was similar to the England average according to both indicators.

(Source: NHS Digital)

Queen Mary’s hospital contributed to national audits in order to measure patient outcome. These audits included the national joint registry, this national joint registry monitored patient outcomes after knee or hip replacement. It enabled patients to be monitored and recalled if necessary as a record is kept of all the information relating to their operation.

Competent staff

Appraisal rates

Between July 2016 and June 2017, 82.2% of staff within surgery at the trust had received an appraisal. The trust told us in their provider information request that their completion target is 85%, though this only applies to staff that have been employed for more than one year.

The service had an appraisal rate of 87 per cent which was equal to trust target.

The split by staff group at trust level and each site can be seen in the graphs below.

Trust level

There was only one qualified healthcare scientist in the whole surgery core service.
There were only three NHS infrastructure suppose staff, two of whom (66.6%) had completed an appraisal.

(Source: Routine Provider Information Request P43 Appraisals)

Patients were assessed for their needs, choices and preferences by staff who had the right skills and knowledge. Staff had the required training and opportunities for personal and professional development. There was the right number of staff to look after patients safely and in accordance with national guidance.

We saw a number of nurses on Avery Hill ward had undertaken a specialist course in caring for patients who had undergone hip or knee replacements. This enabled staff to provide the best care and treatments to these patients.

We reviewed two staff appraisal documents and found they contained achievements obtained and had objectives set for three and six months in the future. The documents also contained mandatory training attendance and additional training needs and training choices identified.

Staff undertook competency training for example in undertaking pregnancy tests; we saw completed competency documents during our inspection. This ensured staff had the correct skills and knowledge and were competent to undertake their role. Competencies were reviewed annually.

The trust had processes to ensure poor or variable performance was identified and managed, including providing support to staff. There was a process to review staff absence if they had repeated periods of absence over a short period of time. Support for staff was available such as referrals to occupational health.

Multidisciplinary working

Staff told us that patients with social care needs were only discharged home within the daytime and with the knowledge, ongoing care was in place. This was in line with National Institute for Health and Care Excellence NG27 Transition between inpatient settings and community or care
home settings for adults with social care needs. For example, we saw at each shift handover and ward round, members of the hospital-based multidisciplinary team reviewed and updated the person's progress towards hospital discharge.

The service had a theatre scheduling meeting every Monday to review theatre schedules this was attended by all members of the theatre multidisciplinary team. This ensured the service was planned and there was suitable capacity, staffing and equipment available.

Physiotherapists based at Darent Valley hospital provided physiotherapy input pre and post-operatively for patients undergoing surgery. Physiotherapists reviewed theatre schedules in advance, which ensured they could provide correct cover.

Staff attended a half-day academic training once a month. Theatre schedules were reduced on these days to allow staff to attend. In October, the topic was human factors training. Human factors training aims to raise awareness across the NHS of the important role human factors plays in improving patient safety.

**Seven-day services**

We saw there was a reduction in services offered to patients out of hours.

Operating lists were occasionally undertaken on Saturdays if demand deemed it necessary.

Support services such as pharmacy advice or physiotherapy was available via telephone from staff working at Darent Valley hospital out of hours.

The pharmacy was open on a Saturday morning, which enabled any take home medicines to be processed for patients being discharged at the weekend.

Resident surgical officers provided medical care and treatment 24 hours a day seven days a week. If they required support, they could contact colleagues at Darent Valley hospital.

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

**Mental Capacity Act and Deprivation of Liberty training completion**

This information was routinely requested within the universal provider information request spreadsheet, to be completed within a standard template. The trust was unable to provide the correct data and this will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

(Source: Routine Provider Information Request P40 – Statutory and Mandatory Training)

The Mental Capacity Act was included in the welcome to the trust days and in the mandatory updates that staff were required to attend. Deprivation of Liberty Safeguards was covered briefly during the welcome to the trust induction days and to all staff and mandatory core skills update.

Queen Mary's hospital did not treat any patients that were subject to a Deprivation of Liberty Safeguard. Patients who had additional needs for example dementia were assessed at pre-assessment to establish if their needs could be met at the hospital.

The Mental Capacity Act training was included in the 'Welcome to the trust days and in the mandatory updates that staff were required to attend.
There were e-learning modules for both consent and mental capacity assessment, which were tracked through the clinical education department. All junior staff and staff on induction received training in consent processes including managing patients unable to consent. Staff we spoke to could describe an awareness of the mental capacity act and deprivation of liberty safeguards.

However, data supplied to us by the trust showed poor compliance with Mental Capacity training amongst nurses. Overall across surgical services only 3% of staff were up to date with training. Rowan ward was the only ward where 100% (three) nurses were up to date with Mental Capacity Act training. This meant nurses may not have up to date knowledge regrading patients who the Mental Capacity Act may apply to.

Mental Capacity Act training compliance amongst doctors was 100% across surgical services.

Mental capacity and Deprivation of Liberty Safeguards policies were in place and in date. A poster identified the safeguarding leads in all areas. Staff could refer directly to the lead or raise a concern via the electronic reporting system.

Staff received dementia training, which was mandatory. The trust had a Clinical Lead for Dementia and Delirium (a doctor) and Dementia Specialist Practitioner who staff had access to. The trust had a dementia strategy and clinical guidelines.

The trust employed a Learning Disabilities Liaison Nurse who provided a link for people with learning disabilities. The nurse worked with the patient with learning disabilities to produce a patient passport, improve communication with ward staff, support with reasonable adjustments, support capacity assessments and be a link person.

If input from the dementia and learning disability teams was required, this was highlighted at pre-assessment to ensure any special arrangement regrading admission could be made.

Data supplied to us from an audit undertaken between 15 August and 22 September 2016 100% of patients had a consent form in their notes for the procedure that the patient is to undergo. The same audit showed that 98% of consent forms had the benefits of the operation documented and 96% had the potential risks documented.

The audit showed overall good compliance but highlighted areas for improvement for example documenting on the consent form if patient information leaflets had been given to the patient.

Consent was obtained in outpatients or at pre-assessment to avoid consenting on the day of surgery, where possible; consent was then confirmed on the day of surgery. Consent to treatment is the principle that a person must give permission before they receive any type of medical treatment, test or examination. Patients were encouraged to take a copy of their consent and written information was provided. Consent remains paper based due to the complexity of obtaining signatures on an electronic system.

We reviewed three patient records and found that consent had been obtained from patients in line with NHS guidance, they were fully completed, legible and did not contain any abbreviations.

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**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The Friends and Family Test response rate for surgery at Dartford and Gravesham NHS trust
was 16%, which was worse than the England average of 29% between September 2016 and August 2017.

A breakdown of response rate by site can be viewed below.

Friends and family test response rate at Dartford and Gravesham NHS trust, by site

Ward breakdown

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(Source: NHS England Friends and Family Test)

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Staff paid good attention to ensure patients dignity and respect were maintained. Staff closed doors to patients’ rooms and drew the curtain to avoid people looking in through internal and
external windows when supporting patients with personal hygiene activities, or when medical staff examined patients.

The pre-assessment department at Queen Mary’s hospital achieved a response rate of 99% in their Friends and Family Test in June 2017. They had received a letter of congratulations from the Secretary of State for health. The staff were extremely proud of this achievement.

Patients spoke overwhelmingly of the kindness of the staff in the pre-assessment departments. We reviewed comments from patients written on the Friends and Family Test, which included:

“Caring friendly and knowledgeable staff”

“Nicest staff I have ever met” and

“Friendly, on time, no problems speaks volumes”

We saw 32 thank you cards on Avery Ward. All were dated within the 12 months prior to inspection.

Patients commented upon how staff took the time to ensure things were explained in a compassionate way.

Staff paid good attention to ensure patients dignity and respect were maintained. Staff closed doors to patients’ rooms and drew the curtain to avoid people looking in through internal and external windows.

**Emotional support**

Staff could request support from the multi-faith chaplaincy, which included volunteer visitors, from Darent Valley hospital, as they did not routinely visit the hospital.

Staff recognised that emotional support extended beyond patients’ physical needs. We also observed staff supporting a very anxious patient in theatre, staff provided reassurance and comfort.

Throughout our inspection, we witnessed staff supporting patients, responding to their needs and communicating in a supporting way.

All patients received a phone call 24 hours after discharge, which followed a set format: pain assessment, everything clearly explained and anything we could improve

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

We spoke to two relatives and three patients. They told us they had no concerns about the care they had received. They told us the staff were caring and respectful of them as individuals. The families and carers had been involved in the decisions regarding surgery.

Patients could choose to wait for their procedure in the day surgery unit or could chose to sit in a room off the ward with relatives. Relatives were provided with regular updates for example when the patient had reached the recovery unit.

All patients were discharged with contact number of the ward and encouraged to contact ward if any problems. We saw this in discharge information.

We spoke to ten patients across the surgical wards who felt the staff were friendly and listened carefully to their needs. Patients were given time to ask questions about their care and treatment...
and address any anxieties or fears. Patients were supported in making decisions about their own care and treatment.

**Is the service responsive?**

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

All surgery performed at the hospital was elective therefore it could be planned in advance. Staff told us that due to the large geographical area that Darent Valley and Queen Mary’s hospital covered it was more convenient to attend Queen Mary’s hospital. Only patients who met the hospital admission criteria could be treated at the hospital.

Due to the design of the theatre, holding bay patients confidentiality was not maintained. We observed mixed sex patients waiting in a room for surgery, when the ward staff handed over private and confidential information to theatre staff other patients heard. This meant the patients confidentiality was not maintained in line with the Data Protection Act.

We raised this issue with the trust who told us they had undertaken a number of actions to address our concerns. They told us that the holding bay had been reconfigured, to maintain single sex seating area, whilst also providing separate areas for individual patient staff/patient conversation with privacy and dignity. The information governance team was going to undertake a visit to the area to provide advice to staff in the theatre holding bay on how patient information could be obtained without breaching confidentiality. Specific guidance was going to be included within the next information governance newsletter for trust-wide learning.

There was a big emphasis on minimising hospital visits for patients. For example, pre-assessment arranged for blood tests to be done at the patients local GP if that was easier for the patient.

During the inspection, we observed staff being flexible to accommodate a pre-assessment appointment for a patient who could only attend on specific days of the week. This showed the staff were willing to work with patients to make things easier for them to attend.

Patients attended appointments at the hospital from different boroughs. This meant different payment methods were used on buses. We saw the letter sent to patients with their pre-assessment appointments contained information regarding public transport and payment methods.

**Average length of stay**

**Trust Level – elective patients**

Between July 2016 and June 2017, the average length of stay for elective patients at the trust was 2.6 days, which was lower compared to the England average of 3.3 days.

For general surgery elective patients the average length of stay at the trust was 2.5 days, which was lower compared to the England average of 3.3 days.

For trauma and orthopaedics elective patients the average length of stay at the trust was 3.2 days, which was as expected compared to the England average of 3.4 days.

For urology elective patients the average length of stay at the trust was 2.1 days, which was as expected compared to the England average of 2.0 days.

**Elective Average Length of Stay – Trust Level**
Queen Mary’s hospital Sidcup - elective patients

Between July 2016 and June 2017, the average length of stay for all elective patients at Queen Mary’s hospital was 2.0 days, which was lower compared to the England average of 3.3 days.

The average length of stay for orthopaedics elective patients at Queen Mary’s hospital was 2.3 days, which was lower compared to the England average of 3.4 days.

The average length of stay for general surgery elective patients at Queen Mary’s hospital was 1.0 days, which was lower compared to the England average of 3.3 days.

The average length of stay for urology elective patients at Queen Mary’s hospital was 1.7 days, which is as expected compared to the England average of 2.0 days.
Meeting people’s individual needs

We found reasonable adjustments were made to take into account the needs of different people for example on the grounds of religion, gender disability, or preference. The service was very responsive to patient’s needs. Staff gave us an example of a patient with extreme hospital phobia who had their pre-assessment undertaken in car park.

We found reasonable adjustments were made to take into account the needs of different people for example on the grounds of religion, gender disability, or preference. The trust employed a Learning Disabilities Liaison Nurse who provided a link for people with learning disabilities Any patient with a learning disability, who was known to the learning disability liaison nurse at the hospital, was ‘flagged up’ on the internal electronic systems and a hospital passport would be used. The hospital passport would include information on the patient’s medical history, whom to contact as well as their likes and dislikes. This ensured that staff were aware and could make adjustments where required.

Staff sought accessible ways to communicate with people to meet their needs. Staff assessed patients’ communication needs to ensure effective communication. The trust used a hospital communication book this set out how to make sure people who had difficulties understanding and or communicating got an equal service in hospital. The book contained useful information about why people may have difficulties understanding or communicating. It had useful tips on tips staff could use to improve communication, and pages of pictures that could be used to help staff communicate

Patients with dementia and their families could access support from the Alzheimer’s and Dementia Support Services. It was an independent registered charity, which had developed a wide range of
multicultural services to provide practical and emotional support to people with dementia, their carers, supporters and other relatives.

The trust had one full time Dementia Specialist practitioner. We saw there was a variety of policies and guidelines in relation to caring for a patient with dementia available on the staff intranet. Staff could verbally describe what they would do to ensure dementia patients were cared for.

The trust offered a dementia buddy volunteer. The volunteer was specially trained and had a good understanding of dementia and knew how to engage positively with dementia patients. They promoted dignity and respect, provided social support whilst in an acute hospital setting, engaged in activities to help maintain cognitive capabilities and assisted patients at mealtimes.

The trust provided a translation and signing service to use for patients who were deaf or did not speak English. Staff we spoke to were able to describe how they could access this service.

Double appointments were booked for patients with additional needs. For example, people with a learning difficulty or living with dementia. Staff could request a member of the dementia or learning difficulty team attended appointments with patients.

Patients with additional needs were allowed to have relatives/carers stay and a separate quiet room was available for this purpose.

The service had a policy of never discharging a patient home after 10.00pm at night. The staff confirmed this was the case.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Between September 2016 and August 2017 the trust's referral to treatment time (referral to treatment times) for admitted pathways for surgery has been worse than the England average and has followed a similar trend over time. In the latest period, August 2017 60% of this group of patients were treated within 18 weeks versus the England average of 70%.

Between September 2016 and August 2017 the Trust's referral to treatment time for incomplete pathways for surgery was similar to the England average and followed this trend over time. In the latest period, August 2017 92% was achieved.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Surgery broken down by specialty is below. All three surgical specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>65%</td>
<td>73%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>57%</td>
<td>62%</td>
</tr>
<tr>
<td>Urology</td>
<td>67%</td>
<td>77%</td>
</tr>
</tbody>
</table>

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this was recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Dartford and Gravesham NHS Trust

Over the two years, the percentage of the trust’s patients whose operation was cancelled and were not treated within 28 days showed a trend of improvement. In Q3 and Q4 of 2016/17 and Q1 of 2017/18, all patients whose operation was cancelled were treated within 28 days. This was a considerable improvement from Q3 of 2015/16, when over 21% of such patients waited over 28 days. This took place against a background of more or less consistent performance against this metric at the national level.

Over the two years between July 2015 and June 2017, cancelled operations at the trust varied considerably as a percentage of elective admissions. In every quarter except Q2 2016/17, the trust's performance was better than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

All patients were having an operation at the hospital attended the day surgery unit, this was joined to Avery Hill ward where patients stayed overnight.

Patients were greeted by ward clerk and allocated a patient trolley within the male or female bay where they waited for assessment by the nurse, anaesthetist and surgeon. Patients went from here to the theatre holding bay to wait for their procedure. After their procedure patients spent time within recovery, which ensured their pain was controlled and they were sufficiently recovered to return to the ward. Day case patients went from recovery to the day surgery ward and patients staying overnight went to Avery Hill ward.
In the day surgery unit there was a concealed patient board which detailed at what stage each patient was at, for example when seen by the nurse one tick was marked on the board. This meant staff knew what stage each patient was at.

Each consultant operating on that day was allocated a specific nurse to help them. This provided continuity of care.

Every hour the nurse in charge undertook checks, which ensured each patient, was in the correct place and updated patients on their expected surgery time. We saw completed records, which confirmed this.

There was a standard operating procedure in place which ensured operations were cancelled it was decided in a risk based way. Factors such as the reason for operation and if the patient had been cancelled before were considered before cancellation.

Referral to treatment times were discussed at weekly operational meetings, with each speciality providing an update on their current referral to treatment times position and a plan to address and improve.

Theatres were monitored to determine reasons for delays. Weekly operational meetings were undertaken to review the forthcoming admissions for surgery. This ensured the correct capacity, equipment and specialist care was available.

**Learning from complaints and concerns**

The trust had a central team of three staff to deal with complaints, with additional leadership from a senior nurse. There was also a Patient Advice Liaison Service officer who supported this work. Surgical services provided complaint responses with actions to the central team for logging and these were then reviewed by the Director of Nursing who was the executive lead for complaints. The Chief Executive Officer saw every complaint response and had overall sign off.

We saw information in all areas about how to complain and information leaflets on how to contact the Patient Advice Liaison Service office.

We saw meeting minutes, which confirmed complaint reports being reviewed at various committees for example the Quality and Safety Committee. Quality and Safety Committee sent reports to individual directorate meetings this ensured local teams could have sight of relevant learning as well as performance issues and any required actions.

The day surgery ward and Avery Hill ward meeting minutes showed the meetings did not follow a set agenda. We reviewed these meeting minutes and complaints were not discussed. This meant that managers did not have assurance that staff were learning from complaints or knew any actions resulting from complaints. However, staff could give us examples of leaning from complaints. For example, patients had complained that they could not sit with their friends or relatives whilst they wait for surgery therefore another room off the ward was utilised for this purpose. This showed that managers listened to feedback from patients and acted upon feedback.

We saw in the day surgery ward there was a notice board with a “you said we did” section. For example, we saw patients had commented that there was not a television in the male waiting area. The ward manager told us that a television had been ordered.

The trust had one complaint that was escalated to the parliamentary health ombudsman and this was upheld.
The matron in charge was responsible for investigating all complaints and had received training to undertake this.

**Summary of complaints**

Between August 2016 and July 2017, there were 45 complaints about surgery. The trust took an average of 43 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 25 days, or “up to 60” days for complex complaints. There were 13 complaints, which had not been closed.

Of the 45 complaints, three were regarding surgical services at Queen Mary’s hospital. All three related to care receive in theatres.

(Source: Routine Provider Information Request P61 Complaints)

**Is the service well-led?**

**Leadership**

Surgical services at Queen Mary’s hospital was led by a matron who was supported by two ward managers and a theatre manager.

Surgical services had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. All nursing staff spoke enthusiastically of the matron and they felt supported by her. Staff told us that the matron undertook daily ward and department visits.

Staff told us that ward and department managers were approachable and supportive offering advice and training as required.

We saw managers arranged ward or departmental unit meetings regularly to ensure staff were kept up-to-date with relevant information about the ward and the hospital. Managers placed a notice within the staff room for staff to add items to the staff meeting agenda. This meant staff had the opportunity to raise issues, which affected them.

Leadership development in the trust was co-ordinated by the Clinical Education Department, through the Leadership Faculty. The new Consultant Development Programme consisted of six sessions over the year aimed to provide the consultants with a better understanding of the role of a consultant in the modern NHS. The Foundation Leadership Programme consisted of five sessions, which included leadership in multidisciplinary teams and service improvement.

There was a focus on the development of leadership skills for clinical staff. Programmes included Leadership Development Days that provided an introduction to the tools required to be an effective leader.

We observed that each ward had a photo board with pictures of the senior management team of the trust. On Avery Hill ward there was a poster identifying the meaning of each uniform. This ensured patients could identify staff.

Managers were very responsive to our concerns that we raised during the inspection and took immediate action to address concerns.
Vision and strategy

The trust described the purpose of the organisation as ‘Our Family, caring for yours’ This captured the approach taken by the teams which made the difference to the care that the patients and their families experienced as well as the value they had for their teams.

The trust had identified the following values:

Care with compassion - Delivering high quality care with compassion to every patient
Respect and dignity - Demonstrating respect and dignity for patients, their carers’ and our colleagues, patients, colleagues
Striving to excel in everything, we do
Professional standards - Sustaining the highest professional standards, showing honesty, openness and integrity in all our actions
Working together - to achieve the best outcomes for our patients

The staff had developed the values as a group. These values provided a set of standards for how they were expected to behave towards others and conduct themselves as professionals.

We saw posters with the values displayed on wards, and computer screen savers.

Surgical services at Queen Mary’s hospital was going through a re-design programme. The aim was to review the complexity of patients who could receive operations at the hospital. This would relieve pressure from Darent Valley hospital if they undertook some of the operations usually performed there. We heard how the programme was undergoing a comprehensive risk assessment to ensure patients needs could be met.

Culture

Managers promoted a positive culture that supported and valued staff creating a sense of common purpose based on shared values. Staff we spoke with felt the organisation supported them to deliver high quality patient care. Morale throughout the surgical services was generally good.

We asked staff if they were aware of the Freedom to Speak up Guardian role. We had a mixed response, which may indicate staff were unaware of the role, its function or benefits.

Governance

Ward and department managers attended monthly clinical governance meeting. There was a discussion of complaints, incidents, ward level audits and friends and family test performance. Information from this meeting was cascaded to staff via department meetings.

Staff told us they received feedback from incidents they had raised and learning from incidents raised throughout the trust. This meant wider learning from the organisation was reaching staff at department or ward level.

The Director of Operations led the team brief to the senior management team every month. The board received a monthly quality report highlighting good practice as well as concerns. Data showed trends in areas such as tissue viability, falls and the safety thermometer, which were discussed, and action plans developed. Quality and Safety Committee presentations fed into the board on a monthly basis.

Non-executive members of the board had oversight of targeted areas such as infection prevention and control.
We reviewed Avery Hill ward and day surgery unit meeting minutes and saw a formal agenda was not kept for consistency. We saw the same issues were raised at several meetings for example the trust uniform policy. This may indicate the meetings were ineffective.

**Management of risk, issues and performance**

National Safety Standards for Invasive Procedures were not embedded in the organisation. National Safety Standards for Invasive Procedures provide a framework for the production of Local Safety Standards for Invasive Procedures and dedicated Safety Standards for Invasive Procedures checklists were also not in place for invasive procedures such as catheters, cardiac, central line insertion and tracheostomies. Trusts have responsibility to ensure Local Safety Standards for Invasive Procedures are created for all invasive procedures and are harmonised with National Safety Standards for Invasive Procedures. National Safety Standards for Invasive Procedures are a set of national safety standards to support NHS hospitals to provide safer surgical care.

National Safety Standards for Invasive Procedures were not in place therefore the trust was unable to audit and benchmark performance and share best practice.

We saw poor compliance with the completion of the World Health Organisation surgical safety checklist. This was despite a drive on the checklist following never events Queen Mary’s hospital. Data also showed varied compliance with the World Health Organisation surgical safety checklist. Managers had taken a number of actions to address poor compliance, which were outlined within the safe domain.

There was an effective process, which ensured only patients whose needs could be met were treated at the hospital. Patients were thoroughly pre-assessed which ensured they were suitable to have their procedure undertaken at the hospital. Patients who were deemed not suitable were treated at Darent Valley hospital where more support services were available.

In theatres, there was a lack of quality assurance processes in place. For example, compliance undertaking anaesthetic machine safety checks.

In theatres, there was not an effective process, which ensured agency staff had the correct skills, checks and qualifications to undertake their role. Managers had taken action to address this issue, which are outlined in the effective domain.

There was an established risk register to monitor the risks across surgical services at Darent Valley hospital at Queen Mary’s hospital. The electronic incident reporting tool was linked to the risk register, which provided an enhanced level of over sight of risk. Risks were scored between five and fifteen to determine the level of risk. Twenty-nine risks were recorded on the risk register. These included risks related to performance targets, the World Health Organisation safer surgery checklist, recruitment of qualified staff, lack of junior medical staff within orthopaedics, and slips, trips and falls. We noticed that some of the risks were old, the oldest was entered as a risk in January 2012 and still had not been closed. In addition, risks were repeated for example the World Health Organisation safer surgery checklist was on the risk registers four times. Eight risks on the register had not been reviewed within the last 12 months. The risks on the register did not reflect the risks we identified during our inspection.

We reviewed meeting minutes of the orthopaedic clinical governance meetings and saw that the risk register was discussed. For example, we saw in the July 2017 meeting the lack of junior medical staff was discussed and this was added to the risk register.

We saw discussion of the risk register was a standard agenda item on the surgical, urology and renal clinical governance and risk committee meetings.
We asked the trust to provide evidence of mortality and morbidity meetings. We were supplied with presentations regarding orthopaedic mortality and morbidity for two individual consultants that were presented at the orthopaedic clinical governance meetings. We did not see any discussion regarding mortality and morbidity in any other committee meetings. This surgical service was, missing an opportunity to discuss errors and adverse events in an open manner, review care standards, and make changes if required.

**Information management**

Staff had access though the trust's computer system to policy and practice guidelines. In addition, they could also access mandatory training information and training opportunities.

Staff spoke positively about the trusts computer system, they said it was very informative especially articles and blogs relating to incidents.

The trust was in the process of implementing an electronic patient system, paper records were scanned into the system after the patient was discharged.

Data Quality Meetings were held bi-monthly and involved system managers, training team, managers/supervisors throughout the trust. The data quality group reported to the Information Governance committee.

The trust had a Business Intelligence Teams who were responsible for the running of data quality and to correct patient demographic data on the trusts databases. The trust had a data quality team who corrected admissions, transfer and discharge information on a daily basis. Logs of errors made were collated by the team and fed back to the source to minimise reoccurrences.

Any data quality issues raised to the Business Intelligence team were investigated and if necessary checked against nationally defined standards (NHS Digital).

**Engagement**

A patient representative attended trust board meetings and patients were able to talk about their experience of care they had received. This enabled patients to give feedback regarding their experience to the board members to act upon.

There was a Patient Experience Committee, which discussed feedback from patients. Attendees at this meeting included Health Watch. The public were invited to the trust annual general meeting.

The Chief Executive attended the Heath Overview and Scrutiny Committee and had spoken at patient user groups such as the Speech and Language Group and Older People's Forum.

Coffee mornings and other engagement events had taken place to obtain views on current experiences. Engagement with the public was through social media and kept them informed of developments such as the Accident and Emergency campaign.

Patients could leave feedback on social media and NHS choices website and all comments were responded to by the trust. National patient surveys were undertaken regularly and the feedback used to create an action plan.

The trust had not had to formally undertaken any public consultations over the past 12 months.

The Charitable Funds Manager spoke at community events, local schools, corporate businesses and charitable committees. The trust were building relationships with their community provider to try and improve the outreach and at home care schemes.
Staff said they were actively engaged in the planning and delivery of services and in shaping the future development of the service, with the matron. The matron then escalated service improvement ideas.

The trust had an annual awards programme to recognise staff excellence and commitment. Awards included excellence, leadership care and compassion awards.

Staff were able to self-refer for physiotherapy services within the trust.

**Learning, continuous improvement and innovation**

The trust had completed the first phase of the THINK 2020 Programme, which involved transforming the core services to work more efficiently and create the capacity to meet increasing demand.

The trust had developed several performance dashboards including one for monitoring infection control performance. They undertook a number of initiatives involving staff across the trust including a Rapid Improvement Programme, which focused on improving the discharge planning processes. This involved representatives from partner organisations across the local health economy and was done in conjunction with NHS England and NHS Improvement. It has contributed to a significant reduction in average length of stay on the core inpatient wards.

A new patient information leaflet had been developed to help manage patient expectation around admission and discharge. The programme had been nominated for a Health Service Journal award.

The trust had a Lean Thinking Transformation Programme, which empowered staff to make small changes within their own areas with a view to improving patient care. They had implemented over 150 lean projects across the trust as a result. The programme formed part of their strategic objectives.
Elm Court

Medical Care (including older people’s care)

Facts and data about this service
The trust has a (up to) 39-bedded facility called Elm Court based within a care home in Dartford. Elm court is for medically fit patients who require a short period of rehabilitation, assessment and mobilisation. The aim is to provide beds for those ready to leave hospital and free up beds for those requiring acute surgical or medical admission at Darent Valley. It has an on-site dedicated physiotherapists and occupational therapists with full hospital support.

The Adult Medicine Directorate includes: respiratory, neurology, ageing and health, diabetic, stroke and dementia services, ambulatory care, general medicine, rehabilitation, nephrology, endoscopy and gastroenterology.

The Ageing and Health Department is currently responsible for inpatients on Spruce, Ebony, Linden, Maple (ortho-geriatric and medical outliers), medical outliers on Mulberry, Cherry and Rosewood.

Respiratory has specialist ward rounds in chronic obstructive pulmonary disease, asthma and non-invasive ventilation services supported by the nurse specialist. Endobronchial ultrasound procedures are also carried out. Stroke services include thrombolysis, acute care and rehabilitation. There is a Monday to Friday Transient Ischaemic Attack clinic with Doppler and Magnetic Resonance Imaging. The service is waiting for the outcome of the Kent-wide Stroke Services Review. The endoscopy service is, Joint Advisory Group on Gastrointestinal Endoscopy, accredited with inpatient and outpatient slots.

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 31,991 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 11,835 (37%), 5,994 (19%) were elective, and the remaining 14,162 (44%) were day case.

Admissions for the top three medical specialties were:
General Medicine 11,496
Gastroenterology 5,718

(Source: CQC Insight)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training figures had improved since our last inspection. However, they were still not meeting trust targets. The most recent mandatory training figures showed an overall compliance of 81.4% which is below the trust target.
At Elm Court the trust target of 85% had only been met in one topic, Infection control level 1, where 100% of staff had completed the training. The lowest completion rates were in Infection control level 2 with only 37% of staff having completed the training.

We saw that mandatory training was a mixture of online and classroom based training. Staff told us that if it was quiet on the unit they were able to undertake online training, staff could also undertake training from home.

The trust set a target of 85% for completion of mandatory training modules, apart from infection prevention level 2 where the target was 95%.

In their Provider Information Request the trust provided separate breakdowns of their training completion data by staff group and by core service, but not by core service and then by staff group.

We contacted the trust on 31 October 2017 and asked them to supply a breakdown by staff group for each core service.

Below is a breakdown of compliance for mandatory training modules between April 2016 and March 2017 for all staff in the Medical Care core service at the trust.

### Trust wide

![Mandatory training completion rate (all staff groups)](image)

Completion rates were above target for six modules, and below target for the remaining four modules. Completion was particularly low for infection prevention level 2 (approximately 55%).

Completion rates were the same as or similar to those at trust level for all modules.
The trust reported that only three staff were eligible for infection prevention level 1 at Elm Court, and only two for manual handling – object. This meant only one member of staff had completed the training for manual handling.

Mandatory training was tracked online and reviewed at weekly matrons’ meetings within the department. We saw evidence in the minutes of discussions around low attendance and were told that staff numbers had increased recently.

We saw action was being taken both at operational and executive levels to identify and improve mandatory training figures. Staff told us time was now allocated for mandatory training. The trust had also aligned incremental progression with completion of mandatory training from January 2017.

The trust launched e-learning in December 2016, and used the e-learning platform. Staff reported this enabled them to complete their mandatory core skills at a time and place that was convenient with their work schedule.

In April 2017 all mandatory core skills monitoring and recording was centralised within each department. In medical care this had enabled each Matron and ward sister to have oversight of mandatory training figures and address issues as they arose.

Directorate compliance was discussed with each directorate at directorate performance meetings, with low compliance was followed up by the respective Executive Director.

**Safeguarding**

Although staff understood how to protect patients from abuse and report abuse, safeguarding training figures showed the department was failing to meet the trust target of 85%. Safeguarding training was well below the trust target, 67% of staff had completed safeguarding children level 1 and 64% had completed safeguarding adults level 1. The trust had not given safeguarding training enough consideration as staff were working with a vulnerable adults.

The trust set a target of 85% for completion of safeguarding training. Below is a breakdown of compliance for safeguarding training modules between April 2016 and March 2017 for all staff in the Medical Care core service at the trust.
Trust wide

The 85% completion target was not met for any of the three modules for which staff in Medical Care were eligible.

Elm Court

The trust reported that only three staff were eligible for safeguarding children level 1 at Elm Court. This meant only one member of staff had completed the training.

Staff told us, if needed, they would ask for guidance from the safeguarding lead who could be accessed via telephone or bleep. Phone numbers and contact details for the safeguarding leads were available on the computer system, in staff rooms and offices. The trust safeguarding lead has safeguarding training up to level six for adult and level two for children’s’ safeguarding.

A safeguarding committee met quarterly to discuss any learning points and report any incidences. These were also attended by the adult and child safeguarding leads. A biannual report was sent to the Quality and Safety Committee to review and an annual report was sent to the trust board.

In line with national guidance, safeguarding was reported through a number of external bodies, for example a quarterly report to the Clinical Commissioning Group (key metrics set by them), and an annual report to safeguarding adult board for Kent and Bexley respectively. The adult and child safeguarding leads also attended external safeguarding supervision with the local authority.
Cleanliness, infection control and hygiene

We saw some poor compliance with infection control policies throughout Elm Court. The service did not always control infection risk well. We saw some poor management of equipment and on inspection found areas of the hospital were not clean.

Staff told us that the Infection Prevention and Control Team had visited the unit and discussed catheter and Methicillin resistant staphylococcus aureus pathways. However, there was no cleaning strategy or operational plan for Elm Court. We were provided with a copy of the operational plan from Estates and Facilities team at Darent Valley Hospital but this only covered the acute Hospital. The purpose of the cleaning strategy was to show the board commitment to the cleaning service. The operational plan shows how the cleaning is carried out and included, risk assessment of areas, auditing regimes and colour coding. Both these documents are a requirement of the National specifications for cleanliness in the National Health Service.

We interviewed the housekeeping manager who told us the cleaning service was compliant with the National Specifications for Cleanliness and explained to us the colour coding of domestic equipment, red for toilets and bathrooms, yellow for infectious rooms, green for general areas and blue for the clinical staff to clean at night. This did not comply with the national colour coding as set by the National Specifications for Cleanliness in the National Health Service. We were not shown any risk assessment that showed that changing from the National Specifications for Cleanliness was a considered action. The national colour coding is as follows, blue for general areas, green for kitchens / catering areas, red for toilets and bathrooms and yellow for infectious cleans.

Potentially there could be cross contamination if a member of staff used a blue cloth in the ward area and continued to use the same cloth in a catering area. Also the night staff had only blue cloths; this created the potential for the cloth to be used for all cleaning carried out at night and therefore cross contamination from one area to another.

Elm Court used microfiber cloths and we were told by the housekeeping manager, staff had been trained to use the ‘four fold cleaning method’. When a domestic member of staff was asked to demonstrate this method they did not understand the four fold method and could not demonstrate this to us. This could mean that the cleaning method becomes ineffective and therefore is not removing the bacteria from the item being cleaned which could lead to cross infection.

We asked the housekeeping manager if Elm Court was audited for cleanliness and were told that they walk round every day and bring to the attention of the cleaner any areas where they feel are not to the acceptable standard. The National Specifications for Cleanliness states that areas should be risk assessed to determine their risk category and this informs the staff how often the area should be audited and what percentage it should achieve. There was no information regarding auditing available. This meant the trust has no indication if the cleaning is of an acceptable standard and safe for patients.

The unit looked clean but on closer inspection we found in rooms 33, 10a, 9, 12 and 14 there was dark dust on door closures, architraves, emergency lights and general high dusting areas. We were shown a weekly check list which showed that these rooms had been cleaned daily and each room had a “thorough “clean once a week. The evidence found did not support these checklists, with the exception of room 6 where we found no issues. This showed the benefit of formal monitoring as described by the National Specifications for Cleanliness and if this was carried out the trust would know what level of cleaning standard they had in Elm Court.

There was a carpet in the day room area which was stained and worn. When we asked the housekeeping manager what frequency the carpet was cleaned, we were told that the domestic staff carried out spot cleaning and the manager did the main clean when the carpet looked...
“grubby” or at least every six months. There was no evidence that the carpet had a regular clean or a spot clean and the condition of the carpet had deteriorated to a degree that the condition was not suitable for this area.

We looked at the results of the medical care directorate monthly hand hygiene audits. The overall score for Elm Court between August and October 2017 was 90%. Results ranged from 84% to 100%. We saw the hand hygiene audit scores were displayed in corridors. Hand gel was available outside every patient room; we witnessed this being used frequently.

During our previous comprehensive inspection of the trust in 2013 we saw that, in response to the above average rates of catheter and urinary tract infections, a catheter care pathway had been introduced. A checklist had been introduced to ensure the right checks were carried out and dated. During this inspection we saw that the trust audited catheter management on a monthly basis and between August and October 2017, results ranged from 78% to 89% compliance. Elm Court was not meeting the trust target of 90%. In October two patients had urinary tract infection due to long term catheters. The sister told us they planned to remove the catheters and trial the patients not having them in place. However if managed correctly the incidents may not have occurred.

There were monthly commode cleaning audits and we saw the results between August and October 2017. The results ranged from 24% to 44%, this was well below the trust target of 90%. We checked two commodes on inspection and they were both visibly clean and were dated indicating they had been cleaned that day.

There was evidence on the weekly checklists that curtains were being changed every six months or when soiled in line with National Specifications for Cleanliness expectations. On physically checking the curtains in nine rooms all were found to be clean and not stained.

Between April 2017 and October 2017 there have been three Methicillin resistant staphylococcus aureus infections assigned to the trust, against an NHS objective of no avoidable blood stream infection. We saw that one was in medicine and one in surgery, both were deemed avoidable. The third was a contaminated blood culture, this meant that the patient did not have a bloodstream infection, but bacteria entered the blood culture, whilst it was being taken. The trust undertakes a post infection review of all Methicillin-resistant Staphylococcus aureus, bloodstream infections, to identify any themes or trends with outcomes and lessons learned shared with staff. For example, we saw because of the Methicillin resistant staphylococcus aureus bloodstream infections in surgery, new nephrostomy pathway and guidelines had been implemented, in collaboration with the infection control team and urology specialist nurses.

A member of the infection prevention and control team reviewed all patients found to be Methicillin resistant staphylococcus aureus positive weekly during their stay. Staff told us they felt supported by the infection control team and valued their input in ensuring they were delivering good care.

We saw an audit schedule for monitoring infections was in place across the hospital. For example, we saw peripheral intravenous lines, and urinary catheters, hand hygiene and compliance with Methicillin-resistant Staphylococcus aureus screening was undertaken monthly. Matrons told us all audit results were discussed once a month at the weekly band seven forums, where any non-compliances were addressed, and best practice shared.

Environment and equipment

We saw some equipment was not well maintained. The safety of equipment could not be guaranteed as service records were not consistent and chemicals were not held securely.
We saw chemicals were not secure and ‘Control of Substances Hazardous to Health Legislation’ was compromised. For example, we saw the cleaning cupboard was locked; however the key to the cupboard was on a hook on the door frame which was easy to see and access. The door could potentially be unlocked and opened which could mean unauthorised access to this room by a patient, staff member or relative. This could have led to misuse of the chemicals contained within the cupboard. During our inspection we accessed the cupboard unchallenged.

We were told by the Housekeeping manager that all Control of Substances Hazardous to Health data sheets and Control of Substances Hazardous to Health risk assessments were in a folder in the cleaning cupboard. We were also told that not all chemicals required a risk assessment, however the ones that did were contained within the file in the Hazardous Substance Inventory. We reviewed the file and the chemicals within the cupboard and found many discrepancies. This included a hazardous substance summary sheet for a chemical, ‘Horizon Bright’, which was not in the cupboard and incomplete information being recorded about the chemicals that were in the cupboard. On the Hazardous Substance Inventory there were three columns, headed, hazardous substance and trade name, this column listed 14 chemicals. The other two columns that indicated the location and manufacturer of the chemicals had nothing recorded. There were a further 13 chemicals listed in the folder that were not in the cupboard. This potentially meant that if the overall data needed in the event of an incident was not available it may lengthen the time before necessary treatment could be administered, as not all information about the product was available.

We found five store room doors open or unlocked. They were store rooms labelled B, C, E, H, and J. All rooms had a sign on stating that they were fire doors and they were to be kept locked shut. This was a breach of fire safety as the rooms clearly stated they should be locked shut. Although the unit was secure at the entrance, it could be open to an arson attack or in the event of a fire; open doors would increase the risk of a fire spreading, as these rooms stored stationery, mattresses and linen, all of which are combustible materials.

We saw inconsistent use of the ‘I am clean’ green stickers on medical devices and equipment. We inspected 12 walking frames and one had a label and no date, six had no labels and five were dated as being cleaned on 28/9/17. As a result staff would not know when the equipment was last cleaned or the labels were not used correctly. At the time of inspection some dates were over five weeks out of date.

We inspected a further 16 pieces of equipment and seven had no label, five had a label indicating that the equipment had been cleaned on the day of inspection 7/11/17 or the day before 6/11/17, one was labelled but was undated, one piece of equipment had a label indicating they were last cleaned on the 1/11/17. This potentially could lead to cross infection if items were not cleaned to expected timescales and staff not being assured that equipment was clean.

We saw equipment was available for patients with pressure ulcers in line with Royal College of Nursing: Management of Pressure Ulcers: Patients with pressure ulcers should have access to pressure-relieving support surfaces and strategies. We saw, for example, mattresses and cushions were available 24 hours a day. Patients had access to pressure relieving mattresses. We were told that a mattress could be requested and received on the same day. This was in line with Royal College of Nursing: Management of Pressure Ulcers: All individuals assessed as having a grade 1-2 pressure ulcer should, as a minimum provision, be placed on a high-specification foam mattress or cushion with pressure-reducing properties.

Assessing and responding to patient risk
We saw that individual patient risks were identified early at Elm Court. This was important due to the layout as all patients were in single rooms which meant visibility was limited. The department used a series of measures to try and ensure patient safety, including falls mats and low rise beds and call bells. However, there was still a risk due to single rooms being used that patients could not receive constant monitoring.

We reviewed several patient notes across all areas of medical care. There were risk assessments in key safety areas using nationally validated tools. For example staff assessed the risk of falls and pressure damage. We noted when risks were identified, relevant care plans (which included control measures), were generated. We checked a sample of these control measures and found them to be in place. We saw risk assessments were reviewed and repeated within recommended timescales. For example weekly falls and bed rail assessments.

A Malnutrition Universal Screening Tool evaluation was undertaken on admission to identify patients that may require supplements. This was also used to determine if patients needed to be placed on food charts or referred to the dietician.

Nursing evaluations were completed by the nursing staff twice a day, during the afternoon and on night shifts. The senior sister told us that agency staff did not always complete these nursing evaluation forms. This had been escalated to the agency manager at the trust.

The senior sister was able to tell us how they managed sepsis. Observations are done twice a day. If there are any spikes in temperature this was reported to the doctor and blood cultures were taken. We saw from April 2017 to October 2017 that three patients were transferred back to Darent Valley hospital with sepsis. Two of these cases were transferred back on the same day. This could mean they were transferred over with sepsis but this was only picked up at Elm Court and showed staff were quick to raise concerns.

The trust provided the numbers of ward moves at night (between 10 pm and eight am) between July 2016 and June 2017.

Medical care had 162 bed moves at night between July 2016 and June 2017 with the most occurring in Elm Court (30). There have been 4 complaints about Elm Court with issues surrounding discharge being the main theme

(Source: Trust Routine Provider Information Return P51)

The hospital had implemented the National Early Warning System and we saw this was routinely used for inpatients. We noted on observation charts these scores were calculated consistently and accurately. We tracked several instances of increased scoring, indicating a potential deterioration, and saw where escalation protocols were followed, or the rationale for not doing so was documented. This indicated that a potential deterioration in a patient’s condition was escalated. If the registrar was on site the patient’s condition was escalated to them and actions taken as needed, however if there was no medical cover on the unit the nursing staff called 999 and got the patient transferred to Darent Valley via accident and emergency.

We found patients’ physiological parameters such as pulse and temperature were monitored in line with National Institute for Health and Care Excellence guidance: CG50 Acutely Ill Patients in Hospital. We watched observations being taken and noted the technique used to monitor their condition would give accurate results. We checked observation charts and saw physiological parameters were conducted at recommended frequencies. The trust also audited the use of observations and vital signs. From August to October 2017 100% of patients had their
temperature, pulse, blood pressure and saturation levels checked. The audit also looked at whether the correct National Early Warning System score was recorded and if escalation occurred correctly.

Staff had access to the hospital’s mental health liaison team 24 hours a day, seven days a week. We saw examples where patients required an urgent referral and this was arranged via the mental health lead for medicine.

**Nurse staffing**

During our comprehensive trust inspection in 2013 we told the trust they must ensure that the required number of staff with the correct skills are employed and managed shift by shift, to demonstrate that there were sufficient staff to meet people’s needs. During our recent inspection we found that staffing was not always adequate at Elm Court. This was due in part to high use of agency staff, for example, using two agency staff on a shift. This did not ensure the correct skill mix. We were told by the matron that sometimes there would be two agency staff and one regular staff member on shifts. Staff reported feeling busy and overworked, however acknowledged that staffing had improved recently and that pressures had slightly relieved.

We saw from staffing rotas that in the last three months this had slightly improved. We were told this was due in part, to regular staff working extra shifts at the weekend.

All ward managers and their matrons attended a 1:1 meeting with the corporate nursing team and the Assistant Director of Finance, where their staffing establishment were reviewed. The review looked at several areas including: patient acuity and dependency, a comparison of current establishment review data with previous reviews, ward changes including the use of escalation beds.

The review also included an in-depth look at numbers and skill mix of staff against national guidance and included the use of Care Hour per Patient Day standards and current staffing shortfalls for each ward, alongside a review of nursing and midwifery quality indicators. These included falls, hospital acquired pressure ulcers, complaints, friends and family rates and ‘harm events’ as per national guidelines.
Darent Valley Hospital reported its qualified nursing staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Medical Unit (AMU)</td>
<td>27.0</td>
<td>15.3</td>
</tr>
<tr>
<td>Adult Medicine Directorate Management</td>
<td>4.6</td>
<td>4.6</td>
</tr>
<tr>
<td>Adult Medicine Specialist Nurses</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Ambulatory Care Unit</td>
<td>7.8</td>
<td>10.4</td>
</tr>
<tr>
<td>Beech Ward</td>
<td>20.7</td>
<td>11.1</td>
</tr>
<tr>
<td>Cancer Services</td>
<td>21.4</td>
<td>20.8</td>
</tr>
<tr>
<td>Cardiac Care Nursing</td>
<td>7.9</td>
<td>8.5</td>
</tr>
<tr>
<td>Cardiology Nursing</td>
<td>8.4</td>
<td>8.1</td>
</tr>
<tr>
<td>Chestnut Ward (CCU)</td>
<td>19.0</td>
<td>16.9</td>
</tr>
<tr>
<td>DCU Endoscopy Area</td>
<td>28.0</td>
<td>23.9</td>
</tr>
<tr>
<td>Diabetes Centre</td>
<td>3.9</td>
<td>3.9</td>
</tr>
<tr>
<td>Discharge Lounge</td>
<td>0.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Ebony Ward (Elderly Care)</td>
<td>20.0</td>
<td>13.4</td>
</tr>
<tr>
<td>Evergreen (was Hornbeam Day Centre)</td>
<td>13.0</td>
<td>10.4</td>
</tr>
<tr>
<td>Hospital at Home Team</td>
<td>6.6</td>
<td>5.5</td>
</tr>
<tr>
<td>Integrated Discharge Team</td>
<td>4.8</td>
<td>6.6</td>
</tr>
<tr>
<td>Laurel Ward</td>
<td>17.9</td>
<td>17.6</td>
</tr>
<tr>
<td>Linden Ward</td>
<td>18.0</td>
<td>11.5</td>
</tr>
<tr>
<td>Oak Ward (Medical)</td>
<td>17.5</td>
<td>14.3</td>
</tr>
<tr>
<td>Palm Ward</td>
<td>26.3</td>
<td>16.8</td>
</tr>
<tr>
<td>Pine Therapy Unit</td>
<td>14.5</td>
<td>14.5</td>
</tr>
<tr>
<td>Respiratory Services</td>
<td>3.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Resus Training</td>
<td>1.6</td>
<td>1.0</td>
</tr>
<tr>
<td>Rosewood Ward</td>
<td>15.5</td>
<td>11.1</td>
</tr>
<tr>
<td>Short Stay Unit (Prev Obs)</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Spruce (New)</td>
<td>24.4</td>
<td>12.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>333.3</strong></td>
<td><strong>265.4</strong></td>
</tr>
</tbody>
</table>

Elm Court reported its qualified nursing staff numbers as below as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elm Court (Priory Mews)</td>
<td>23.2</td>
<td>13.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – P16 Total numbers – Planned vs actual tab)

Between July 2016 and June 2017, the trust reported a vacancy rate of 18.3% for qualified nursing staff in Medical Care. This did not meet the trust target of having a vacancy rate of 9% or lower. Elm Court had a vacancy rate of 27.3% which was much worse than the trust target.

(Source: Routine Provider Information Request P17 Vacancies)
Between July 2016 and June 2017, the trust reported a turnover rate of 11.7% for qualified nursing staff in Medical Care. This did not meet the trust target of having a turnover rate of 9% or lower. Elm Court had a turnover rate of 22.3% which is much worse than the trust target.  
(Source: Routine Provider Information Request P18 Turnover)

Between June 2016 and May 2017, the trust reported a sickness rate of 3.9% for qualified nursing staff in Medical Care. This did not meet the trust target of having a sickness rate of 3.5% or lower. Elm Court had a sickness rate of 6.8% which was worse than the trust target.  
(Source: Routine Provider Information Request P19 Sickness)

Between August 2016 and July 2017, the trust reported bank usage of 4,876 shifts and agency usage of 5,763 shifts for qualified nurses in Medical Care. Over the same period there were 1,147 shifts that were not filled by bank or agency staff to cover sickness, absence or vacancies. The data supplied by the trust don’t allow us to calculate usage rates.

Elm Court:
- Bank: 607 shifts
- Agency: 356 shifts
- Not filled: 169 shifts

(Source: Routine Provider Information Request P20 Nursing – Bank and Agency)

We saw there was a comprehensive induction booklet given to agency staff on arrival to the unit which set out operational arrangements and expectations of how the nurse would work and report their actions. We spoke with several agency nurses, who confirmed they had completed their induction booklet. Induction booklets were filed once completed, these could be accessed in the sisters’ office. This was demonstrated to us.

We reviewed three months of staffing data and saw that the planned and actual staffing hours were not met for August, September or October for both day and night nurse staffing. For example we saw in September day shifts were planned with 1624 of nursing hours and 1483 hours were actually staffed. This was consistent throughout the three months we looked at.

Medical staffing

The trust reported that Elm Court had no medical staff in post as of June 2017.

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>WTE staff establishment</th>
<th>Number in post as of July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elm Court (Priory Mews)</td>
<td>1.3</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request– P16 Total numbers – Planned vs actual tab)

Between July 2016 and June 2017, the trust reported a staffing surplus of 1.2% above establishment for medical staff in Medical Care. The trust target was a vacancy rate of 9% or lower. Elm Court: 100% (the 1.3 WTE established medical staff posts were vacant).

(Source: Routine Provider Information Request -P17 Vacancies)

Between July 2016 and June 2017, the trust reported a turnover rate of 39.8% for medical staff in Medical Care. This was within the trust target of having a vacancy rate of 9% or lower.

Between June 2016 and May 2017, the trust reported a sickness rate of 2.8% for medical staff
in Medical Care. This was within the trust target of having a sickness rate of 3.5% or lower.

(Source: Routine Provider Information Request - P19 Sickness)

Between August 2016 and July 2017, the trust reported locum usage of 1,709 shifts and agency usage of 2,378 shifts for medical staff in Medical Care. All of these shifts were at Darent Valley Hospital. Over the same period there were no shifts that were not filled by locum or agency staff to cover sickness, absence or vacancies. The data supplied by the trust don’t allow us to calculate usage rates.

(Source: Routine Provider Information Request - P21 Medical Locums)

During June 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average. The proportion of junior (foundation year 1-2) staff was also higher than the England average.

**Staffing skill mix for the 74 whole time equivalent staff working in Medicine at Dartford and Gravesham NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>51%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>15%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>27%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source: NHS Digital - Workforce statistics (01/06/2017 - 30/06/2017)

On inspection we saw that medical staff were now in post. There was a registrar on site Monday to Friday from 9am to 2pm and a regular consultant on the unit on Tuesday am and Thursday pm.

**Records**

Records were not stored in line with national guidance and were not well maintained. Many sets of records were overfilled and we saw sets of notes where the ring holes were broken, this meant there were loose sheets within the folder which could be lost. We checked 10 sets of notes and all sets were difficult to navigate, however medical reviews were well documented.

Patient notes were stored on an open sided trolley or on a shelf in the ward co-ordinator’s office. This office was not kept locked and the door was open and records left unattended. This meant records could have been taken by patients, relatives or mislaid. As a result patient records were not kept in line with regulation. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; Be created, amended, stored and destroyed in line with current legislation and nationally recognised guidance.
We saw good identification and diagnosis to antibiotic times. When people were prescribed an antimicrobial they had the clinical indication and we saw dose and duration of treatment documented in their clinical record. This is in line with National Institute for Health and Care Excellence QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record.

Once a patient had been discharged all notes were scanned and shredded. The electronic records were available online to all areas of the hospital and levels of access were given according to need. The records could be viewed by multiple people at the same time.

Some staff reported problems accessing patient records after patients had been discharged. All patient records were now scanned and shredded after use. This had caused problems when staff needed to access specific notes for investigations or complaints. Notes were placed on the system in no clear order so it was not possible to know when a set of notes that wasn’t already on the system would be uploaded.

Medicines

Elm Court had good access to medicines. A pharmacist and technician visit the unit regularly. If they require medicines on the unit that they do not have someone would go to Darent Valley Hospital to collect.

The unit had two medicine rooms. A fridge was available to store medicines that were required to be stored between 2-8c. The fridge temperature was monitored daily. We reviewed the records and saw they were completed correctly. The fridge had a coded lock to ensure medicines were securely stored.

We saw four medicine round trollies were stored in the medicine room and were securely attached to the wall. Staff undertook medicine rounds four times daily at 7am, 1pm, 5pm and 10 pm.

Locked medicine boxes were found in all the bedrooms to store patients’ own medicines including creams and inhalers. All other patient medicines were dispensed by the nursing staff during the patients’ stay.

Oxygen cylinders were stored correctly and secured by chains to the wall in medicine room two. All cylinders were within the expiry date shown.

A medicines information patient helpline was available to all patients. Medicines reminder charts were also given to people upon discharge to help them take their medicines correctly at home.

Controlled drugs discharge prescription charts were used to request controlled drugs from the pharmacy at Darent Valley Hospital. The controlled drugs were stored in a single locked medicine cupboard in the coded entrance medicine room in line with recommended guidance. We checked Midazolam and Fentanyl quantities against the controlled drugs register. We found the amount documented matched the amount of drugs in the medicine cupboard.

We observed sodium chloride 0.9% fluids were stored in the locked medicine room; however they were stored in an open shelving unit. This is against national guidance as sodium chloride 0.9% fluids should be stored in locked cupboards.

We inspected three sharps boxes in the medicine room. We observed that two were signed and dated, however one was not dated and signed which is against national guidance.

We observed that protein drinks were stored on the floor which is not good practice as objects stored on the floor can prevent good cleaning practices.
We observed boxes of discarded medicines on the work surface. A nurse told us they were waiting to be placed in medicine bags and returned to Darent Valley Hospital. Porters come down from the hospital twice per day to collect these.

**Incidents**

During our comprehensive trust inspection in 2013 we saw the trust needed to ensure that learning from the reporting of incidents was cascaded and that any changes to practice required following a serious incident were implemented in a timely manner. During our recent inspection we saw there were arrangements to ensure serious incidents were investigated promptly. We saw examples of these investigations and noted they were sufficiently thorough, identified lessons learnt and actions to be taken. Staff told us, and we saw from meeting minutes, information regarding serious incidents was shared with the matrons and sisters who then reported anything to staff on the wards via handover or departmental meetings. Staff we spoke to were not aware of any incidents from Darent Valley Hospital which could indicate that feedback was not routinely given.

There was suitable discussion about the lessons learnt and changes in practice needed to prevent recurrence. We were given examples of changes in practice at Elm Court as a result of an incident. For example, there was a recent change in practice following a pressure ulcer that was classed as a Serious Incident. Previously one staff member would review the patient on arrival to the unit however, now when a patient was transferred down to the unit, two nurses reviewed the patient and put together a body map. Also there was clearer documentation regarding patients who refused care and did not wish to be turned or comply with care. Staff now documented that the risks were explained to the patient. Staff also documented the risks each time they had contact with the patient, as well as clear documentation on the skin bundle that they had followed.

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

Between September 2016 and August 2017, the trust reported no incidents classified as never events for Medicine.

*Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)*

In accordance with the Serious Incident Framework 2015, the trust reported 44 serious incidents (SIs) in Medicine which met the reporting criteria set by NHS England between September 2016 and August 2017.
Of these, the most common type of incident reported was

- Pressure ulcer meeting SI criteria with 26 (59% of total incidents)
- Slips/trips/falls meeting SI criteria with 14 (32% of total incidents)
- HCAI/Infection control incident meeting SI criteria with three (7% of total incidents)
- Treatment delay meeting SI criteria with one (2% of total incidents)

(Source: Strategic Executive Information System (STEIS))

All staff were able to access an online system to report incidents. We saw that correct reporting of PU and falls, in line with the Royal College of Nursing: Management of Pressure Ulcers: All pressure ulcers grade 2 and above should be documented as a local clinical incident.

All incidents were reviewed by the matron or ward sister and escalated if appropriate. The trust also fed back about trust wide incidents via a monthly newsletter which was e-mailed to all staff. Staff reported they were aware of this newsletter but not all reported they read these. We also had reports from some staff that they did not receive regular feedback about incidents.

Patient safety alerts were issued via the Central Alerting System, a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the National Health Service and other organisations, including independent providers of health and social care. The trust had an alerts officer and alerts administrator but did not audit compliance.

There were monthly mortality and morbidity meetings held by the ‘Mortality Surveillance Committee’; these were well attended by a multidisciplinary team including representatives from the medicine directorate. They also had Clinical Commissioning Group representation. We reviewed minutes of these meetings and saw they reviewed crude mortality, mortality flags and prepared learning summaries to be shared amongst staff.

We reviewed two Root Cause Analysis reports following on from serious incidents, they were suitably robust and included lessons learnt and showed correct protocol in reference to the duty of Candour. Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008.

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 22 new pressure ulcers, 18 falls with harm and 16 new urinary tract infections in patients with a catheter between September 2016 and September 2017 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Dartford and Gravesham NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>Total Pressure ulcers (22)</th>
<th>Total Falls (18)</th>
<th>Total CUTIs (16)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.0</td>
<td>1.8</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
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<tr>
<td></td>
<td>inspection – Evidence</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>appendix</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Safety thermometer - Safety Thermometer

Safety thermometer data was discussed at the monthly matrons’ meetings and reports sent to the patient safety committee which met monthly to discuss trends and themes.

Staff were able to send photographs to the tissue viability nurses who can give care guidance in between unit visits. We heard staff participated in the trusts’ ‘Pressure ulcer pledge’ this was an ongoing professional pledge to prevent patients developing pressure ulcers where possible. This was signed by staff after the in house training. We were unable to check the pledges as they were stored in personal files.

On the day of inspection we saw safety thermometer information was displayed on the unit. The harm free care was reported as 76%. This was due to urinary tract infections and pressure ulcers. There was no action plan in response to these, and staff were unaware how the percentage of harm free care was calculated. The senior sister had to contact the Safety Thermometer Coordinator for information. This showed that although the unit was collecting the data it was not being used to improve care on the unit.

Is the service effective?

Evidence-based care and treatment

We reviewed a range of clinical policies and found that all expected topics were covered by a policy framework, either locally or at trust wide level. We were shown protocols used in Elm Court. We noted they were referenced and based on relevant National Institute for Health and Care Excellence guidance. Staff were able to access national and local guidelines through the trust’s internal computer system. This was readily available to all staff. Staff demonstrated how they
could access the system to look for current trust guidelines. We noted there were links in place to access national guidelines if needed.

We saw relevant and current evidence based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. For example National Institute for Health and Care Excellence guidance CG161: falls in older people assessing risk and prevention, QS24: nutrition support in adults, QS3: Venous thromboembolism in adults reducing the risk in hospital, QS66: intravenous in adults in hospital therapy, QS90: urinary tract infections in adults, QS2: stroke quality standard and the Royal College of Physicians national clinical guidelines for stroke.

National Institute for Health and Care Excellence guidance is circulated to the identified lead within each directorate or department together with a link to an on-line pro forma. The designated lead completes the pro forma and returns it to the governance department which collated the information. Quarterly reports were prepared for the Quality and Safety Committee who, in turn reported to the trust board on the status of National Institute for Health and Care Excellence guidance. In addition an annual report was prepared for the Quality and Safety Committee. This gave the committee the opportunity to scrutinise whether the guidance was being complied with.

We observed many staff handovers across different areas in medical care; they routinely referred to the psychological and emotional needs of patients, as well as their relatives and carers. This included patients who are suspected to be experiencing depression being referred for a mental health assessment. We reviewed two sets of notes for patients who had depression identified, which included individual patient needs and referral and suggestions from the mental health team.

The trust had a multidisciplinary, Sepsis Steering Group. The role of the group was to review sepsis care across whole acute care system. Improvements included the ‘Vital signs policy being updated to incorporate reference to sepsis screening and escalation process

The trust had been participating in the Royal College of Emergency Medicine ‘Severe sepsis and septic shock audit’ for past three years where data was sent for review. The results have shown steady progress on various sepsis related quality indicators including sepsis-6.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Risk assessments were completed by a qualified nurse when patients were admitted to hospital. This included a malnutrition universal screening tool which identified patients who were at risk of poor nutrition or dehydration, in line with National Institute for Health and Care Excellence, QS24 statement 1: Screening for the risk of malnutrition.

All records we checked showed Malnutrition Universal Screening Tool scores had been recorded. We noted patients who were identified as at risk, had nutrition care plans in place. Staff could request a dietician if needed. Dieticians routinely visited the unit 1.5 days per week. They also attend the multi-disciplinary team. However the senior sister told us that the dietician would come down to the unit if a review was required in between visits. All patients with a Malnutrition Universal Screening Tool score of two were referred to the dietician.

**Pain relief**

Patient pain scores were completed as part of routine observations by nurses but not always consultants. A system of scoring 1-10 was in use and this was used to evaluate the effectiveness of pain relief given. We saw pain scoring documented in patient notes. Patients
who had difficulties communicating used picture boards. However, there was no formal pain scoring used such as the ‘Disability Distress Assessment Tool’ for patients with severe communication difficulties. Staff told us they use facial expression for pain scoring in these cases. However, that could lead to inconsistent scoring of patients’ pain as different staff may not notice a difference from day to day.

Patients we spoke with told us they received adequate pain relief and it was administered promptly when requested.

**Patient outcomes**

Information about the outcomes of people's care and treatment were routinely collected and monitored. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit. For example all areas carried out a series of weekly and monthly audits to identify trends and themes and areas for improvement.

Weekly audits included hand hygiene, commode cleanliness and cannula management. We reviewed the most recent results and found for example that Methicillin-resistant Staphylococcus aureus screening audit at Elm Court was in line with trust targets of 90% compliant in September and October 2017.

We saw there was a system for local audits to be formally presented at the directorate’s audit and governance meetings. This meant results and lessons learnt were shared to improve services.

Monthly audits included falls, Malnutrition Universal Screening Tool compliance, and pressure ulcers. We saw that there were 18 falls with harm across the directorate from September 2016 to September 2017. In the same period there were 22 hospital acquired pressure ulcers reported. The most recent Malnutrition Universal Screening Tool compliance audit compiled data from October 2017 and showed 100% of patients audited received a Malnutrition Universal Screening Tool assessment within 24 hours.

**Trust level**

Between June 2016 and May 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in Medical Oncology had a lower than expected risk of readmission for elective admissions.
- Patients in Clinical Haematology had a lower than expected risk of readmission for elective admissions.
- Patients in General Medicine had a higher than expected risk of readmission for elective admissions.
- Patients in General Medicine had a lower than expected risk of readmission for non-elective admissions.
- Patients in Geriatric Medicine had a lower than expected risk of readmission for non-elective admissions.
- Patients in Respiratory Medicine had a lower than expected risk of readmission for non-elective admissions.
### Elective Admissions – trust Level

![Graph showing elective admissions by specialty](image)

### Non-Elective Admissions – trust Level

![Graph showing non-elective admissions by specialty](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.*

*(Source: HES - Readmissions (01/06/2016 - 31/05/2017))*

### Discharge Scores

Results for Dartford and Gravesham NHS trust results were better than the England and Wales average for five of the seven standards relating to discharge.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Darent Valley Hospital</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEI on discharge (%)</td>
<td>52.8%</td>
<td>61.1%</td>
</tr>
<tr>
<td>ACEI/ARB on discharge (%)</td>
<td>82.1%</td>
<td>73.7%</td>
</tr>
<tr>
<td>Beta blocker on discharge (%)</td>
<td>88.5%</td>
<td>80.4%</td>
</tr>
<tr>
<td>MRA on discharge (%)</td>
<td>48.5%</td>
<td>45.4%</td>
</tr>
<tr>
<td>Received discharge planning (%)</td>
<td>88.3%</td>
<td>87.3%</td>
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<tr>
<td>Referral to HF nurse follow up (%)</td>
<td>42.6%</td>
<td>54.8%</td>
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<tr>
<td>Referral to HF nurse follow up (LVSD only)</td>
<td>70.5%</td>
<td>70.8%</td>
</tr>
<tr>
<td>Referral to cardiology follow-up</td>
<td>47.2%</td>
<td>67.5%</td>
</tr>
<tr>
<td>Referral to cardiac rehabilitation (%)</td>
<td>4.2%</td>
<td>12.1%</td>
</tr>
</tbody>
</table>

*Source: NICOR - Heart Failure Audit (01/04/2014 - 31/03/2015)*
The National Diabetes Inpatient Audit measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 percent, whereas quartile 4 means that the result is in the highest 25 percent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 60 inpatients with diabetes at Darent Valley Hospital, 73% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile one, which is comparable to the 2015 score of 67.3%.

(Source: NHS Digital)

According to the National Audit of Inpatient Falls 2015 (published in 2017) the trust has a multi-disciplinary working group for falls prevention where data on falls are discussed at most or all the meetings.

The crude proportion of patients who had a vision assessment (if applicable) was 22.2%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 17.4%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a mobility aid in reach (if applicable) was 62.5%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

The trust appraisal compliance target was 85%. Appraisal compliance rates were monitored and reported each month at directorate and department level, and to the trust board. Appraisal rates were also monitored by the Workforce Committee, a sub-committee of the trust board which met every two months.

From January 2017 staff that had not been apprised in the last twelve months were not eligible for incremental pay progression.

The 2016 staff survey reported 86% of respondents had an appraisal in the last twelve months. This was comparable with the national average of 86%. Training was offered to appraisers on how to conduct an appraisal meeting.

Staff reported feeling well trained to do their jobs. We spoke to a staff member who had recently had an appraisal and said career progression was talked about and they felt the appraisal was worthwhile.

Between July 2016 and June 2017, 72.9% of staff within Medicine at the trust received an appraisal. The trust told us in their Provider Information Request that their completion target is 85%, though this only applies to staff that have been employed for more than one year.
The split by staff group at trust level and each site can be seen in the graphs below.

**Trust level**

![Appraisal completion rate chart]

### Elm Court

The percentage of qualified nursing staff who had completed their appraisal was 85.7% and 80% of appraisals had been completed in the staffing group “support to doctors and nursing staff”.

There was one member of staff in the staffing group “support to ST&T staff”, who had not completed an appraisal, however 12 out of 14 qualified nursing staff (85.7%) had completed their appraisal, as had 12 out of 15 staff (80%) in the staffing group “support to doctors and nursing staff”.

There were only two NHS infrastructure support staff, of whom one (50%) had completed an appraisal.

In addition to the staff shown in the chart, there were two staff in the staffing group “support to ST&T staff”, and two qualified healthcare scientists. None of these four staff members had completed an appraisal according to the trust data.

*(Source: Routine Provider Information Request -P43 Appraisals)*

Training could be accessed through the online computer system available to all staff who worked in the hospital, staff reported if they were encouraged to do training but sometimes were restricted due to staff shortages. However, many reflected they felt this had improved over the last few months.

Agency staff had their competencies assessed on wards before being allowed to undertake routine tasks.

There was no longer a practice development nurse assigned to the medicine directorate and as a result senior staff were undertaking this role. This could lead to delays in training as staff pressures meant they did not have the time to spend training staff as they would want.

We were told this had been raised to the serious incident group and a request for a practice development nurse had been put forward but at the time of inspection there was no plan in place.
We saw staff who had extended their skills, for example in phlebotomy and a health care assistant had access to NVQ competencies. Staff training was monitored through appraisals, the revalidation process and was signed off by managers.

There was no formal clinical supervision undertaken by nursing staff, we were told it was provided by some senior staff but it was on a voluntary basis and was not recorded in staff records.

A psychiatric liaison team was accessible to staff when further advice or knowledge was needed, the team had further experience and training to work with patients with mental health conditions.

**Multidisciplinary working**

We saw patients with complex needs received prompt screening by a multi-disciplinary team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multi-disciplinary team assessment was undertaken and care plans were put in pace from admission.

There were weekly multi-disciplinary team meetings for people with complex needs, and daily board rounds and handovers were attended by a range of specialist staff. This included the Integrated Discharge Team who helped ensure patients were discharged correctly and in a timely way.

The Integrated Discharge Team took care of many practical aspects of discharge including liaising with family members, checking keys, chasing care packages and working with social services. The occupational therapist and physiotherapist work generically in the team; staff we spoke with felt this was a positive initiative as it enabled staff to improve and maintain their skills and reduced delays waiting for a specific therapist.

The department had a ‘Hospital at Home’ service that enabled patients who still required medical treatment but who were identified as fit for discharge to be discharged. For example, patients who require intravenous antibiotics or oxygen. Staff told us the team would proactively identify patients for this service. Staff felt they had good capacity to take on patients and were easily accessible. We witnessed reference to this service on numerous times on both days of our inspection.

Patients also had access to the Discharge to Access service. The Discharge to Access service was accessed via social services and was based in the community. They undertook home visits for patients awaiting a package of care bundle; this included liaising with the Integrated Discharge Team and could do same day visits if patients were discharged by 2pm.

The medical directorate employed five, band seven, clinical navigators, they worked seven days a week to expedite diagnostic investigations. Staff reported there were no delays in receiving diagnostic results in a timely way.

We saw established links with mental health services, learning disability and dementia services. We saw collaborative working and staff really trying to understand patients’ needs and working together to arrange care.

The service did not discharge a self-caring patient after 8pm and will not discharge with care package unless they are receiving a care visit as soon as they are home.
Seven-day services

Physiotherapists and occupational therapists worked at Elm Court seven days a week. There was a registrar on site Monday to Friday from 9am to 2pm and a regular consultant on the unit on Tuesday mornings and Thursday afternoon.

Although not on site throughout the week the unit could access dieticians and the mental health team who would visit the same day if possible.

Health promotion

We witnessed occasions in board rounds where additional risk factors were identified that required additional support or intervention. There was a multi-disciplinary team approach to these changes and we saw staff take action and make swift decisions.

The trust had a Palliative care team working across the hospital. The team were able to complete fast track Continuing Healthcare checklist assessments and support family to find placements alongside the Integrated Discharge Team.

We saw independence encouraged and occupational health and physiotherapists worked with patients and discussed progress with fellow staff members. If patients were worsening, options and interventions were discussed daily.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff we spoke with had awareness of what to do if patients lacked the mental capacity to make decisions; they understood best interests’ decisions and showed good awareness of the Mental Capacity Act 2005.

There is a policy for enhanced observation of patients with mental health problems. During our inspection at Elm Court there were no patients under Deprivation of Liberty Safeguards (Dols). We were told they are not often accepted as they do not fall under the new referral pathway.

Trust wide any patients under section are supported by the mental health team with paperwork. Staff could access a Crisis Team if required but this had occasionally been problematic due to workload. This had been raised and discussed with the CCG and was on the trust risk register.

The safeguarding and mental health team supported staff to care for patients with mental health problems. Staff reported they would contact them if they had any questions around consent or mental health issues.

All incident and deaths of patients with known mental health problems are discussed at weekly Serious Incident group and any deaths are reviewed by Medical Director.

The trust has a consent policy which describes those situations where consent cannot be taken and how to address this. There were e-learning modules for both consent and mental capacity assessment which are tracked through the clinical education department. All junior staff and staff on induction receive training in consent process including managing patients unable to consent.

The consent policy had recently been updated taking into account recent changes resulting from Montgomery vs Lanarkshire Health Authority. The Medical Director has a number of actions from the last consent audit which showed good documentation, but a number of areas where practice could be improved. As a result a series of talks with senior clinical staff were planned to address these.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff understood and respected the personal, cultural, social and religious needs of patients; we witnessed these being discussed in relation to their care needs. Staff took account of psychosocial aspects of care as well as physical.

Staff took the time to interact with people who used the service and those close to them in a respectful and considerate way. We saw kind interactions from all medical staff in Elm Court. Staff were seen to be encouraging, sensitive and supportive towards and when discussing patients’ needs. We saw multidisciplinary discussions about patient’s care being held on inspection.

There was a ‘red and yellow’ card system for patients with capacity. If patients were issued with a yellow card they would receive a written formal warning and a flag on the hospital wide computer system. If patients received a red flag they were no longer welcome at the trust. Staff reported this had not been an issue as far as they remembered.

We observed several instances where patients’ dignity and privacy had been respected. Patients were covered and doors were closed to prevent private interactions being witnessed by passers-by.

We spoke to four patients at Elm Court. All reported feeling well cared for. Patients reported, “Homely feel”, and “Staff are caring here, lovely atmosphere.”

We witnessed compassionate responses to patients’ needs and anxieties.

We saw staff introducing themselves to patients and their carers in line with NICE Q15 Statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

On discharge a Friends and Family survey was given to patients and their family/carers to enable their feedback to be provided to the trust. There was no format available to enable people with a learning disability to access this form. This had been identified by the department and was under development at the time of inspection.

The Friends and Family Test response rate for Medicine at the trust was 15% which was worse than the England average of 25% between September 2016 and August 2017.

(Source: NHS England Friends and Family Test)
Elm Court Friends and Family results were averaged at 97% which was a positive indication of how patients felt about the care they received. We saw that the low number of questionnaires was mentioned in team meetings dated 13th of September 2017. Staff were reminded to give them to patients before discharge.

**Emotional support**

Staff involved patients and those close to them in decisions about their care and treatment.

Staff showed they understood the impact that a person’s care, treatment or condition would have on their wellbeing and on those close to them. We heard of examples such as the ‘Interactive me’ being used. This was a system where family can record messages for patients which were played if the patient becomes distressed.

The trust had an out of hours care service for deceased patients of Muslim and Jewish faith. This included the completion of the Medical Certificate of Cause of Death documentation protocol. The service aimed to ensure that doctors treating any Muslim or Jewish patient likely to die out of hours can hand over to the on-call doctor. The on-call doctor then visited the patient to gain an understanding of their condition and treatment. In the event of the patient's death out of hours they are then able to complete the Medical Certificate of Cause of Death, this meant the body can be released within 24 hours to Muslim or Jewish families for burial.

The trust conducts an Annual Dementia Carers Audit. We saw a copy of the questionnaire which included information for carers on how to access further support and what services the hospital provided for carers and people suffering with dementia. Carers could also access a clinic for 1-1 advice and carers can be signposted to community support.

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

Staff provided emotional support to patients to minimise their distress. Family members and carers were involved in all discussions around a patient’s care. We witnessed family involvement being discussed at handovers, multi-disciplinary team meetings, and with the patients themselves.

When speaking to family members on inspection they were positive about the involvement they felt in their relatives’ treatment and discharge processes.

People’s carers, advocates and representatives including family members and friends, were spoken to in first name terms on the wards and it was clear that good relationships had been formed between nurses, doctors and therapists.

Patients were given time to ask questions when being told about new treatment options in line with National Institute for Health and Care Excellence, QS15 Statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.

We heard a discussion between therapists and nurses which involved them ensuring that an older patient with complex needs had money for food as they were to be discharged later that day.

**Is the service responsive?**

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

The hospital had plans to develop a ward (Mulberry ward) at Darent Valley Hospital to work in conjunction with Elm Court as ‘Ready to discharge units’. The senior sister told us Elm Court has an operational policy however this was being updated due to the merger with Mulberry ward. Mulberry ward was due to open on 4th December 2017 and will contain 25 beds. Patients at Elm Court and Mulberry ward are for those patients who no longer require medical care and are waiting for discharge.

There was a new system of risk assessment, based on traffic lights which had recently been introduced to prevent inappropriate referrals and admissions. It set clear criteria for transfer to
Elm Court and aimed to avoid inappropriate admissions. Staff at Elm Court were involved in developing the criteria.

There was a register on the Patient Admission System to highlight a formal diagnosis of dementia. Through this system patients were also flagged as blind, deaf or deaf/blind, diabetic, have additional needs, learning difficulties and mental health problems.

Additionally the Electronic Discharge Notice system is updated daily to identify known dementia, suspected dementia and delirium trust wide and is reported monthly. There were 775 dementia patients admitted trust wide in the last year.

The main hospital had an Ambulatory Care Unit which opened seven days a week from 8am 10pm Monday to Friday and 8am until 6pm at weekends. The aim of this service was to expedite care through the accident and emergency department and to help to reduce the number of patients who were admitted into general wards. Of the total medical admissions, 14,162 are Day cases, which has seen a 76% increase. This indicates that the trust has driven forward with their plans to increase their day cases by expanding the Ambulatory Care Unit to offer patients streamlined diagnoses and sent home with ongoing clinical care, requiring no hospital admission.

Referrals are made to the diabetes team, electronically through the Patient Admission System. There is facility on Patient Admission System which listed patients who had been identified as diabetic to be reviewed if they have been admitted to a ward. Patients could also be referred to the diabetic team at their request. Inpatients could self-assess to manage their own diabetes while in hospital.

**Trust Level**

For medical non-elective patients, the average length of stay was 8.4 days, which is higher than the England average of 6.6 days.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in General Medicine is higher than the England average
- Average length of stay for non-elective patients in Geriatric Medicine is higher than the England average
- Average length of stay for non-elective patients in Respiratory Medicine is higher than the England average

**Non-Elective Average Length of Stay – trust Level**

Medical care had 162 bed moves at night between July 2016 and June 2017 with the most occurring in Elm Court (30). In total, there were 473 delayed discharges in the same period (2% of the total discharges were delayed), with the most delays occurring in March 2017 (60).
Meeting people’s individual needs

As the unit is nurse led if patients develop any new or recurring medical conditions they are reviewed by the doctors on site and will be transferred back to Darent Valley Hospital to get more specialised care. The staff at Elm Court can access the advice of an identified Doctor based in Darent Valley Hospital regarding patients whose medical condition had unexpectedly changed. Out of hours the on-call medical team can be contacted for advice over the telephone.

Although the Elm Court Operational policy (2013) instructs staff what to do if a patient’s health was deteriorating this could have been strengthened to give staff specific indicators for clarity. However, in the past year there had been no incidents where patients whose condition had deteriorated had not been managed effectively.

The trust has one full time Dementia Specialist practitioner. We saw that a dementia bundle of policies and guidelines were available on the staff intranet. These included information on clinical and social assessment as well as support and discharge planning. However, staff we spoke with had generally not had specific dementia training. However, staff verbally described what they would do to ensure patients living with dementia were cared for, and their extra needs taken into account.

Patients living with dementia are not generally referred to Elm Court as the environment is not safe, for example fire doors open straight to the outside. However in the Elm Court Operational Policy (2013) it states: Patients with Dementia will not be excluded, if care needs meet the Eligibility Criteria, (unless they have major behavioural problems).

A patient living with dementia was at Elm Court on the day we visited. We observed the patient was in the lounge in the afternoon where staff could observe them more easily. There were no environmental amendments in place or specialist equipment for example coloured cutlery, toilet seats or dementia friendly signs. The medical department had several volunteers recruited in the role of ‘Dementia Buddies’ they had specialist dementia training to carry out the role and could be accessed by Elm Court.

Bariatric patients are not referred to Elm Court as the unit has no beds or equipment to care for them, for example beds with a higher weight limit. They were able to take patients who are large in size. To support these patients the unit has a large blood pressure cuff, a hoist up to 250kg and one wheelchair.

The senior sister told us patients’ social and religious needs were reviewed on admission. The social worker attends the multi-disciplinary team. Staff can make referrals to the social worker through ‘patient centre’.

The environment at Elm Court was not always well maintained and we saw lots of equipment in inappropriate places like the main lounge and dining area. We saw several mattresses stored in the dining room that could prevent patients from moving around safely. The cluttered environment could be confusing for patients with dementia or special needs and could also cause a trip hazard for patients with limited mobility.

The trust had a Patient Engagement Strategy plan in place but at the time of inspection this had not been embedded into practice. Involvement of patients with any of the nine protected characteristic was being developed in line with the strategy. There was no data collected from patients with protected characteristic such as sexual orientation, civil partnership and gender reassignment. There was a Diversity Management Group and we were told they would be discussing how this data could be collected in the future.

A Learning Disability Liaison Nurse was available to offer advice and help with care plans. The safeguarding lead was also a registered learning disability nurse. Ward staff told us they would alert the learning disability nurse when patients are identified as having a learning disability. The Learning Disability Liaison Nurse is also able to make referrals to specialists who could confirm diagnosis for example, autism services, psychologists.
We saw on wards staff did daily care rounds; these were documented in patients’ notes. They asked if the patient was comfortable, pain free or had any nutritional needs. We also witnessed several multidisciplinary discussions around discharge and the services complex patients would need once at home, for example the ‘Hospital at Home’ service, where teams would visit patients who required medical care such as Intravenous antibiotics, at home to aid discharge from hospital.

We saw arrangements put into place that took account of patients’ individual needs when being discharged. This included patients with complex health and social care needs that required special considerations, for example older people with dementia or co-morbidities. The integrated discharge team were present and accessible throughout the day across the department.

There were several means to aid communication with patients requiring additional needs. These included easy read pictures that could be made into documents, easy read books on a number of conditions and hearing loops were available. Chaperones were offered for patients uncomfortable being seen by a medical professional of the opposite sex or if there were any concerns generally.

The service offered both face-to-face and telephone interpreting. In the past financial year (Apr 2016 – Mar 2017) there were 797 bookings in total, of which 21 were unallocated. This means that 97.4% of interpreter bookings were fulfilled.

**Access and flow**

A new system of risk assessment, based on traffic lights had recently been introduced to prevent inappropriate referrals and admissions. There was an Elm Court transfer sheet that was completed by the staff at Darent Valley Hospital. If a patient was considered within the amber and green criteria the ward nurses completed a referral form. If they indicated they fell into the red criteria then they were not suitable for transfer.

We asked the senior sister to review a list of patients transferred back to Darent Valley Hospital from Elm Court from July 2017 to October 2017; out of the 25 people transferred back she felt that three patients on the list were inappropriately transferred to Elm Court. All patients on the transfer list were before the new admission criteria was introduced.

If a patient from Elm Court had to go to Darent Valley Hospital for any reason, for example an x-ray or scan appointment, staff at Elm Court told us they were unable to book hospital transport, instead staff had to request a 999 ambulance. However, to transfer the patient back to Elm Court after the procedure Darent Valley Hospital staff can book hospital transport. We were told occasionally patients have had to go to accident and emergency, for example over a weekend. This system meant that staff found it hard to keep to appointment times and made staff feel they were not part of the wider hospital. In the operational policy for Elm Court it states, “12.1 Patients requiring transfer back to DVH For patients whose condition deteriorates so that they require transfer back to an acute bed, the patient will be transferred back to either A&E; CDU or Evergreen for assessment and intervention. Non-urgent transfers will be done via NSL and can take up to 4 hours. More urgent transfers may need to be transferred via 999 ambulance.” This indicated some confusion over the transporting of patients.

Antibiotics can be prescribed and delivered at Elm Court but if a patient needs a doctor’s review they have to be transferred back to Darent Valley Hospital. During the inspection we observed a man being transferred to Darent Valley Hospital for a blood transfusion.

Between September 2016 and August 2017, the trust’s referral to treatment time for admitted pathways for Medicine for September 2016, showed 97% of this group of patients were treated
within 18 weeks versus the England average of 90%. In the latest period, August 2017, the trust showed 87% of this group of patients were treated within 18 weeks versus the England average of 90%.

(Source: NHS England)

Three specialties were above the England average for admitted RTT (percentage within 18 weeks).

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<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
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<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.7%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>100.0%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>95.9%</td>
<td>83.5%</td>
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</tbody>
</table>

One specialty was below the England average for admitted referral to treatment (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>93.1%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The trust had introduced Discharge to Access service for patients who were medically fit but still required additional support at home. Each patient was given a home assessment within two hours of their discharge. This included a personal care plan for their therapy, goals, carer provision and any equipment they required. The Discharge to Access was reported to have helped to ease the demand on hospital beds and staff and made better use of community services.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. There have been four complaints about Elm Court with issues surrounding discharge being the main theme. We saw an action plan for Elm Court which focused on recent complaints and what actions would be undertaken in response to them. We saw progress was mapped on the action plan however it had not been updated since July 2017, so it was unclear if all measures had been put in place.

Between August 2016 and July 2017 there were 60 complaints about Medical Care (including Older People). The trust took an average of 46 working days to investigate and close complaints and seven complaints had not been closed. This is not in line with their complaints policy, which states complaints should be responded to within 25 days.
There were between four and six complaints from each ward with a main theme of patients being unhappy with the level of care and treatment.

(Source: Routine Provider Information Request -P61 Complaints)

The trust had a central team of three staff to deal with complaints, with additional leadership from a senior nurse. There was also a Patient Advice and Liaison Service officer who supported this work. The medical care directorate provided complaint responses with actions to the central team for logging and these were then reviewed by the Director of Nursing who was the executive lead for complaints. The Chief Executive Officer saw every complaint response and had overall sign off.

We reviewed two recent complaints and saw that they were responded to openly. Both complaints involved discharge issues. Both complaints we reviewed were responded to within the trusts target of 25 days.

We saw information in all areas about how to complain and information leaflets on how to contact the Patient Advice and Liaison Service office.

We saw evidence of complaint reports being reviewed at various committees for example the Quality & Safety Committee. Quality and Safety Committee sent reports to directorate meetings so that local teams could have sight of relevant learning as well as performance issues and any required actions.

**Is the service well-led?**

**Leadership**

The hospital had recently implemented a new model of care that brought the emergency care directorate and adult medicine into one directorate. This included all staff under one umbrella. There was a new lead allied health professional for the new directorate governance and a Business Operations Manager in place since August 2017. This model also included streamlining the devolved leadership structure for medical workforce and charting the team under one management line. This new management structure was not fully embedded at the time of inspection.

Staff at Elm Court were aware of the changes to the department and the inclusion of Mulberry ward also offering discharge beds. However, less senior staff we spoke to were unclear of the new directorate structure and showed limited knowledge of the impact it would have on the department.

There were several matrons across medical care; they managed wards sisters and managers who managed staff nurses and health care assistants. Matrons were in charge of several wards each and spent time between them during the day.

Matrons reported directly to the Director of Nursing who reported to the Medical Director and the Chief Executive Officer. The Matron at Elm Court was a part of matrons’ meetings and also was in charge of wards at Darent Valley Hospital. Staff reported seeing the senior management team on the unit. The new Director Of Nursing had been down to see the unit recently.

Staff across the directorate reported leadership up to matron level was clear and supportive. Staff knew their managers and felt free to contact them. They felt valued and that their opinions counted. The sister we spoke with knew what Elm Court were doing well and could clearly articulate the challenges and risks faced in delivering good care. However, this did not seem to pass between wards and there was little awareness of how other wards were doing from staff below matron level.
Staff we spoke with were aware of the whistleblowing policy and felt able to raise concerns with managers, sisters and the matron.

Staff had access to a mental health liaison team, 24 hours a day, seven days a week that covered the whole hospital. We saw examples where patients required an urgent referral and this was arranged via the mental health lead for medicine.

**Vision and strategy**

Apart from the senior staff there was not a clear vision and a set of values that staff recognised. We saw a poster with the values displayed but staff could not repeat these to us.

The Elm Court unit and Mulberry ward at Darent Valley Hospital were planned to both offer ready for discharge beds to patients who were medically fit for discharge. Staff were aware of these changes. We were told the main focus of the directorate for the next 18 months was to review the specialty bed base and medical working model to ensure delivery of safe, high quality and effective inpatient care in adult medicine and improve the flow of the patient journey.

We saw work had already started to make improvements and adjustments to the service, for example an increased numbers of junior doctors and the bleep 111 filtering. However we did not see a timeline for completion of the new medical model and no clear outline of how this would be achieved.

**Culture**

Staff reported feeling valued and supported at Elm Court. We spoke to new starters as well as longer serving members of staff who said that it was a friendly and supportive working environment. We saw supportive interactions from staff throughout our inspection.

Staff reported feeling proud to work for the organisation. Staff did report they felt partly isolated when there were staff shortages as staff do not come over from Darent Valley Hospital when they are short staffed at Elm Court.

We saw a culture that included the needs and experience of people who use services. Handovers, record keeping and care and treatment plans included patients’ mental health and emotional wellbeing.

We were told that the culture encouraged openness and honesty at all levels within the organisation. Leaders and staff demonstrated they understood the importance of staff being able to raise concerns without fear of retribution. We did witness open conversations in multi-disciplinary team meetings and board rounds which included challenging care decisions. This was welcomed and we felt staff interactions were positive.

Appraisals were undertaken and staff development formed part of this process. Staff told us that development and training opportunities could be accessed, however there were barriers due to lack of staffing.

In the latest National Health Service England – National Health Service Staff Survey dated March 2017, staff reported ‘Communication between senior management and staff’ (%) was worse than the previous staff survey, with 38% of staff reporting communication was good compared to 41% last year.

The same survey revealed that Staff experiencing harassment, bullying or abuse from staff (%) was similar to the previous year with 25% of staff reporting they had experienced this behaviour. We did not see any action plans relating to staff survey results.

**Governance**

The trust were told to improve on aspects of the medical care service they delivered during our previous inspection in 2015. These had not always been addressed and showed a lack of
commitment by the leadership team to implement the recommendations. Examples included poor information governance and infection control practices.

Although there were effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services, these were not effectively reviewed to ensure safe practice. Several audits were undertaken on a weekly and monthly basis, but we saw these were not effective in reporting failings within departments, for example cleaning audits.

We saw examples where staff were not clear about their roles and staff did not always understand what they are accountable for, and to whom. For example we spoke to staff who were completing audits but were not sure what happened to them after completion, only that they had to be handed over to matrons.

There was effective interaction with partners and other service providers which promoted coordinated and person-centred care.

**Management of risk, issues and performance**

During our inspection in 2013 staffing was top of the risk register. During this inspection we saw staffing remained high on the risk register and the trust had a workforce strategy in place. A weekly meeting was held focusing on higher risk/vulnerable areas (mostly in medicine) with an improving picture. Staffing remains a national challenge and the trust was working with other providers in Kent on European and international recruitment. A monthly report was fed up to the board outlining fill rates and more detailed reports go to the Workforce Committee which is a sub-committee of the board.

The trust had an antimicrobial stewardship group which included a representative from the medical directorate. They met every two months and reported to the Medicine Management Committee. They in turn reported to the Quality and Safety Committee. This was in line with NICE QS121 Statement 5: Individuals and teams responsible for antimicrobial stewardship monitor data and provide feedback on prescribing practice at prescriber, team, organisation and commissioner level. Data on antimicrobial usage from 2013/14 up to and including Q1, Q2, Q3 and Q4 2016/17 had been submitted to Public Health England.

The trust had a Local Emergency Preparedness Resilience Policy dated July 2015; this was due for review in July 2019. It was a comprehensive document and included information on ‘Smart Triage’ cards and individual plans for critical incidents including mass casualty plan and an evacuation plan.

The trusts current Hospital Standardised Mortality Ratios is 96.2 and Summary Hospital-level Mortality Indicator is 1.037. The Summary Hospital-level Mortality Indicator reports on mortality at trust level across the NHS in England using a standard and transparent methodology. These are both within the expected range. The trust had a number of alerts on Dr Foster data, Dr Foster exists to help healthcare organisations improve their performance through better use of data, we were told they were being monitored addressed and reported monthly to the board quality and safety committee. The trust lead for mortality was the Medical Director who was responsible for this. The Medical Director also chaired the mortality review group which met before the trusts patient safety committee and all mortality data was presented and challenged at this group, which included Clinical Commissioning Group representation. We requested meeting minutes for the morbidity and mortality meetings but were not provided with formal minutes to evidence attendance, regularity, and quality of the reviews and learning.

Unexpected deaths were raised by incident reporting and reported to the trust’s weekly serious incident declaration group where a decision was made whether to carry out a further investigation.
and proceed to manage any further actions through the patient safety committee. We saw all deaths were screened to determine whether they were potentially avoidable. Those raising concerns were reviewed and presented to the mortality review group which had the same membership as the patient safety committee, and included representation from the Clinical Commissioning Group.

Following discussion and further investigation, some of these cases could go on to be declared as Serious Incidents for the trust and subject to a full investigation and declaration. Occasionally care with organisations outside the trust was questioned and this was then either handed to that organisation or jointly investigated. Complaints, Claims and Coroners hearings are monitored for any deaths that may later raise concerns.

There was a Service Transformation team, who were helping the implementation of the SAFER care bundle on medical wards. This includes the ‘red2green’ reporting and surveillance.

**Information management**

Staff have access though the trust’s computer system to access policy and practice guidelines; they can also access mandatory training information and training opportunities. Only certain staff had access to some meeting minutes and information on audits. This could mean staff were unable to challenge information as they were not able to access it.

At Elm Court during our recent inspection we saw patient records were not kept in line with regulation. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17(2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; Be created, amended, stored and destroyed in line with current legislation and nationally recognised guidance. We saw patient notes with loose pages and broken ring binders, there were cases where there were too many notes in files. They were also not stored in locked rooms and were held on open sided trolleys.

Although there were clear and robust service performance measures in place we saw these were often not carried out in line with policy and that there was no check to see if practice was carried out as should be. For example we saw that maintenance of equipment was not well managed and staff did not seem to realise that they needed assurances that equipment was well maintained.

Departments undertook routine weekly and monthly audits that were reported and monitored in monthly matrons meetings. These were then fed back to the Audit leads committee. The Audit leads Committee had core members of staff from all directorates and included the senior governance manager and the Medical Director. The Audit leads Committee fed into the Quality Safety Committee twice yearly, who fed directly to the trust board.

**Engagement**

Staff at Elm Court were involved in the development of the new system of risk assessment, based on traffic lights had recently been introduced to prevent inappropriate referrals and admissions. However, staff were not actively engaged in the planning and delivery of services and in shaping the future development of the department.

A Consultant was recently appointed as one of 20 national ‘diabetes clinical champions’. The role included meetings with stakeholders in developing a robust community diabetes service; delivery
of several education sessions and meet and greet sessions for local General Practitioners to improve the competency, confidence and knowledge in managing patients with diabetes.

We saw positive and collaborative relationships with external partners to help with challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. For example social services and a local rehab service who provided equipment for patients to use at home.

Antimicrobial pharmacists manned a stall in Antibiotic Awareness Week which took place in November 2017.

The trust had working relationships with local stakeholders such as the Local Authority Health Committee, Alzheimer's and Dementia Society & Learning Disability Forum. Healthwatch representatives were also invited to and sit on a number of patient focused forums.

The trust takes part in the Equality Delivery System 2 project and with local people and partners aimed to review and improve performance for people with characteristic protected by the Equality Act 2010. However, we did not see any clear action plans in relation to this at the time of inspection.

Learning, continuous improvement and innovation

We saw all wards across medicine had a ‘visbordar’, by the nurse’s station. This board contained information about patients on the ward, such as name and where they were on the ward. Staff showed us a discrete symbol, which identified patients who had a Healthcare associated infection. This meant all staff who were involved in the care or visited patients on the ward, were able to see this information. This was an improvement on our inspection in June 2016, where we found this practice was not consistent.

Departmental meetings were held monthly and all staff could attend. They covered incidents and any changes to practice/policy. Staff reported that if they were unable to attend that minutes were placed in staff rooms. We observed this on inspection. However, we did not see effective participation and learning from internal and external reviews was cascaded to all staff.

The trust launched a ‘Micro Guide’ in July 2016; this was available as an app and also via the intranet for patients to learn about the hospital and treatments that it offered.

The trust had recently launched a nurse-led bleep filtering (111) to support junior doctors’ workload and streamline clinical resources to demand. It enabled triaging of bleeps and helped to ensure the most urgent patients got seen first.