Maidstone and Tunbridge Wells NHS Trust

Evidence appendix
Maidstone District General Hospital
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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 locations registered with CQC:
- Maidstone Hospital
- The Tunbridge Wells Hospital at Pembury,
- Crowborough Birthing Centre.

Services provided at the trust:
- Urgent and emergency services
- Medical care (including older people's care)
- Therapy Services (Urgent Care)
- Surgery
- Critical care
- Maternity
- Gynaecology
- Services for children and young people
- End of life care
- Diagnostics
- Outpatients
Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust in the south east of England. The trust was legally established on 14 February 2000 and provides a full range of general hospital services and some areas of specialist complex care to around 560,000 people living in the south of West Kent and the north of East Sussex.

The trust’s core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs, and it operates from two main clinical sites: Maidstone Hospital and Tunbridge Wells Hospital at Pembury. The latter is a private finance initiative hospital and provides wholly single bedded en-suite accommodation for inpatients. This means the building is owned by a private sector company, and the trust leases the building. It also operates a birthing unit: Crowborough Birthing Unit which was newly acquired in January 2016, and other small community and satellite services.

In addition, the trust provides specialist cancer services to around 1.8 million people across Kent, Hastings and Rother, via the Kent Oncology Centre, which is sited at Maidstone Hospital, and at Kent and Canterbury Hospital in Canterbury. The trust also provides outpatient clinics across a wide range of locations in Kent and East Sussex.

Maidstone and Tunbridge Wells NHS Trust is in the boroughs of Maidstone and Tunbridge Wells, and serves the population living in south west Kent. The population is mainly white (97.3%), and the highest ethnic minority is Asian, making up 1.1% of the local population. Maidstone ranks 217th out of 326 local authorities for deprivation (the local authority that ranks first is the most deprived and the one ranked 326th is the least deprived.) Life expectancy for both men and women is slightly higher (better) than the England average.

**Facts and data about the trust**

| Total number of inpatient beds | 756 |
| Total number of outpatient clinics per week* | 1136 |
*physical healthcare services only

| Total number of community clinics per week | 71 |
| Total number of day case beds | 110 |
| Total number of children’s beds (Acute setting) | 46 |
| Total number of children’s beds (CHS setting) |  |
| Total number of children’s beds (MH setting) |  |
| Total number of dedicated EOLC inpatient beds | 0 |
| Total number of inpatient wards | 40 |

(Source: Provider Information Request 2017)

The trust employed 5820 staff.

(Source: Provider Information Request 2017)

**Financial position**

The trust was placed in Financial Special Measures in July 2016 as a consequence of not agreeing to the control total set by NHS Improvement and being significantly at variance to that control total. The trust reported a deficit of £10.9 million, post sustainability and transformation funding which was £15.6 million adverse to the control total set at the beginning of the financial year 2016/17. The key drivers of the adverse variance reported were: significant use of agency staff and the associated premium; the need to open escalation areas during the winter period; the impact on the trust's ability to deliver elective activity due to the increasing demand of non-elective
activity; inclusion within the financial recovery plan of a number of high risk income schemes which were unable to be delivered and part-delivery of the sustainability and transformation funding performance and financial targets. For 2017/18 and 2018/19, the trust has agreed to the control total which returns the trust to a break even position (pre sustainability and transformation funding) at the end of 2018/19. The financial projections are based on the trust delivering cost improve programmes of £31.7 million in 2017/18 and £10 million in 2018/19.

(Source: Provider Information Request 2017).

Is this organisation well-led?

As part of the inspection process, we interviewed all the members of the board, both the executive and non-executive directors, and a range of senior staff across the hospital. We looked at a range of performance and quality reports, audits and action plans. We attended a board meeting, looked at previous board meeting minutes and papers to the board.

We looked at investigations of deaths, serious incidents, complaints and sought feedback from patients, local people and stakeholders. We spoke with a wide range of staff and asked their views on the leadership and governance of the trust.

Leadership

The trust had continued to make improvements since the last inspection, despite being put in financial special measures. The trust board had been through a period of significant change since the last inspection, which had no impact on patient care or the delivery of improvement.

The work of Maidstone and Tunbridge Wells NHS Trust was overseen by the trust board, which had a statutory responsibility for the trust.

The board consisted of a chair (non-executive), five other non-executive directors (voting members), the chief executive, and four executive directors (voting members). Other directors (non-voting) also attended the board, and contributed to its decision-making.

Non-executive directors are members of the public who live in the area that the trust serves and who responded to advertisements for the posts. The Secretary of State for Health, via NHS Improvement, appoints the chair and the other non-executive members. Technically, they are not employees of the trust (and have no employment rights), and the terms of their appointment (including their remuneration) are set by NHS Improvement.

The acting chief executive joined the trust in April 2015 as deputy chief executive and had acted into the role of chief executive since September 2017. Before joining Maidstone and Tunbridge Wells NHS Trust, they worked in the NHS Trust Development Authority, with responsibility for oversight of NHS Trusts in the south of England.

The chief operating officer had been in post since 2011 and joined the trust in 2004 from another NHS hospital. They had worked in a variety of senior nursing and management roles, most recently as deputy chief operating officer and previously as the 18-week programme director for the trust.

The medical director was appointed in 2017. Prior to this they were the medical director of a community health trust from 2012. By background, they worked as a consultant in general and geriatric medicine with an interest in stroke medicine and had worked at the trust from 2005, becoming the clinical lead in 2007.
The interim chief nurse had been in post since 2017. They joined the trust in April 2016 as deputy chief nurse. Prior to this, they had a variety of general management and senior nursing roles within acute trusts, most recently as the deputy director of nursing.

The director of finance had been in post since 2014 and had joined the trust from an acute trust, where they had been deputy director of finance; which included 12-months as a director of finance. They held various positions within the finance function in a number of NHS organisations across in a NHS career of over 20 years.

The director of workforce joined the trust on 1 December 2017. Prior to this they were the director of human resources and organisational development at a trust for 11 years. Before becoming a director, they worked in a number of human resources positions at an acute trust and other NHS organisations.

The director of infection, prevention and control led the trust’s infection prevention strategy. They were a consultant microbiologist and joined the trust in 2007. They had previously worked as consultant microbiologist at an acute trust.

The trust chair had been appointed in May 2017. Prior to this, they were a ministerial advisor on private sector involvement and public private partnership to the minister of public health in Qatar. Prior to moving to Qatar, they worked in the independent health sector and was an NHS chief executive from 1991 to 2003.

The chair’s appointment had been well received by the executive team. In the six months prior to inspection there was a period of transition from the outgoing chief executive. Non-executive posts had been left vacant in order for the new chair to establish the requirements of the board. The chair had appointed to these posts and had already had an away day with the board to establish board development needs.

The trust had five non-executive directors and one associate non-executive director. They had a variety of backgrounds, which included previous experience as a chair of a trust; chief financial officer; deputy leader of a county council; nursing; working in local authority; director at NHS Improvement and a chief executive

We spoke with the non-executive directors and were assured they had a clear understanding of their roles and responsibilities.

The executive team told us they had healthy challenge and debate from the nonexecutive directors and we observed a board meeting which confirmed this was the case.

The chair of the trust board and its non-executive directors are independently appointed by NHS Improvement. The chief executive and other executive posts serving on the trust board are appointed by the trust in liaison with NHS Improvement. All members of the trust board were subject to a performance framework which stipulates that: The chair of the trust board is appraised via a national framework operated by NHS Improvement; non-executive directors and the chief executive are appraised by the chair; executive directors are appraised by the chief executive.

We reviewed all executive and non-executive files and saw the administrative and employment processes to ensure fit and proper persons were employed were in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust board secretary managed the quality of confidential record keeping and documentation control, along with regular reviews. This was indicated with a fit and proper persons requirement checklist and due diligence checklists on the front of each record.
All of the records referred to in the fit and proper persons requirement and due diligence checks were retained within the individual files to indicate the checks had been undertaken with the exception of documentation relating to objectives and appraisals which were held separately on individual personnel files held by the human resources department.

The dates when appraisals were undertaken was noted on the fit and proper persons requirement checklist for executive directors and some documentation in relation to objectives and appraisals was missing from the executive directors file held by the human resources department.

In relation to the non-executives, the appraisal documentation was held on individual fit and proper persons requirement files which confirmed the appraisals were undertaken by the chair.

The trust had three clinical divisions. The three clinical divisions were the women’s, children’s and sexual health division, the planned care division and the urgent care division.

Planned care and urgent care were further subdivided. Planned care had one subdivision of cancer, haematology and radiology; pathology and pharmacy; outpatients and health records.

A director of medical physics and associate director for cancer and clinical support reported to a director of operations. A general manager for pathology, chief pharmacist reported to a clinical director for pathology and pharmacy and general manager for radiology reported to a clinical director of cancer, haematology and radiology. A lead chemotherapy nurse, health records manager and outpatient manager reported to an associate director of nursing.

The director of operations, two clinical directors and an associate director of nursing reported to the chief operating officer.

The other subdivision was of surgery, urology and gynae-oncology; trauma and orthopaedics; head and neck; theatres anaesthetics and critical care.

General managers for surgery; head and neck; trauma and orthopaedics and critical care reported to head of performance and delivery who reported to a director of operations. This subdivision had four clinical directors for surgery, urology and gynae-oncology; trauma and orthopaedics; head and neck; and critical care. Lead matrons for critical care, trauma and orthopaedics, surgery and a lead nurse for ophthalmology reported to an associate director of nursing.

The director of operations, four clinical directors and an associate director of nursing reported to the chief operating officer.

The urgent care had staff reporting to both director of operations and clinical directors or associate directors and clinical directors.

For example: The trust discharge manager; general manager for acute and emergency; head of therapies and general manager for specialist medicine reported to the director of operations. There was also a reporting line for the general manager acute and emergency to clinical director of acute and emergency and for the head of therapies to report to the clinical director of specialist medicine. The lead matrons for acute and emergency and specialist medicine reported to the associate director of nursing, but also had reporting lines to the corresponding clinical directors.

The director of operations, associate director of nursing and two clinical directors reported to the chief operating officer.

The paediatric, women’s and sexual health and sexual health subdivision had a different structure in that no one in the leadership team reported to the clinical directors.
Two lead matrons for sexual health and paediatrics and two general managers for sexual health and women’s and paediatrics all reported to an associate director of operations.

Three lead matrons for outpatients and community midwifery; inpatient midwifery and gynaecology, a safeguarding nurse and a deputy head of midwifery reported to a head of midwifery.

An associate director of operations, two clinical directors and head of midwifery reported to the chief operating officer.

The board met monthly, had public attendance and either a presentation from a clinical directorate or a ‘patient story’.

Board members were encouraged to visit departments and the new director of workforce was planning a day as a health care assistant as part of his induction. We saw reports to the board which detailed visits by various board members to different areas of the trust, which indicated this was occurring.

Staff told us they felt the leadership team were visible and the non-executive directors met with staff both informally and on request.

The workforce strategy incorporated leadership and talent management. Succession planning and talent management within the divisions was managed through the appraisal process and business planning and development opportunities were available dependent on individual need.

Through these processes gaps were identified in development for Band 5 staff to transition into Band 6 and 7 supervisor or manager posts and an in-house leadership programme was developed to support this. Staff at Band 6 or 7 and above were funded for accredited programmes with Health Education England to support transition into senior leadership positions. Heads of service were supported to apply for scholarships to assist them in director level posts.

In the last 12 months the trust supported a number of staff on leadership development programmes: 17 staff on in-house leadership and management courses; three on CIPD business leadership development; two on Florence Nightingale leadership scholarships; five doing masters degrees in healthcare leadership and management; two doing masters degrees in health and management; one on the Mary Seacole leadership course; 53 on a middle manager boot camp; five doing leadership and management certificates and one doing a master’s degree in business administration.

We looked at 10 staff files and saw they were complete, contained job descriptions, qualifications, professional registration checks, disclosure and barring service checks, references, occupational health clearance, fitness to practice declarations and evidence of right to work. We saw examples where staff had undergone capability reviews and evidence all meetings were documented and clear processes followed.

**Vision and strategy**

The trust’s mission was to provide safe, compassionate and sustainable health services.

The vision of the trust was to provide the highest, consistent, quality care to our patients, whether in or outside hospital setting.

They aimed to deliver their vision through their core values: Patient first; Respect; Innovation; Delivery; Excellence (PRIDE).
Staff we spoke with during the unannounced inspections knew the trust’s’ values and felt they delivered their services in line with them.

This was to be achieved through three strategic objectives for the organisation:

- To be recognised as a caring organisation
- To provide sustainable services
- To be improvement driven

The leadership team had identified elements which would be key to developing a culture of quality improvement. They were:

- A revitalised approach to engagement;
- A single approach and methodology for improvement and innovation
- Capacity and capability to drive change, with dedicated resource and executive leadership.

The trust had invested time in Listening into Action which is an approach that enables and encourages staff to initiate and drive improvement. It enabled the trust to focus on areas where there were issues and identified solutions to longstanding problems.

The trust strategy ‘Time to change…’ had been designed to provide a guide as to how the trust would need to evolve over the next five years to fulfil its vision. The trust had aligned its vision with Five Year Forward View. The NHS Five Year Forward View was published in October 2014 and set out a new shared vision for the future of the NHS based around new models of care. This included the need for acute trusts to provide services with community based service providers.

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 within the Kent and Medway Sustainability and Transformation Plan.

Work was underway to remodel services to support more of them outside the hospital setting and improve the integration of services. Steps were being taken with healthcare partners to improve pathways of care. The annual refresh of the strategy was underway at the time of inspection.

The trust strategy was developed from a clinical strategy. Over a six month period clinical leads from Maidstone and Tunbridge Wells NHS Trust and partner organisations were involved in initial ‘specialty’ or departmental level strategy sessions to identify how services could evolve to improve quality whilst addressing the financial pressures we are facing. Each specialty or department developed their ideas in line with the five year forward view and with local partners.

The trust’s vision overarched the values, which delivered the strategic objectives and helped to support the strategic focus.
It was clear with all members of the board we spoke with; quality of care was the priority for the trust, in spite of its financial difficulties.

The estates strategy was being revised to take into consideration changing needs of the population.

The trust had several identified several key issues:

- Poor patient flow affecting bed availability.
- Financial position.
- Workforce issues.

They had already taken steps to address these issues

- Use of Acute Medical Units and more efficient discharge processes.
- Recognition that increased step down provision was needed in West Kent.
- Activities to attract clinical candidates as well as filling long standing vacancies.

The senior leadership team felt there were three elements which would be key to develop a culture of culture of quality improvement, they were:

- A revitalised approach to engagement.
• A single approach and methodology for improvement and innovation.
• Capacity and capability to drive change, with dedicated resource and executive leadership.

Listening into Action had been an enabler to improving engagement and the trust had signed up with Advancing Change and Transformation Academy to make use of its Quality, Service Improvement and Redesign suite of programmes. They had identified this improvement methodology as the best fit for to assist improvement activity and one which complimented the Listening into Action methodology.

Culture
The trust recognised engagement and communication with staff had not historically been strength in Maidstone and Tunbridge Wells NHS Trust, which had affected the culture of the organisation. They felt they had made good progress more recently and could build on that.

We found throughout the organisation an open and honest culture. Staff felt able to raise concerns amongst their peers and with leaders. Leaders and staff understood the importance of staff being able to raise concerns.

The trust was in the process of appointing 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. A non-executive director supported this role. The trust benchmarked this role against two other acute trusts. As the trust was in the process of appointing the Freedom to Speak-up Guardian there was no documentation on their appraisal or supervision at the time of inspection.

Prior to this the trust had been running a ‘speak out safely’ campaign. This included an anonymous email address, where staff could send their concerns. We saw examples of anonymous reporting, the details of the concerns, investigations and actions taken by the person handling the report. They indicated serious consideration was taken into the concerns. An overview of concerns, investigations and resulting actions were reported to the board and we saw papers which indicated this was the case.

The trust’s staff could also access an employee assurance line, which could be used by family members too.

Staff told us they felt the human resources team were very approachable and open. They felt employee relations were fair and consistent. The human resources team told us there were a decreasing number of disciplinary actions as they had worked with staff and managers to resolve matters informally at earlier stage.

Staff told us they would be happy to challenge poor performance. We saw personnel files which detailed actions taken with staff as a result of concerns in line with the trust’s performance management policy. This included fitness to practise assessments and referrals to professional bodies.

The trust worked with trade unions and staff side described a good working relationship with the trust. Senior leaders shared policies with staff side for their consideration prior to implementation. Staff side had some concern staff were not always being encouraged to attend meetings because of work force pressures.

Implementing the Workforce Race Equality Standard is a requirement for NHS commissioners and NHS healthcare provider. It ensures employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.
We saw the trust had completed the Workforce Race Equality Standard reporting template and had an action plan arising from it. This was included in the annual equality report and monitored by the director of workforce and through the workforce committee.

The trust had lesbian, gay, bisexual, transgender, disability and cultural diversity networks in place. Staff told us they welcomed them and they were well supported by managers. The networks had executive support and senior champions.

A trust’s sickness level can be an indicator of culture within an organisation.

The trust’s sickness levels between June 2016 and April 2017 followed the England average trend for the whole time period. The trust was slightly better with their sickness absence rates being lower than that of the England average and found to be around 3% at April 2017 compared to around 4% for the England average.

![Graph showing sickness levels]

(SOURCE: NHS Digital - Staff sickness)

Training and appraisals were reported monthly to divisions in the integrated performance report, to the board via the integrated dashboard and quarterly to the workforce committee.

**Governance**

We spoke with staff, the senior leadership team, observed a board meeting and reviewed committee minutes. We had assurance there were effective systems, processes and accountability at all levels to provide good quality care throughout the trust.

The committee structure was detailed and had numerous committees and groups, but was clear in its lines of accountability and reporting.

Seven committees reported directly to the trust board. The patient experience committee; workforce committee; finance and performance committee; audit and governance committee; charitable funds committee and quality committee met regularly and provided written reports to the trust board. The renumeration and appointments committee met when required. These committees oversaw the trust’s quality governance arrangements.

Fifteen subcommittees reported to the trust management executive and although it was not a sub-committee of the trust board, submitted a report on its activities to the board.
Thirty two groups, committees and panels fed into the trust clinical governance group which provided a report to the quality committee. The trust clinical governance group was one of the 15 subcommittees which reported to the trust management executive.

We looked at the terms of reference for several of the committees and saw they met requirements. We saw meetings were always quorate, which meant they always had the necessary number of people in order to make decisions.

The board’s sub-committees operated to enable assurance to flow from clinical areas. Clinical directorates reported to each main quality committee, and the output of these meetings was reported to the trust board.

We reviewed the board papers and minutes of board meetings for 2017. They indicated performance and committee reports were presented and approved.

The board operated with a number of subcommittees:

- The audit and governance committee provided assurance to the board the effectiveness of controls to minimise or mitigate risk to the trust. It was chaired by a non-executive director and other non-executive directors were members. They submitted an annual report to the board.

- The charitable funds committee aimed to ensure the trust’s charitable funds were managed efficiently and effectively in accordance with the charity commission. A non-executive director chaired the committee.

- The finance committee gained assurance on financial management, treasury management, investment, capital expenditure and financial governance. A NED chaired it.

- The quality committee ensured that risk to achieving excellence in clinical and organisational operation were being effectively understood, managed and mitigated. It occurred monthly and was chaired by a non-executive director.

- The workforce committee ensured the necessary strategies, policies and procedures in place to ensure a high performing and motivated workforce was in place to provide a quality service. The Committee was chaired by a non-executive director.

- The patient experience committee presented patient and public views of services which had been gained from engagement with service users and stakeholders.

- The renumeration committee sets appropriate remuneration and terms of service for the chief executive, other executive directors, and other senior employees.

Although not a board sub-committee, the trust management executive oversaw the effective operational management of the trust. This included the achievement of standards, targets and other obligations; and the identification, mitigation and escalation of assurance and risk issues. The trust management executive met monthly, and was chaired by the chief executive.

The board assurance framework is the document through which a trust board identifies the principal risks to the trust meeting its agreed objectives and to ensure adequate controls and measures are in place to manage those risks. The aim of the board assurance framework is to help ensure the objectives agreed by the board are met. It was managed by the trust secretary, who liaised with each responsible director to ensure it was updated through the year. The board assurance framework differed from the risk register as the board assurance framework only contains the risks posing a direct threat to the achievement of the trust’s objectives.
The board assurance framework was reviewed regularly by the trust board and by the audit and governance committee. Specific items on the board assurance framework could be reviewed by specific committees (i.e. the finance committee reviews the financial aspects of the board assurance framework)

The five key objectives in the 2017/18 board assurance framework were approved at the board in April 2017. The rating of the five objectives in terms of the responsible director’s confidence that it would be achieved by the year-end was as follows:

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<tr>
<th>Objective</th>
<th>Confidence</th>
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<tr>
<td>1. To reduce mortality (HSMR) in line with the national average</td>
<td>Amber</td>
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<tr>
<td>2. To deliver the agreed 2017/18 trajectory for the accident and emergency four hour waiting time target</td>
<td>Amber</td>
</tr>
<tr>
<td>3. To maintain an vacancy rate of no more than 8.5%</td>
<td>Amber</td>
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<tr>
<td>4. To deliver the control total for 2017/18 (of a pre-sustainability transformation framework deficit of no more £4.5million, or otherwise agreed by NHS Improvement)</td>
<td>Amber</td>
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<tr>
<td>5. To deliver the agreed 2017/18 trajectory for the 62-day cancer waiting time target</td>
<td>Green</td>
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Each division produced a monthly integrated performance report. This fed in to the trust’s integrated performance dashboard. Indicators were a measure of performance and included metrics such as: indicators of harm free care; staffing levels; complaints; waiting times; friend and family test results. Each indicator had a target and were aligned to the five key questions. Each performance indicator was coded red, amber or green. Red was for failing to reach the target, amber was for underachieving the target and green was for achieving or exceeding the target.

The dashboard enable the trust trust to identify areas of good performance, areas for improvement and compare indicators to establish any effect of one on the other. For example: if an increase in falls was related to a decrease staffing levels or if an increase in complaints was related to an increase in waiting times.

**Management of risk, issues and performance**

We saw there were systems and processes in place to assess, prevent, deter, manage and mitigate risk throughout the organisation. Assurance was gained; the senior leadership team understood the need for a strong framework to balance finance, performance and quality. In addition to this it was clear good working relationships between the medical director, chief nurse and director of finance meant solutions could be sought if patient safety issues required extra financial resource.

The chief executive had responsibility for ensuring an effective risk management system was in place. The medical director and interim chief nurse were jointly responsible for patient safety.

The monthly trust clinical governance committee reviewed the complaints, litigation, incidents, patient advice and liaison services and audit (CLIPA) which was a two way process for sharing learning and good practice. Quality improvement was also measured by reviewing the key recommendations from the reports of the trust’s internal inspections, executive visibility and six monthly performance and quality reviews undertaken with each division. The trust’s internal inspections or corporate quality rounds involved patient representatives, clinical commissioning group representatives and non-executive directors would visit a clinical area and review a variety of indicators in line with the key lines of enquiry. They would then send a report to the divisional leads with their findings.
The trust had a risk management policy and strategy, which staff could access. This included the procedures on how to report an incident, managing complaints, risk assessment, investigation of incidents, health and safety, and 'being open' to staff and patients. Staff we spoke with during the core service inspection, knew about the policy and how to access it.

The trust's governance department included clinical risk management; clinical governance; clinical audit; complaints; the Patient Advice and Liaison Service staff health and safety; medico-legal service and claims handling; research and development; and the management of all clinical and non-clinical incident reporting.

Each division and speciality had identified clinical governance and risk leads. There was a forum for clinical governance and risk management within each division and within the majority of clinical sub-specialties. Training on risk management was available to the risk leads and led by the patient safety team.

The trust had an electronic risk register. All staff were involved in risk management process. An identified risk would be raised with the risk lead, who would carry out a risk assessment and enter the risk onto the register. The registered could be filtered so managers could see risks by division, speciality, location or rating. The risk lead was responsible for identifying mitigating actions and reviewing the risks in their speciality. Any risks given a red rating would receive additional scrutiny by the risk manager.

At the quality committee divisions submitted written report, which was on a standard template. The clinical director or the matron, who highlighted key issues, presented this. A written summary of each quality & safety committee meeting was then submitted to the next a trust board meeting. In addition to this, the chair and most non-executive directors regularly attended the quality committee.

More specific risks could be escalated to the board via division meetings and a summary report, if required. In addition to this, the board invited presentations from divisions in order for the divisions to seek additional support in managing risk or in order to provide assurance risk was being managed effectively.

The risk register and board assurance framework were submitted to the trust management executive and a summary of the meeting was submitted to the next board meeting.

This gave assurance there were a variety of mechanisms through which risk could be escalated to the board and the board had oversight and assurance of the management of risk through the organisation.

Clinical audit was supported by a central team, within the governance department, and was primarily overseen by the Trust Clinical Governance Committee (a sub-committee of the quality committee) which is chaired by the medical director. The audit and governance committee approved the internal audit plan for the year and received details of the findings from each of the internal audit review which had been undertaken.

An example of regular audit was cleaning standards audit. This included decontamination spot checks. Cleaning audits were feedback into performance dashboards. In addition to this the director of infection prevention and control worked with the clinical commissioning group and attended Kent and Medway infection control group to share learning and best practice.

The trust also participated in a number of external audits as part of the healthcare quality improvement partnership and provided us with the reports of audits and external reviews they had participated in. The trust had identified issues with data provided to external sources. This was
with regard to inconsistencies with clinical coding. A review had been undertaken and a data cleanliness group had been identified. The clinical coding team had begun working with the clinical audit team to ensure correct and consistent coding.

We reviewed the process for managing serious incidents. As soon as staff were aware a serious incident had occurred, the division, chief nurse and medical director would review and declare the incident. A reviewer external to the division in which it occurred would be appointed and investigation undertaken. This would be presented to the serious incident panel. The clinical commissioning group, chief nurse and head of quality attended the panel. Manager’s told us this collaborative approach had led to an improvement in action plans. The serious incident report would then be discussed at divisional meetings and at the clinical governance meeting. A combined report would be presented to the quality committee and the trust management executive.

We looked at five serious incident investigation reports. They all included detail of the incident and evidence of root cause analysis in the investigation. All met duty of candour requirements. Although action plans were produced there was no section to indicate when all actions had been complete. In addition to this, even though learning was identified there was no process of monitoring that learning had been shared across the trust.

Risk, issues and performance were discussed every day at patient safety huddles. At these meetings, risks, safety and patient flow was discussed. They were attended by the chief operating officer, matrons, division leads and senior operational staff. In addition to this delayed transfer of care meetings were held daily to assist with patient flow.

The trust was placed in financial special measures in July 2016 as a consequence of not agreeing to the control total set by NHS Improvement. The trust reported a deficit of £10.9 million, post Sustainability and Transformation Funding, which was £15.6 million adverse to the control total set at the beginning of the financial year 2016/17.

For 2017/18 and 2018/19, the trust had agreed to the control total which would return the trust to a break even position (pre sustainability and transformation funding) at the end of 2018/19. The financial projections were based on the trust delivering cost improve programmes of £31.7 million in 2017/18 and £10 million in 2018/19.

The finance committee and board met monthly to go through financial plans identify issues and review cost improvement targets. The detail was discussed at the finance committee and a summary of findings presented to the board.

The finance committee and board were committed to achieving a balance between finance, quality, performance and human resources.

The trust had a sponsor at NHS Improvement who they could contact and liaise with when required.

The trust had deployed flexibility in order to achieve their target in month six and was in a position of revising their target at the time of inspection. They were using incentive aligned contracts and felt their financial performance was improved with this style of contract as compared to a performance by results contract.

Temporary staffing meetings were held fortnightly to discuss expenditure. The workforce transformation programme reviewed what levels of staff were required in each area. The trust had increased bank payment rate to retain regular bank staff and reduce agency costs.
As part of the Carter review, a ‘model hospital’ has been developed which will advise NHS trusts on the most efficient allocation of resources and allows hospitals to measure performance against other trusts. Maidstone and Tunbridge Wells NHS Trust used this model in order to identify areas where cost savings could be achieved.

Each division, who reported to the finance committee, were delivering cost improvement plans. There were two elements to each cost improvement plan. One was the management of waste and the second was providing services in an efficient way, which included reviewing patient pathways. Prior to a cost improvement plan being implemented, a quality impact assessment was carried out.

The trust’s quality impact assessment process was a well embedded, business as usual practice within the trust. Any change, whether linked to a cost improvement or a service improvement was subject to an assessment. With the scale of the challenge the trust was facing, mitigation in terms of patient quality and safety of any service change was an essential part of the trust’s assurance process. The trust assigned a clinical lead to every project or scheme, engaged at all stages of the assessment and sign off process. The clinical lead completed the quality impact assessment template for every project. The quality impact assessment template included; patient safety, clinical effectiveness, patient experience, staff experience, inequalities and targets/performance. It was completed with a risk rating. We discussed quality impact assessment with the senior leadership team and reviewed a sample of assessments. We found the system to be well embedded and of good quality.

At the time of inspection the estates strategy was being refreshed as the one in place was 10 years old. This meant the strategy in place did not include Tunbridge Wells at Pembury Hospital which was seven years old.

The estates team had identified £8 million back log maintenance for the next financial year. Maintenance requirements had changed over the years in response to changing demand. For example: an additional ward had been opened and a reconfiguration of theatres had been considered. In addition to this an original strategy to replace buildings at Maidstone had to be reviewed as it would have meant bed closures, which was not possible with the demand on bed space.

The Tunbridge Wells at Pembury Hospital was a private finance initiative. This is where private firms are contracted to complete and manage public projects. The trust had negotiated the terms of the contract at the start and felt it worked well.

The estates team told us they had good relationships with external companies to ensure the required standards were delivered. They worked with the infection control team to ensure regular cleaning audits were completed and acted on.

The estates team had been tasked with cost savings for the next financial year. They would suggest a scheme to the executive team who would make a decision and then a quality impact assessment would be completed prior to the implementation of the scheme.

As part of the trust facet surveys in 2015, the trust had a review to identify areas for improvement and or refurbishment in general and in line with the disability discrimination act. The trust produced a rolling programme with regards to improvements towards physical access and the following has been completed:

• Refurbished disabled toilets.
• Improved disabled car parking and signage, including additional pavement ramps and rails.
• General paving refurbishments.
• A site signage review and installation to improve wayfinding.
• Refurbishment of the main reception.
• Integration of appointment letters with wayfinding information.
• Large external wayfinding monoliths near main entrances to the buildings.
• New light-emitting diode external lighting for walkways and carparks.

Areas which were being progressed were:

• Reviewing the provision of changing facilities within the trust.
• Refurbishment of the main entrance with improved drop off areas.
• Streaming for general practitioner patients within the emergency department.

We saw the trust conducted fire risk assessments annually and saw copies of those risk assessments.

We saw the most recent fire safety officers report (July 2017) and saw that as part of compliance with the Regulatory Reform Order (Fire Safety) 2005, Fire Risk Assessments were on schedule. In addition to this, they were compliant and in line with HTM 05-03 Park K “Firecode”, which included a regular inspection of all fire doors to ensure they were compliant with HTM 05-03 Park K “Firecode”. It also stated it was a ‘safe hospital, good standard of fire safety and are low risk’.

The trust’s quality account provided direction for quality improvement. The 2016/17 to 2017/18 quality account had been agreed with all commissioners and had support from Kent County Council and Healthwatch Kent. The quality priorities were grouped into three themes: patient safety, patient experience and clinical effectiveness.

The trust assessed the quality of service user's experience through several means. Patient surveys conducted in house were reported at the patient experience committee. Friends and family test results and NHS patient survey results were reported to the board, quality committee and patient experience committee.

The pharmacy team had good systems and processes in place for the safe management of medicines. New clinical staff received medicines management training; junior doctors undertook prescribing assessments and received additional support where necessary. Staff appraisals were undertaken annually and all of these were complete for 2017-18.

The pharmacy team worked closely with the local clinical commissioning group. The pharmacy team had undertaken joint work with the clinical commissioning group to improve service quality and promote financial savings.

Processes were in place to handle, review and share learning from medicines incidents across the trust. The pharmacy team had worked to develop the Medicines Safety Group over the last few years and its remit and productivity had increased. Pharmacy staff had undertaken audits to monitor and improve the safe and effective use of medicines. These included audits on antimicrobial prescribing and missed doses of medicines.

There were systems in place to manage Patient Group Directions across the trust. A dedicated team had responsibility for managing high cost drugs within the trust.

The timely dispensing of medicines is important in reducing delays at discharge. For the trust overall, between April and October 2017, the average time taken to dispense medicines for discharge (from an electronic discharge note) was between 144 and 148 minutes. The most up to date information on trust rates for medicines reconciliation was 77% at 24 hours post admission. This was higher than the national average. To help improve medicines reconciliation provision, the
pharmacy team had piloted a “Medicines Optimisation Overnight” service. Early analysis had shown that this intervention improved medicines reconciliation rates.

**Information management**

The trust used information from a variety of data sources to gain assurance and measure improvement in the quality of its services.

The trust undertook quality checking as required by the information governance in addition to its own quality assurance processes and those required by national and contractual data quality standards.

The trust regularly audited information access and gave examples where they identified staff had accessed information in an inappropriate manner. They had disciplined the staff member concerned.

The Information Governance Toolkit is the mechanism for NHS organisations and service providers to demonstrate compliance to statutory information governance requirements.

In 2016 to 2017, the trust achieved attainment level two in relation to the Data Output Quality Standards (Information Governance Toolkit Requirement 507) and had developed an action plan to deliver improvements in the current year. This indicated secondary uses data quality assurance checks had been completed.

The trust achieved a score of 74% (72% in 2015/16) satisfactory (Green in the toolkit grading scheme) against the Information Governance Toolkit Version 14, and achieved 10 (8 in 2015/16) of the 45 requirements at level three. The remaining requirements were achieved at level two as required by the Operating Framework for England for 2011/12.

The director of health informatics, head of information governance, senior information risk owner, the caldicott guardian, head of information technology and senior operational representatives, worked together and oversaw compliance to information governance.

The information asset owners group, information administrators group, health records committee and data quality committee all reported to the information governance committee, who reported to the trust management executive.

We saw many levels of checking of data quality was performed to assure the trust of the quality of data.

Data quality reports were reviewed, monitored and actioned by the data quality steering group which reported via the trust information governance committee to the trust management executive and board.

The data quality steering group ensured a consistent data quality standard. The group ensured action plans for improvement were developed annually and monitored with updates provided to the information governance committee on their progress.

Locally agreed data quality standards were monitored at monthly performance review meetings with commissioners.

The trust was investing in an information, communication and technology strategy (2014-19) which supported electronic data capture to enable improvements in the quality of care given to patients. Through this strategy, the trust could provide good quality information and analytical tools to inform the process of redesigning services.
The trust utilised data quality reports from external organisation to monitor its data quality and inform improvements to its processes and procedures.

Reports were regularly taken from:

Commissioners - regular performance review meetings at which data quality was considered

NHS Digital (Secondary uses service data quality dashboards) – reviewed monthly to identify areas for improvement

NHS Digital (Hospital episode statistics data quality indicators) – reviewed monthly to identify areas for improvement

Data quality was monitored for each submission the trust was required to make throughout the year to NHS Digital, Secondary Uses Service for inclusion in the Hospital Episode Statistics which were included in the latest published data.

The trust also ensured data was subject to an annual external audit, on key performance indicators such as referral to treatment times and cancer waiting times. This was reported back to the trust’s information governance and audit committees, with any resulting action plan managed by the data quality steering group.

In 2016/17 a clinical coding audit and process review was undertaken by an external company and the results produced in March 2017. The audit scored the trust at level three using the information governance toolkit’s scoring mechanism. The recommendations within the audit report had been fed into an action plan to address the issues identified. Managers told us quality teams and clinicians were working with the clinical coding team to ensure clinical coding was consistent.

In addition to this, analysts peer checked data within the trust and data quality was monitored. The operations team validated referral to treatment time data prior to its submission.

Integrated performance reports and dashboards provided an overview of information to provide assurance of performance to divisions and the board and enabled managers to identify areas for improvement.

The trust health informatics team engaged with the sustainability and transformation partnership digital working group. Health service providers within the sustainability and transformation partnership and local areas were aligning information technology systems so they could communicate with one another.

Cyber security was an important concern for the health informatics team. They told us systems were regularly updated to ensure security and although a major systems failure scenario had not recently been rehearsed, one was being considered. Failure of computer systems was part of the business continuity plan, which we saw.

**Engagement**

The trust engaged with staff and its local community in a variety of ways. Although engagement with staff had been a challenge in the past, the trust felt this was an improving picture. Staff we met around the trust felt engaged.

In the NHS Staff Survey 2016, the trust performed better than other trusts in one question, about the same as other trusts in 28 questions and worse than other trusts in five questions. The trust had improved its score on 14 indicators compared to last year, and declined in trend against nine compared to the previous year.

The overall score for engagement was 3.82 almost in line with the national average of 3.2.
In addition to the national staff survey, the trust conducted its own survey to gain information on issues and sought ideas on how to progress.

The trust had invested in Listening into Action to improve staff engagement and empowerment. Listening into action aims to increase the trust’s capacity to successfully deliver improvements in a timely and effective manner, through strengthening clinical leadership. It aims to provide a voice to staff, whatever level they are, and supports the delivery of changes that matter most to staff and patients.

Following a survey carried out as part of Listening into Action, the workforce committee members agreed to support a Staff Charter. This would be discussed at the Joint Consultative Forum and developed with input from staff.

The leadership team told us this programme of work had been a great enabler in focussing on areas where staff had concerns and identified issues. They felt the Listening in Action approach was open and non-judgemental and was a means of engaging with frontline staff. Two Listening into action teams had been invited to present at the trust’s annual general meeting.

They planned to review how to combine Listen into Action survey results with their contractual surveys to ensure all actions were shared and brought together in a meaningful way.

One method of achieving this was by a crowd fixing event held in September 2017. It brought staff together to focus on finding both quick fixes and long lasting solutions to on-going frustrations.
Following the publication of surveys and review of results with staff, the urgent care division introduced several initiatives:

- In order to address low morale in high vacancies areas, the senior management team ensured they were more visible and there was an on-going review of recruitment strategy and skill mix to alleviate effect of staff shortages.

- In order to address junior doctors’ concerns regards engagement level, meetings with divisional senior managers resulted in regular ‘walk the floor’ events with union representatives and executives.

- A staff engagement group was established and staff across divisions were encouraged to co-design the engagement process and review this regularly.

- Monthly open forums were established and senior managers gave objective based presentations, held question and answer session, shared information, engaged in staff feedback and concerns. A generic email address was established to aid feedback from staff.

- A staff recognition award scheme was established and recipients were celebrated in a division monthly newsletter.

Staff side felt engagement of staff with the trust generally was good, however, there was some concern that staff may not be released to attend joint committee meetings because of workforce pressures. Good staff to human resources engagement had reduced the number of disciplinary actions and the trust reported no employment tribunals in the last 12 months.

The trust had put some processes in place in order to encourage retention of staff. For example; facilitating care support workers to gain care certificates, which had encouraged some to apply for the associate nurse role.

The trusts annual equality report, 2016 set out its vision for 2017 and used tools such as the Equality Delivery System two the Public Sector Equality Duty, and the Workforce Race Equality Standard. This was presented to the board.

Key achievements included:

- The role of Head of Staff Engagement and Equality was recruited to in April 2016 demonstrating the trust board's commitment to the equality agenda.

- The trust implemented a new translation service in June 2016, providing a one stop shop for all translation services. Services provided include written translation, face to face language translation, British Sign Language, Deaf/Blind services and telephone interpreting. Telephone interpreting was available 24 hours a day, seven days a week, 365 days a year.

- The Disability Confident Scheme was launched by the Government in July 2016 which replaced the Positive about Disability “Two Ticks” scheme. The scheme aimed to help employers make the most of the opportunities provided by employing disabled people. The trust had obtained Level 2 Disability Confident Employer status.

- The Equality Delivery System two had been produced for 2016 and four Equality Objectives had been created.

- A Workforce Race Equality Standard was completed, submitted to NHS England, and an action plan was in progress.

- A Cultural Diversity Network was set up in November 2016 to celebrate the diverse cultural backgrounds of trust staff, to provide support and career development advice and guidance and drive forward the workforce race equality standard action plan.
Stonewall Diversity Champion-Maidstone and Tunbridge Wells NHS Trust worked with Stonewall, a charity which supports people from the lesbian, gay, bisexual and transgender communities, and became Diversity Champions. The trust completed the Stonewall Workplace Equality Index in September 2016 and results demonstrated an increase in score from the Index submitted in 2015.

Ten transgender Awareness Workshops had been delivered, between November 2016 and January 2017, in which attendees heard the transgender journey of a staff member, learnt about terminology associated with transgender people and found out how to support transgender patients and colleagues.

A Transgender Policy policy had been created providing managers with guidance about how to support staff members who may undergo transition whilst employed by Maidstone and Tunbridge Wells NHS Trust. This had input from transgender staff and Stonewall.

A Lesbian, gay, bisexual and transgender survey which was created in collaboration with another hospital, assessed how members of lesbian, gay, bisexual and transgender survey community were treated at the trust was launched in January. The results were to be used as a basis for creating an inclusive environment for lesbian, gay, bisexual and transgender community as patients and staff within the organisation.

The trust’s website and intranet have dedicated education and development areas signposting staff, patients and visitors to relevant policies and educational pages regarding equality and diversity.

The trust implemented an Employee Assistance Programme in September 2016, providing staff with online access through a portal to advice and guidance regarding health and wellbeing including the provision of face to face and telephone counselling.

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

The summary identified four objectives:

1. The implementation of “one stop shop” translation service to provide the trust with 24 hours a day seven days a week access to interpreters from June 2016.
2. The implementation of the Accessible Information Standard from August 2016.
3. To work with the Learning and Development team to create a recruitment training program addressing unconscious bias to enable a robust recruitment process to be in place with appropriate checks and balances to avoid discrimination.
4. To create and work with Cultural Diversity Network group to celebrate diversity in the trust and provide a supportive environment to enable the black and minority ethnic community to have a voice.

Some workshops delivered by the network groups were also delivered to the local community. For example staff went to a hospice to help them to understand how to support a transgender patient at the end of their life.

The trust had lesbian, gay, bisexual and transgender, disability and cultural diversity networks. A member of the board supported the networks.

The trust engaged with its public via the patient experience committee. This was a sub-committee of the board, which met quarterly. The committee’s purpose included capturing the patient and public view of the trust’s services and monitoring any aspect of patient experience, on behalf of the
board. Its first stated duty was “To positively promote the trust’s partnership with its patients and public”, and its membership included representatives from the public, patient and carer support groups, Healthwatch Kent, the local Independent Health Complaints Advocacy service, and the League of Friends. The committee’s terms of reference also reflected its role as the primary forum by which the trust involved and consulted with patients and the public on the planning of the provision of services, proposals for changes in the way services were provided, and significant decisions affecting the operation of services.

The trust engaged with the public and its local community in a variety of ways:

- The Kent Oncology Centre engaged with the West Kent Locality Group run by the Patient Representatives and has progressed work for the delivery of the Recovery Package. In addition to this, the centre has run cancer health and well-being events. They were aimed at patients who were in transition from treatment to a ‘normal life’ and gave advice on diet, exercise, financial support, emotional wellbeing and health awareness.

- The trust was involved with clinical leads and representation in the Kent & Medway Cancer Alliance whose core membership included patient representatives.

- Following the outcome of a complaint investigation, the trust had implemented an acute emergency medicine public engagement event ‘Meet the Matron’ at Tunbridge Wells. This was aimed mainly at local groups with learning disabilities. These occurred monthly.

- Staff in the emergency department learnt basic sign language and taught basic first aid to and resuscitation to groups of the public. The concept was to breakdown the barriers of entering a hospital environment for this particular group of patients.

- A Maternity Services Liaison Committee had regular well attended meetings with good user representation.

- The trust had recruited over 600 women to participate in a pilot scheme with regards to birthplace.

- The Maidstone Birth Centre held a five year party to celebrate the success of the service.

- The trust worked in partnership with Lullaby trust to ensure mothers are aware of safe sleeping practices.

- The introduction of Baby Box eLearning package enabled women to seek advice about local services and public health messages

- Public health promotions were displayed at various sites around the trust, which we saw.

- The trust of work experience opportunities to local students and held career development days for local education centres.

**Learning, continuous improvement and innovation**

The trust had systems in place to share learning from incidents and complaints. However, we noted there was no system of monitoring to indicate learning had been shared.

The trust gave a monthly award to one employee and one team, to recognise outstanding effort, commitment and professionalism. Anyone, from patients and their families to other healthcare professionals, could nominate a member of staff or a team. The executive team considered the nominations and certificates presented every month.
The trust encouraged staff to come forward with new ideas and innovation. They referred to this as the generation of intellectual property. The innovation and intellectual property policy outlined the process for the management of new innovation and intellectual property. The innovation and intellectual property committee worked with NHS innovations for south east England to encourage innovation and service improvements.

Successful innovation was celebrated through the chief executive’s weekly newsletter, trust’s staff magazine, the annual staff awards had an innovation section and through the annual quality improvement projects awards day.

The trust had an aligned incentives contract with the clinical commissioning groups and managers told us this had removed income as a barrier to innovation.

The finance department had been awarded the Healthcare Financial Management Association, Kent, Surrey and Sussex “Finance Team of The Year” award and the head of financial management had been awarded the “Outstanding contribution” award.

The NHS National Quality Board guidance on Learning from Deaths, 2017 and the 2016 CQC report ‘Learning, candour and accountability’, guidance requires NHS trusts to produce and publish an updated policy on learning from death. There was a requirement for this to be presented to a board by the end of September 2017. A quarterly mortality report should then go to a trust board, with the first by the end of 2017. The trust had delivered on both of these requirements.

We looked at the review of death policy, which was in line with national guidance, demonstrated a clear process, was well structured and had clear lines of accountability.

The trust carried out a review of every death. The doctor in charge of the patient’s care completed a form. A consultant not in charge of patient care reviewed the form. The review of the death was reported to the mortality surveillance group, which met monthly and provided feedback from learning. The mortality surveillance group reported to the board. Doctors were trained in the use of the standard judgement framework review. We saw a flow chart for the mortality review process which provided a clear guide.

We reviewed five investigation of death files. The review forms were based on the structured judgement framework review. We found learning outcomes were identified and action plans were documented. However, there was no indication of who would monitor the action plan or evidence to indicate the action plan had been complete. We saw families were included in sharing findings from mortality reviews and duty of candour was complied with at each stage of the review.

The hospital standardised mortality ratio is an important measurement tool that compares a hospital's mortality rate with the overall average rate for other hospitals.

The trust recorded a poor hospital standardised mortality ratio and investigated what the cause for this may be. They found the ratio for patients who had sustained a fractured neck of femur was of concern. Further investigation revealed those patients who took longer to get to theatre had a poorer outcome. This resulted in the implementation of a dedicated trauma theatre and the ratio improved.

Since then the trust had continued to look at outcome data in more detail to look for trends if outcome scores had changed in any speciality or division.

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>3</td>
<td>50.9% against a target of 100%</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>72.73% against a target of 75%</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>58.33% against a target of 75%</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

(Source: Provider Information Request 2017)

The trust resolved 2883 complaints between July 2016 and June 2017. Seven complaints were referred to the parliamentary health service ombudsman from April 2016 to March 2017. Three of those seven were partially upheld.

On receipt of a low or moderate risk formal complaint, the corporate complaints lead identified what information or input was required from which wards, department or respondent and approached them directly to request comments.

Each directorate had a defined core team who were notified of each new incoming complaint and ensured all comments requested were provided within the required timescale. Where relevant, the complaints lead requested a clinical opinion from someone not directly involved in the episode of care being complained about. On receipt of the information, the complaints lead drafted the response, which was returned to key respondents for factual accuracy checking and to the core team for directorate approval. Once approved, the complaint and response was passed to the chief executive (or a nominated representative) to review and sign off. The corporate complaints team maintained an electronic and hard copy complaint file.

For high risk formal complaints, the complaints lead would ask the lead directorate to identify an investigator to complete a root cause analysis. The complaint was also shared with key personnel (including medical director, chief nurse & deputies, associate director for quality governance, chief operating officer, patient safety team, legal services, complaints & patient and liaison services manager) for awareness or to facilitate consideration of any potential serious incident declaration associated with the complaint. The response was drafted by the complaints lead, approved by the directorate and either the medical director or chief nurse before being passed to the chief executive for review and sign off.

Learning from complaints was shared at ward and division level through meetings, newsletters or email. Learning was also discussed at clinical governance meetings and ward meetings. Trustwide learning was shared through the governance gazette and the chief executive’s update. A summary of trust wide learning was provided to the trust clinical governance committee. A summary of all upheld or partially upheld complaints and the learning was included as part of the complaints annual report which was available on the website.

Staff and managers gave us examples of change made as a result of complaints, which included:

- New guidelines being developed for the monitoring of women in the latent phase of labour.
- Sugar-free paracetamol being made available routinely in wards and emergency departments.
• Guidelines being developed for baseline echocardiograms and testing for hormones to be included in screening for patients with neuroendocrine tumours.

• Closure of head wounds added to emergency department’s doctors' education programme.

• Identifying a need for a policy regarding blood testing prior to venesection.

• Suggestion of using a sticker to mark notes of patients who had quick labours in the past.

• Exercise advice sheet being reviewed by orthopaedic and physiotherapy multidisciplinary team.

• Changes made to storage of different doses of medication to reduce the risk of dispensing error.

• Chest x-ray refresher training added to the doctors induction training; an alert added to patient's radiology records to alert staff to particular clinical need.

We reviewed five complaint files. We saw letters were sent to acknowledge receipt of the complaints and complaints were responded to within the timescales set by the trust. The files were well ordered and the trail of communication was clear. Although we saw evidence of change made as a result of complaints, there was not always evidence this was communicated to complainants.

We saw duty of candour was applied and managers had a good understanding of the requirements. Staff we spoke also understood duty of candour and told us if it needed to be applied, they would be supported through the process.

Patient stories were used at board meetings, whether the patient or their relative had good or bad experiences.

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 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>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy Unit at Maidstone (April 2014) and Tunbridge Wells (January 2014) due for reassessment 2019</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>March 2015</td>
</tr>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>CHKS ISO 9001 accreditation</td>
</tr>
</tbody>
</table>
The trust had carried out a self-assessment of leadership and governance, which it presented to the board in October 2017. In addition to this, it had commissioned external reviews of their leadership and the way in which the trust organised improvement activities. The recommendation was to find a single approach to improvement work and the trust had identified an improvement methodology which was the best fit with the work which had been undertaken with the Listening into Action methodology.
Maidstone Hospital

Urgent and emergency care

Facts and data about this service

We carried out an unannounced inspection of the emergency department at Maidstone Hospital as part of the new phase of our inspection methodology.

We last inspected the unit in June 2015 and rated it as requires improvement.

Activity and patient throughput

Total number of urgent and emergency care attendances at Maidstone and Tunbridge Wells NHS Trust compared to all acute trusts in England.

- There were 167,829 attendances between July 2016 and June 2017 at Maidstone and Tunbridge Wells NHS Trust as indicated in the chart above.
- Children attending A&E accounted for 23% of all attendances.
- Attendees arriving by ambulance accounted for a further 23% of all attendances.

(Source: NHS England)

Urgent and Emergency Care attendances resulting in an admission
The percentage of A&E attendances at this trust that resulted in an admission fell between 2015/16 and 2016/17. In 2016/17, rates were higher than the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>29,283</td>
<td></td>
</tr>
<tr>
<td>Discharged*</td>
<td></td>
<td>95,035</td>
</tr>
<tr>
<td>Referred^</td>
<td></td>
<td>35,352</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,520</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>138</td>
<td></td>
</tr>
<tr>
<td>Left department#</td>
<td>5,253</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>452</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>796</td>
<td></td>
</tr>
</tbody>
</table>

^ Includes: to A&E clinic, fracture clinic, other OP, other professional

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training across 13 courses and a completion for information governance at 95%.
A breakdown of compliance for mandatory courses between April 2017 and June 2017 for medical/dental and nursing staff in Urgent and Emergency care is shown below:

Medical and dental staff did not reach the trust target of 95% for information governance with a training completion rate of only 41%. The trust target of 85% were met and exceeded for four of the remaining 13 modules. Blood transfusion had the highest completion rate of 96% while conflict resolution training was not completed by any medical and dental staff member. Low completion rates were reported for dementia awareness (including privacy & dignity standards) (50%) and medicine management (54%).

Maidstone Hospital had a 76% average mandatory training completion rate, below the trust target of 85%.
Nursing staff did not meet the trust target of 95% for information governance with a completion rate of 89%. The trust target of 85% was met and exceeded for nine of the remaining 13 modules. Conflict resolution and dementia awareness (including privacy & dignity standards) had the lowest completion rates of 76% and 53% respectively.

Maidstone hospital had an 87% average mandatory training completion rate, meeting and exceeding the trust target of 85%

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

Safeguarding

Safeguarding training completion rates

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

A breakdown of compliance for safeguarding courses between April 2017 and June 2017 for medical/dental and nursing staff in Urgent and Emergency Care is shown below:
Safeguarding adults level 1 (89%), safeguarding children level 1 (90%) and safeguarding children level 2 (85%) all had completion rates meeting and exceeding the trust target of 85%.

Safeguarding children level 3 and safeguarding adults did not meet the trust target with completion rates of 64% and 81% respectively.

Maidstone Hospital had an 87% safeguarding training completion rate, meeting and exceeding the trust target of 85%.

Safeguarding adults level 1 and 2, safeguarding training level 1 and 2 all had completion rates above the trust target of 85%. Safeguarding children level 3 had the lowest completion rate of 79% and did not meet the trust target of 85%.

Maidstone Hospital had an 88% safeguarding training completion rate, above the trust target of 85%.

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

The nurse in charge of each shift maintained oversight of safeguarding issues through a two-hourly quality round system. This included a check of escalation plans, assurance that safeguarding documentation was up to date and a check that each patient knew who their named nurse was.

Nurses we spoke with demonstrated detailed knowledge of safeguarding escalation policies as well as how to identify signs a patient or visitor was a safeguarding concern. Staff nurses said they felt confident in speaking with the senior clinical team about any safeguarding concerns they had, including suspected abuse or female genital mutilation (FGM).

A safeguarding children and young people policy and practice guidance document was available to staff on the intranet and provided guidance and pathways for responding to suspected child sexual exploitation and FGM. However, this document was out of date and was due to be reviewed in October 2016. A safeguarding adults at risk of harm policy and procedure was in date and due for review in August 2018.
Cleanliness, infection control and hygiene

The department participated in the national monthly Saving Lives audit. This audit involves auditing up to four elements of hand hygiene practice, use of personal protective equipment and continuing care bundles for central venous catheter, peripheral lines and urinary catheter care against trust standards. Between November 2016 and October 2017, the emergency care centre (ECC) team achieved 100% compliance with trust standards in all measures in the Saving Lives audit.

We found unmitigated infection control risks in the paediatric area. For example the flooring was damaged and staff had taped over this area. However the tape was also damaged and there was evidence of dirt and dust in and around this area. There were damaged fabric chairs in the waiting area, which presented a risk of build-up of bacteria.

Environment and equipment

The department participated in the national patient-led assessment of the care environment (PLACE). PLACE enables assessors who have experience of the hospital environment to review the ECC against five areas: cleanliness; privacy; condition, appearance and maintenance; dementia and disability. Each category relates to adaptations in the environment that improve accessibility for people. In the 2017 PLACE scores, the ED performed highly in four of five categories:

- Cleanliness 99%
- Privacy, dignity and wellbeing 100%
- Condition, appearance and maintenance 91%
- Dementia 92%
- Disability 88%

In each category the ECC performed better than the national average and significantly better in the privacy category (16% higher) and the dementia category (16% higher).

The director of infection prevention and control used a weekly environmental care dashboard to assess the ECC against national standards for clinical areas identified as at very high risk of poor environmental cleanliness. Between November 2016 and November 2017 the ECC achieved an average of 97%, which met the minimum target of 95%.

We did not see that staff always maintained the environment in line with trust fire safety standards. For example we saw a fire door wedged open with paper in a corridor next to the CDU. This meant the door would not automatically close in the event of a fire alarm.

Staff did not always complete consistent safety checks on emergency equipment. For example we looked at the daily safety checklist for the resuscitation trolley in the rapid assessment point (RAP) unit. Between 19th October 2017 and 12 November 2017 staff had not documented checks on six dates. In addition security seals were not coded, which meant staff could not be assured the seal used to secure the trolley had not been tampered with or changed without authorisation.

Assessing and responding to patient risk

Emergency Department Survey 2016
The trust scored “about the same” as other trusts for all of the five Emergency Department Survey questions relevant to safety. Low scores were recorded for: “How long did you wait before you first spoke to a nurse or doctor?” and “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?” Both questions received a score of 6.2 out of a possible ten.

<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>9.0</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>6.2</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>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.7</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>9.7</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 recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for all months over the 12 month period between September 2016 and August 2017.

Performance against this standard showed an even trend over the period. A slight increase in waiting times can be seen over the winter months of November and December 2016, and again in June and July 2017. Performance over the 12 month period was consistently better than the England average.

**Time to treatment between September 2016 and August 2017 at Maidstone and Tunbridge Wells NHS Trust**

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

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

Between October 2016 and September 2017 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Maidstone Hospital.

Over the period an average of 42% of ambulance journeys had a turnaround time over 30 minutes. Percentages increased month on month during the winter months of November and December 2016 and January 2017. Turnaround percentages increased again in September 2017. In October 2016 37% of ambulance journeys had a turnover time above 30 minutes while this figure was 45% in September 2017.

Over the period an average of 19 ambulance journeys had a turnaround time over 60 minutes. An increase in numbers can be seen over the winter period from November 2016 to February 2017, peaking in January 2017 when 38 journeys had a turnaround time over 60 minutes. Overall numbers decreased after the winter period from 38 in February to 11 in September 2017.

Ambulance: Number of journeys with turnaround times over 30 minutes - Maidstone Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Maidstone Hospital

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

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.

From August 2016 to July 2017 the trust reported 364 “black breaches”, with an upward trend over the period. Over the period an average of 30 black breaches were reported per month. The number of “black breaches” reported showed an increase over the winter months of November and December 2016, reaching the highest number reported in January 2017, with 78 “black breaches” reported. Numbers decreased after this period but escalated again in May 2017 with 55 breaches reported. Insufficient capacity was cited as the reason for 93% of all breaches reported; a further 5% were reported as “cases unknown”.

Comment from trust: “There is some discrepancy between the data presented by SECAMB and the Trust. This has been discussed at the WK A&E Delivery Board and there is to be a joint action plan between SECAMB and the Trust to be in place by” September 2017.

### Number of black breaches reported per month

(See figure for chart)

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

The trust had taken action to ensure they followed updated 2016 Resuscitation Council guidance that resuscitation medicines be kept locked away. For example, medicines kept as part of resuscitation trolleys and kits were stored in tamper-proof or tamper-evident containers that were tagged and checked daily by staff. Monthly resuscitation trolley audits were carried out sporadically and between February 2017 and November 2017 monthly audits had taken place on two occasions. However the audit results indicated compliance with minimum trust standards.

All ECC nurses completed paediatric life support training based on their grade and level of responsibility. For example staff nurses and senior staff nurses completed paediatric immediate life support training. Senior nurses completed the European paediatric advanced life support course.

### Nurse staffing

The trust reported their staffing numbers below for the period April 2017 and June 2017.

There is a difference in the number of staff in post compared to what was planned by the trust, for the most recent month of June 2017, the data shows there were 46.85 less nursing staff in post then what the trust planned for to provide safe care.
The numbers below are for qualified nurses described by the trust as either qualified nursing midwifery staff or qualified nursing and health visiting staff.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>210.71</td>
<td>171.54</td>
</tr>
<tr>
<td>May 2017</td>
<td>209.71</td>
<td>173.60</td>
</tr>
<tr>
<td>June 2017</td>
<td>218.5</td>
<td>171.64</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>638.92</strong></td>
<td><strong>516.78</strong></td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a vacancy rate of 15.7% in urgent and emergency care;

- Maidstone Hospital: 16.9%

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

The paediatric team had four full time vacancies and maintained a service by relying on regular agency nurses, who had staffed the service for up to three days per week for the previous four months.

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a turnover rate of 0.7% in urgent and emergency care;

- Maidstone Hospital: 0.7%

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

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a sickness rate of 4.5% in urgent and emergency care;

- Maidstone Hospital: 3.8%

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

**Bank and agency staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
Between July 2016 and June 2017, the trust reported a bank and agency usage rate of 94% in urgent and emergency care;

- Maidstone Hospital: 92%

For qualified nurses there was a total of 6,978 shifts over the 12 months up to June 2017, of which bank staff were used to cover 40% of shifts, agency staff were used to cover 3,675 shifts a total of 506 shifts (on average 42 a month) were unfilled within this time frame.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

A team of four paediatric nurses provided care in the paediatric emergency unit and worked cross-site at the Tunbridge Wells hospital. A team of 15 emergency nurse practitioners (ENPs) worked in the department and provided minor injuries cover with support from clinical support workers.

We looked at the records of five handovers. We found in each case staff identified patients with safeguarding, mental health or complex needs and prioritised them for clinical review. The senior team also used this system to escalate staff shortages and to book bank or agency staff to resolve this.

Medical staffing

The trust reported their staffing numbers below for the period April 2017 and June 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>197.87</td>
<td>144.40</td>
</tr>
<tr>
<td>May 2017</td>
<td>197.86</td>
<td>147.00</td>
</tr>
<tr>
<td>June 2017</td>
<td>187.25</td>
<td>146.60</td>
</tr>
<tr>
<td>Total</td>
<td>582.98</td>
<td>438.00</td>
</tr>
</tbody>
</table>

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

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a vacancy rate of 19.4% in urgent and emergency care;

- Maidstone Hospital: 16.6%

There is a higher medical and dental vacancy at Tunbridge Wells hospital compared to Maidstone Hospital.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

We spoke with the matron during our inspection who said a recruitment programme had been successful and as of November 2017 three new whole time equivalent (WTE) band five nurses were starting and the remaining vacancies were for 0.5 WTE band seven cover and 0.6 WTE band six cover.
**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a turnover rate of 1.7% in urgent and emergency care;

- Maidstone Hospital: 1.7%

There is a higher medical and dental vacancy at Maidstone Hospital compared to Tunbridge Wells hospital.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a sickness rate of 0.1% in urgent and emergency care;

- Maidstone Hospital: 0.1%

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

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From July 2016 to June 2017, the trust reported a bank and locum usage rate of 100% in urgent and emergency care;

- Maidstone Hospital: 100%

For medical and dental staff there was a total of 11,333 shifts over the 12 months up to June 2017, of which locum staff were used to cover 87% of shifts, agency staff were used to cover 1,447 shifts and a total of 20 shifts were unfilled within this time frame.

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

**Staffing skill mix**

As at July 2017, the proportion of consultant staff reported to be working at the trust were same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 46 whole time equivalent staff working in Urgent and Emergency Care at Maidstone and Tunbridge Wells NHS Trust.**

<table>
<thead>
<tr>
<th>Staffing Skill Mix</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>41%</td>
<td>31%</td>
</tr>
<tr>
<td>Junior</td>
<td>29%</td>
<td>25%</td>
</tr>
</tbody>
</table>
A team of 15 consultants worked in the ECC and cross-site at the emergency department at Tunbridge Wells Hospital. A team of 49 other doctors, including clinical fellows, middle grade doctors, specialist registrars and foundation year 2 doctors provided 24-hour medical cover in the department. In addition a GP was based in the department daily from 12pm to 6pm and six emergency department practitioners had also been introduced to the service.

A paediatric consultant was available in the ECC from 9am to 7pm Monday to Friday. Outside of these hours staff referred to a paediatric registrar or consultant based at the Tunbridge Wells site.

Records

In May 2017 the ECC team introduced a new auditing tool that would help them to audit the quality of patient records against the trust’s note-taking standards. This was based on audit results published in February 2017 and May 2017 that indicated only 38% of patient records met the standard. This was a significant deterioration from the 54% standard achieved in the previous audit.

Monthly clinical governance meetings were used to discuss the results of rolling quarterly audits for the quality of patient records. In October 2017 the audit identified that foundation level two doctors did not know there was a note-taking standard for ED patient records. In response the auditing team recirculated the standards and planned a future reaudit.

In November 2016 a senior nurse audited 10 patients records completed by ENPs. The audits highlighted areas of good practice such as clarity of detail and legibility. The audits also identified areas for improvement such as documenting tetanus status after an animal bite and recording pain scores more consistently.

In February 2017 a senior nurse observed the triage nurse for two hours to assess the quality of their observations. They found the detail and accuracy of notes to be acceptable and in line with trust and department standards.

Practice development nurses (PDNs) at both of the trust’s emergency departments were working on a joint project to ‘complete the perfect ‘CAS (casualty) card’. The PDNs were delivering training to staff to improve standards and then planned to complete an audit to assess impact.

The psychiatric liaison team used a different patient records system to the ED team. This meant ED staff could not access a patient’s crisis plan if they were known to the liaison team and instead relied on the liaison team being available to visit the patient. The ED team used a risk assessment to initially assess patients against their level of risk for issues such as self-harm or suicidal intent.

In two records we looked at staff had completed the care plans and there was evidence in the ECC’s paper notes system that the patients had been referred to the liaison team.

Medicines

The urgent care divisional team included medicines errors in monthly clinical governance reports. We saw the number of errors was noted and a senior clinician or member of the pharmacy team discussed with staff the contributing factors and any learning to be actioned.
Nurse prescribers were able to prescribe medicines for certain conditions using patient group directions (PGDs). We found PGDs to be up to date and that nurses referred to them appropriately. In February 2017 an audit observation of a triage nurse noted they checked PGDs thoroughly before prescribing and recommended a check for contra-indications with other medicines patients may take be completed in each instance.

Incidents

**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.

From September 2016 to August 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from September 2016 to August 2017.

Of these, the most common type of incident reported was.

- Treatment delay meeting SI criteria with 10 (43% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with six (26% of total incidents).
- Slips/trips/falls meeting SI criteria with four (17% of total incidents).
- Abuse/alleged abuse of adult patient by staff with two (9% of total incidents).
- VTE meeting SI criteria with one (4% of total incidents).

(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)}
Both SIs involving allegations of abuse by patients occurred at the Maidstone site. We spoke with the matron about this who explained the incidents and how the investigations were carried out. No abuse was found in either case and the investigating team identified a need for clearer communication from doctors when examining patients. For example there was a need to recognise if a patient was in pain or cognitively impaired they might misinterpret why a member of staff was touching them. There was also a renewed focus on the trust’s chaperone policy, which we saw advertised around the department.

In September 2017 the senior team added open incidents to the divisional risk register because there were 400 unresolved incidents between both sites. The risk indicated that learning may be delayed or missed and the senior team did not have capacity to make significant progress with investigations and closure. The trust incident team and patient safety team had implemented a series of one-day sessions to help the ECC team complete their incident investigations.

There was evidence of changes to operational procedures as a result of incidents. For example as a result of the failure of a set of crutches given to a patient to take home, staff issued this equipment for single-prescription use only.

From looking at the outcomes of incidents it was not evident staff were always aware of trust policies or care pathways. For example one incident noted a patient was discharged home without appropriate prophylaxis, which then resulted in a deterioration of their condition. In addition staff had missed a fracture due to a communication barrier with the patient. In response the senior team discussed with staff strategies to ensure thorough physical examinations took place for those patients who could not communicate clearly.

**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 one new pressure ulcer, two falls with harm and seven new catheter urinary tract infections between September 2016 and September 2017 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Maidstone and Tunbridge Wells NHS Trust
Is the service effective?

Evidence-based care and treatment

The trust participated in the national Department of Health essence of care audit, which established the service in the ECC against 10 quality benchmarks. The latest results for the ECC related to March 2017 to October 2017. In eight categories the ECC achieved a B score, which indicated there was clear evidence to demonstrate that the standard had been achieved. In the food and nutrition and communication categories, the ECC achieved a C score, which meant there was some evidence to suggest the standard was being achieved.

The trust managed a document version control system that meant staff had access to the most up to date policies and national guidance online.

Staff used the sepsis 6 pathway and a ‘red flag sepsis’ pathway to ensure patients received timely and appropriate care. The ECC team worked with the critical care outreach team in the management of patients with sepsis in line with guidance from the UK Sepsis Trust.

An audit and service review was a standard part of monthly clinical governance meetings. We saw from looking at the minutes of meetings that staff used this time to remain up to date on policy changes and the outcomes of audits. For example in October 2017 the team reviewed the outcome of an acute urinary retention audit. This highlighted overall good practice with a need for more proactive prescribing and screening.

The trust’s dementia operational policy and procedure was in date and due to be reviewed in 2019. A dementia strategy group had ratified a dementia strategy for 2017 to 2020. Staff accessed these policies and others using the intranet, which we saw was easily accessible.

Extended scope physiotherapists met quarterly with consultants to review clinical studies as part of a drive to ensure practice met the latest best practice.

Nutrition and hydration

Emergency Department Survey 2016
In the CQC Emergency Department Survey, the trust scored 6.8 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was the same as other trusts.

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

Staff offered water jugs to patients who were in the department over four hours and catering was available.

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.1 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was the same as other trusts.

The trust scored 7.7 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

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

The nurse in charge reviewed each patient’s pain assessment and analgesia needs as part of a two hourly quality round system. However the results of patient notes audits identified a need for more consistent practice.

A notice in the waiting area explained to patients the process for accessing pain relief and directed them to the most appropriate member of staff.

Patient outcomes

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 RCEM audit for severe sepsis and septic shock, the Maidstone District General Hospital was in the upper quartile compared to other hospitals for two of the 12 measures and was in the lower quartile for six of the 12 measures.

The measures for which the site performed in the upper quartile were:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival (100%)
- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED (84%)

The measures for which the site performed in the lower quartile were:

- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to): Within one hour of arrival (0%)
- Standard 4: Serum lactate measured: Within one hour of arrival (0%)
- Standard 5: Blood cultures obtained: Within one hour of arrival (0%)
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival (0%)
- Standard 7: Antibiotics administered: Within one hour of arrival (0%)
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival (0%)

(Source: Royal College of Emergency Medicine)

Following inspection, a data quality issue was identified. Further analysis of the results indicated the service achieved 100% for observations, 95% for Fluid administration within 1 hour and 95% for antibiotics within 1 hour.


Maidstone District General Hospital

In the 2015/16 RCEM audit for vital signs in children, Maidstone District General Hospital was in the upper quartile compared to other trusts for four of the six measures and was in the lower quartile for none of the six measures.

The measures that performed in the upper quartile were:

- Standard 1a: temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score,
- Standard 1b: capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest.
- Standard 2: 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.
- Standard 4: There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: VTE Risk in Lower Limb Immobilisation in Plaster Cast 2015/16**

Maidstone District General Hospital

In the 2015/16 RCEM Audit for Lower Limb Immobilisation in Plaster Cast, Maidstone District General 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 97.4% in 39 cases.
- In the upper for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation’, with a score of 76% in 50 cases.

(Source: Royal College of Emergency Medicine)

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

Maidstone District General Hospital

44
In the 2015/16 Procedural Sedation in Adults audit, Maidstone District General Hospital was in the upper quartile for one measure, the lower quartile for three measures and the middle quartiles for the remaining three measures.

The measure that performed in the upper quartile was:

- Standard 3: Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities.

The measures that performed in the lower quartile were:

- Standard 1: Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status
- Standard 5: 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) ECG
- Standard 6: Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant Sign Off (2016/17)

The 2016/17 Consultant Sign Off Audit monitors the proportion of patients of various groups who were reviewed by a consultant in emergency medicine prior to discharge from the ED. For each group, the RCEM standard is that 100% of all patients receive a review from senior medical staff on discharge.

- Of all patients aged over 30 admitted for chronic chest pain in the 2016/17 audit, 11.8% were seen by a consultant and 76.5% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.
- Of all children under 1 year of age admitted with a fever in audited in 2016/17, 20% were seen by a consultant and 90% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%. Seen by an ST4 or above.
- Of all patients making an unscheduled return to the ED in 2016/17 with the same condition within 72 hours of discharge, 22.2% were seen by a consultant and 77.8% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.
- Of all audited patients over 70 years of age who were admitted with abdominal pain, 30.8% were seen by a consultant and 69.2% were seen by an ST4 or above. This did not meet the RCEM standard of 100%.

Although not achieving 100%, Maidstone and Tunbridge Wells were above the national average in all four domains.

Unplanned re-attendance rate within 7 days

From September 2016 to August 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average.

The trust have been consistently worse than the national average since September 2016 when the trust performance was 10.2% compared to an England average of 7.8% whereas most
recently in August 2017 the figure is still high with a trust performance was 10.0% compared to an England average of 7.8%.

**Unplanned re-attendance rate within 7 days - Maidstone and Tunbridge Wells NHS Trust**

(Source: NHS Digital - A&E quality)

Monthly sepsis audits: Oct 100% screened and antibiotics; Sept 95%/88%; Aug 100%/93%; July 100/100; Jun 95/95;

Where patients attended the ECC under the influence of alcohol or drugs, the psychiatric liaison team reviewed them without the need for them to be medically fit.

**Competent staff**

**Appraisal rates**

From April 2016 to March 2017, 87% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 100%.

A split by staff group can be seen in the graph below:
Maidstone Hospital had an 87% appraisal completion rate, NHS infrastructure support and Medical and Dental staff (Hospital) both had 100% appraisal rate by staffing group.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Practice development nurses (PDNs) carried out competency assessments on triage nurses. The last observation had taken place in February 2017 and indicated the triage nurse demonstrated good clinical knowledge and understanding of all the cases they were presented with.

PDNs and senior nurses had delivered foundations of emergency practice to all clinical staff in the department.

New starters in the nursing team were assigned two mentors each for their induction and introductory periods in the ECC. After the initial period, which varied in time depending on individual need, the PDN worked with the new staff to identify their next training needs.

Emergency department practitioners (EDPs) worked under the supervision of consultants and within RCEM qualification guidelines. This team could apply for advanced practitioner certification after three years of training. We spoke with two EDPs who told us they were well supported by consultants and felt able to work within their clinical knowledge whilst developing professionally.

Adult ECC nurses and doctors had to provide care and treatment to child patients whenever the paediatric unit was closed. The senior team acknowledged this presented a clinical competency challenge. To address this the PDN team was completing paediatric training with adult nurses, including paediatric seizure training.

Clinical nurse specialists from the psychiatric liaison team provided staff training in providing care for patients with mental health needs, including those with learning disabilities or dementia. All clinical staff undertook training in completing mental capacity assessments with patients as part of their induction.

The PDN worked with the simulation suite team to plan and deliver practical training and simulated scenarios. The nursing team at the Tunbridge Wells Hospital could observe this by videolink.

Emergency nurse practitioners had access to dedicated teaching and learning time.

Staff had access to a wider range of teaching through a network partnership with other emergency departments (EDs). For example they could attend an evidence-based emergency practice course at another hospital, which enabled colleagues from the other trusts to participate in this hospital’s ED foundation course.

A paediatric PDN was working to improve opportunities for adult nurses to develop their skills and competencies in care and treatment for children. This included creating rotational posts and holding focus groups to identify the important areas of focus for nurses.

Nurses we spoke with said the opportunities they had to develop were very positive and that they felt able to ask for additional training at any time.

A high impact therapy (HIT) team of physiotherapists and occupational therapists provided support for patients in majors, minors and the clinical decision unit. The HIT team also supported patients over the age of 75 as part of the fast track elderly care pathway as well as patients who were referred to an inpatient rehabilitation pathway.

Clinical support workers were supported to undertake training in extended areas including venepuncture to NVQ level 3, cannulation, urinalysis and carrying out ECGs.
Multidisciplinary working

All nurses had link roles and were each given one month of space on the staff noticeboard to present their work. Link roles included for dementia. This was a strategy to improve engagement within the team and amongst other teams and also encouraged each nurse to spend time increasing their skills in other clinical areas.

Speech and language therapists provided support and communication tools where patients had difficulty communicating due to a learning disability or mental health need.

The psychiatric liaison team worked with ECC staff to complete a physical health checklist for patients who were due to be admitted to an inpatient ward or the acute mental health unit. This enabled the team to plan in advance for coordinating care and treatment for patients with complex needs.

Physiotherapists were based in the department Monday to Saturday. Four extended scope physiotherapists worked cross-site as autonomous practitioners and independent prescribers to provide care for patients with strains, sprains and rehabilitation needs.

A high impact therapy (HIT) team of physiotherapists and occupational therapists provided support for patients in majors, minors and the clinical decision unit. The HIT team also supported patients over the age of 75 as part of the fast track elderly care pathway as well as patients who were referred to an inpatient rehabilitation pathway.

Seven-day services

All areas of the ECC operated 24-hours, seven days a week with the exception of the paediatric ED, RAP and the GP service.

Consultant cover was provided seven days a week.

The HIT team provided a seven day service from 8am to 8pm.

Radiology services were available adjacent to the ED including 24-hour, seven day x-ray and computed tomography (CT) scanning.

Although the paediatric ED was not open 24-hours, two children and young people’s registrars were available on call in the Tunbridge Wells Hospital 24-hours, seven days a week.

Health promotion

Staff said there was a consistent theme of patients presenting in the department while intoxicated or under the influence of drugs. They said they had limited capacity to provide health promotion interventions but they would refer patients to the crisis liaison team if they repeatedly presented in the department.

Staff did not routinely document if they offered health promotion or advocacy services to patients awaiting assessment by the psychiatric liaison team.

The hospital’s sexual health team were preparing for the national HIV testing week and had displayed signs in the ECC to encourage patients to test for HIV. We spoke with a senior nurse in
the sexual health clinic who said training was planned for the ECC team to encourage them to carry out opportunistic testing and referral to the service. We asked one ECC nurse about this who said they would not feel comfortable talking with patients about HIV or sexual health and would instead only refer them onwards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from April 2017 to July 2017 Mental Capacity Act (MCA) training has been completed by 95% of staff in within Urgent and Emergency Care.

(Source: Trust Provider Information Return P14/P49)

We looked at the records of two patients who staff had referred to the psychiatric liaison team. In both cases there was no documented evidence of a capacity assessment or consent.

Is the service caring?

Compassionate care

Friends and Family test performance

The trust’s urgent and emergency care friends and family test performance (% recommended) was generally better than the England average from September 2016 to August 2017.

Most recently in August 2017 the trust performance was 91.9% compared to the national average of 88.0% Since December 2016 the trust has seen an increase in performance and it has steadily remained between 92% and 94% for the rest of the time period.

A&E Friends and Family Test Performance - Maidstone and Tunbridge Wells NHS Trust

(Source: NHS England Friends and Family Test)
The ECC team displayed patient feedback in public areas to demonstrate how people felt about the service. For example one patient feedback comment read, “I had] five star treatment about a process I was dreading. This was 100% down to the individual nurse that acted with compassion and professionalism at all times.”

**Emotional support**

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all 24 questions relevant to caring.

<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>4.0</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>8.5</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>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.3</td>
<td>About the same as 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>7.9</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>8.4</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>7.3</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>8.9</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>7.9</td>
<td>About the same as other trusts</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>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.8</td>
<td>About the 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>5.4</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>8.2</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>8.0</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>8.9</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>9.3</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>4.5</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>5.6</td>
<td>About the same as 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>5.9</td>
<td>About the same as 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>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Understanding and involvement of patients and those close to them

We saw that when patients were seen in the ECC staff asked questions to help understand their needs. For example when a patient under the care of a community mental health team did not want staff to contact their care coordinator, the ECC team took appropriate alternative action. We saw staff gave a copy of each patient’s care plan to them to take away.

We spoke with the parents of three children in the paediatric area. All four parents told us reception staff had warmly welcomed them in the ECC and made them feel at ease. However none of the individuals knew what their waiting times was or what they were waiting for. One parent said, “We’ve been triaged but sent back out here without being told why. I don’t know why, maybe we’re waiting for a [specialist].”

Is the service responsive?

Service delivery to meet the needs of local people

Between November 2016 and November 2017 48 adult patients and eight child patients were admitted to the hospital from the ECC on a psychiatric pathway. Amongst adult patients, 38% related to a drug overdose and 12% related to suicidal intent.

A new head of security had introduced behaviour contracts with patients who were abusive or violent towards staff. Nurses and security staff we spoke with said this had been an effective way to reduce inappropriate behaviour and ensure patients with urgent clinical needs were still seen.

Staff used a specific triage pathway for patients with mental health needs who arrived by ambulance. This meant the rapid assessment team assessed the patient within 15 minutes of arrival to identify their immediate needs and to put in place a one-to-one nurse to patient ratio to keep them safe.

Staff maintained a noticeboard in the waiting area that included details of the current wait time for each ECC service as well as information relating to current health risks, such as seasonal flu. The sign also included information on how the department maintained confidentiality. Staff had produced an information leaflet that provided guidance on why waiting times different and why patients were not seen on a first-come, first-served basis. We saw these were readily available and staff proactively offered them to patients when wait times increased.

An occupational therapy rehabilitation team provided services for patients on site and could carry out assessments in the ECC for fractures, including fractured neck of femur.

The Home First team worked from a central local referral unit to ensure patients due for discharge were home by 6pm. A member of staff from this service provided a ‘meet and greet’ to each patient when they arrived home and started their care package the next day. The HIT team liaised with the community team to ensure essential elements of care such as access to day centres and home modifications were put in place.

Emergency nurse practitioners (ENPs) led care in minors for minor injuries, pain relief and x-ray between 10am and 10pm. Outside of these hours a registrar and ECC nurses provided care and treatment in minors.
Meeting people’s individual needs

Emergency Department Survey 2016

The trust scored “about the same as other trusts” for all 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>7.2</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>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

The nurse in charge completed a two hourly quality round to manage risks to patients and ensure individual needs were met. As part of this system staff ordered a hospital bed for patients who had been in the department for over four hours and ensured they had a call bell within reach. We reviewed a sample of five quality round checklists and found staff were responsive to individual needs including in escalating delays in care or transfer.

Staff had access to a learning disability passport that helped them to understand the needs of individual patients. This tool also helped in handovers from paramedics to ECC staff or when transferring a patient to an inpatient ward.

Staff used a dedicated mental health assessment room for patients with elevated risk. This room was minimally furnished with soft, heavy items that could not cause injury. There were no ligature points in the room and an alarm call system was fitted. In addition staff could clearly see into the room at all times. The nearest toilet for this room had ligature points and could pose a risk to patients who used this without supervision.

Reception staff used the electronic patient records system to flag to nurses or doctors issues that meant a patient might need more support, such as dementia or a learning disability. However a nurse we spoke with said they did not routinely do this during triage and instead would wait for the doctors to do it.

We observed a nursing handover and saw staff included a discussion of each patient’s social situation as part of their care planning.

The ECC was preparing for a visit from a guide dog organisation to assess their planning for supporting patients with reduced sight during major incidents or an evacuation.

Nursery nurses worked alongside paediatric nurses to provide play and distraction to infants and children. Toys and games were available in the department. Tools to help children and young people with learning disabilities were also available such as a lighted ‘bubble tube’ and aquarium to provide distraction.

Access and flow

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 A&E.

The trust did not meet the standard from October 2016 to September 2017.

The trust breached the standard 12 times from October 2016 to September 2017.

Between October 2016 and September 2017 performance against this metric showed a trend of improvement.

The trust performance has improved since January 2017 it has been below the 95% standard for the entire time period, and only recently been better than the national average since June 2017, most recently it is in line with the England average as of September 2017.

Four hour target performance - Maidstone and Tunbridge Wells NHS Trust

(Source: NHS England - A&E Waiting times)

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

From October 2016 to September 2017 Maidstone and Tunbridge Wells NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. Performance against this metric showed a trend of improvement over the period.

The trust performance has improved since January 2017, it has been consistently worse than the England average. The trust percentage at its peak in December 2016 was above 32% compared to the England average of around 20%, whereas now the trust percentage is around 16% and the England average is around 12%.

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Maidstone and Tunbridge Wells NHS Trust
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, two 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>426</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
<td>616</td>
<td>0</td>
</tr>
<tr>
<td>Dec-16</td>
<td>950</td>
<td>1</td>
</tr>
<tr>
<td>Jan-17</td>
<td>1195</td>
<td>1</td>
</tr>
<tr>
<td>Feb-17</td>
<td>674</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>473</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>523</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>601</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>329</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>320</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>285</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>538</td>
<td>0</td>
</tr>
</tbody>
</table>

( Source: NHS England - A&E Waiting times )

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From October 2016 to September 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average.

From October 2016 to September 2017 performance against this metric showed a trend of improvement. Most recently in August 2017 the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 3.0%, compared to the England average which was 3.0%.

Percentage of patient that left the trust without being seen - Maidstone and Tunbridge
Median total time in A&E per patient (all patients)

From October 2016 to September 2017 the trust’s monthly median total time in A&E for all patients was consistently higher the England average. Performance against this metric showed a trend of decline.

In August 2017 the trust’s monthly median total time in A&E for all patients was 172, which is worse than that of the England average which was 144. The trust has consistently been worse than the England average for the whole time period.

(Source: NHS DIGITAL - A&E quality indicators)
Median total time in A&E per patient - Maidstone and Tunbridge Wells NHS Trust

(Source: NHS DIGITAL - A&E quality indicators)

Staff used the rapid access point (RAP) to assess patients and reduce pressure on majors and minors and to reduce ambulance waiting times. The RAP was open from 10am to 10.30pm.

The dedicated paediatric service was available from 10am to 10.30pm seven days a week.

The ECC had recruited a practice development nurse (PDN) whose initial action was to focus on the triage process and reduce waiting times by streamlining the process.

Staff referred patients to specialist services using a clinical method and planned to introduce a clerical method with clinical backup in the near future.

The nurse in charge used the quality round checklist to identify if any patients had remained in a seated area, rather than a bed or trolley for over six hours. They shared this information with the wider hospital team at board rounds, which took place four times daily, to identify how to move them to a more appropriate area.

The psychiatric liaison team were responsible for discharging patients from the ECC to an appropriate community bed if needed. Staff told us this process usually took about four hours but if there were significant delays or the patient’s mental state deteriorated, an escalation pathway was in place that enabled the operations manager and duty director to intervene.

The urgent care matron, ECC discharge coordinator, medical matron and site manager attended a bed meeting three times each day.

Learning from complaints and concerns

From July 2016 to June 2017 there were 62 complaints about urgent and emergency care services. The trust took an average of 34.9 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 days or 60 for more complex complaints. 55 of the 62 related to all aspects of clinical treatment.

Maidstone Hospital: There were 29 complaints, the trust took an average of 45 days to complete
the complaints, and the main themes were around missed fractures as well as communication between staff to patients.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The matron had a good understanding of the complaints in the department and had identified four trends. These were communication; missed diagnosis; lost property and discharge arrangements. The senior team held a weekly meeting to keep track of complaints and investigations and to encourage timely responses from the staff involved in them.

We looked at the outcomes of two formal complaints made to the department. Although the trust responded to both complainants, there was no indication of learning or improved policies as a result. For example one patient complained of unmanaged pain. The trust’s response noted they could not identify if pain relief was initially offered because of a lack of detail in the triage nurse notes. The second complaint noted a lack of neurological investigations in the ECC, which the trust upheld but did not identify what could have been done differently.
Is the service well-led?

Leadership
An urgent care director led urgent and emergency services, supported by an associate director of nursing, a general manager, a lead matron for the emergency care centre (ECC) and three matrons. A clinical director was the overall lead for medical care in the ED and a lead consultant had been in post for four years.

All of the staff we spoke with were positive about leadership in the department and said they felt able to approach the senior team at any time. Medical staff noted there had been an improvement in clinical leadership and consultant support.

Vision and strategy
The ECC team had contributed to a vision and strategy for the department that was in addition to the trust’s overall vision. The vision had four key areas that focused on early intervention and critical decision-making, access to appropriate specialties, minimising patient recalls and stabilising the staff team.

The psychiatric liaison team members we spoke with said they did not know if the trust had an overriding mental health care and treatment strategy.

The practice development nurse (PDN) role was new to the department and this individual worked with their counterpart at Tunbridge Wells Hospital to develop the scope of the role. For example they worked with PDNs at other trusts in the local area to share teaching and learning at four-monthly meetings.

Culture
Staff told us the senior executive team, including the chief executive officer, chief operational officer and operational lead, were more visible in the last year and they felt more involved with the trust as a result.

Although all of the staff we spoke with told us the working atmosphere was positive and they felt well supported, there was room for improvement in how all teams contributed to this. For example one senior nurse we spoke with said they typically saw two patients each day who needed significant mental health support. However the member of staff did not know if the psychiatric liaison team were based on site and said there were usually not enough nurses to provide enhanced care on a one-to-one basis. This issue reflected patient safety and service responsiveness but was indicative of a need for improved communication in some aspects of the team’s work.

Governance
A clinical governance lead was in post and led monthly cross-site governance meetings. Attendance at this meeting was compulsory, which the lead consultant had implemented to ensure all staff maintained an up to date understanding of complaints, near misses, serious incidents and mortalities. The trust clinical governance committee maintained oversight of departmental governance and outcomes.
The matron and lead consultant attended a monthly quality and safety committee that maintained oversight of governance in the ECC.

We saw from looking at a sample of presentations and meeting minutes that the ECC team used clinical governance meetings to discuss audit results, learning from incidents and other areas of work that impacted safety. Governance meetings were well attended by a wide range of ECC staff and there was documented evidence of multidisciplinary learning and involvement.

The psychiatric liaison team prepared a report for the quarterly safety and patient experience meeting. The governance team used this report to identify delays to care and to monitor relationships between the trust and community service providers.

The quality and safety committee or the policy ratification committee were responsible for approving the policies and standard operating procedures formed by committees and clinical teams. We saw all of the policies in use by staff had been appropriately ratified before being implemented.

**Management of risk, issues and performance**

The senior team used a risk register to identify key risks to the service and to strategise plans to address them. As of November 2017 there were 10 risks on the risk register for the Maidstone site and 26 risks that applied to both urgent care sites. The key ECC risks included the lack of bed availability in the hospital, particularly psychiatry beds, and overall low levels of middle grade doctor cover. The service had recruited emergency department practitioners who could provide cover for middle grade doctors. The operational and senior clinical teams used daily bed meetings to address the risks of low bed capacity and where possible identified alternatives such as community beds to help access and flow. All of the risks identified had an accountable owner and there was evidence in most cases of work to reduce the overall impact of the risks. For example, a new emergency call bell system had been installed and new patient flow systems had been implemented. One risk related to the inability to lock down the radiology area of the department if a dangerous member of the public was in attendance. This risk was dated April 2017 but there were no controls yet in place.

The nursing team used a weekly shift brief and safety huddle briefing to ensure all staff were up to date with learning from incidents and complaints and with policy or procedure changes. In addition senior nurses encouraged everyone in the department to engage with the trust’s ‘Take 5ive Talk Five’ initiative. This aimed to focus on one topic each week and encourage staff to talk about it and improve their knowledge and skills. For example one week’s theme had been citizenship, which encouraged staff to remember to introduce themselves to patients, visitors and new colleagues and to exercise politeness with everyone they interacted with.

The ED team demonstrated understanding of the security risks to staff and to patients that resulted from patients who were under the influence of alcohol or drugs or those who behaved violently. To manage this risk security staff were on site 24-hours, seven days a week and the team worked closely with local police to provide a rapid response to incidents. The senior team used a clinical governance investigation system to identify how behaviour could be deescalated in future and to ensure all staff involved were offered support if needed.

A dedicated major incident team worked cross-site to deliver practical and simulated training exercises to all staff in the department. Two members of the team had an emergency care background and tailored the training to the needs of ECC staff.
The senior team had prepared for the ‘winter pressure’ period by meeting with the clinical commissioning group, district nurses, the estates and facilities teams and the catering contractor to ensure services would continue during times of exceptional demand.

**Information management**

The senior team had focused on information management as part of a weekly staff initiative to improve knowledge in targeted areas. For example staff were reminded to log in and out of shared computers and to ensure confidential information was stored securely.

We saw effective information management between the ECC team and the psychiatric liaison team. For example care plans and treatment checklists were copied to each team’s system and given to the patient and receiving ward or community unit.

**Engagement**

The senior team recognised there had been limited opportunities for band five nurses to progress into leadership roles as a result of a stable senior team. However the matron had recently completed a restructure of the team, which had resulted in new opportunities for band five progression.

The trust participated in the ‘listening in action’ campaign and had carried out a series of open staff forums to ask staff for cost-saving ideas. This was also a strategy to reduce anxiety about the trust’s financial position and enabled them to contribute to the future sustainability of the service.

The director of urgent care held quarterly open days and all staff were invited.

Staff used a secure social media communication group to stay up to date with changes or new projects in the department. In addition the trust provided periodic nursing engagement and learning forums to enable nurses and clinical support workers to have access to guest speakers and information on trust initiatives. The divisional team issued monthly newsletters to support staff in ensuring they understood changes to policies or new policies.

**Learning, continuous improvement and innovation**

New practice development nurses worked cross-site and had developed a significant improvement in staff training and networking opportunities. This included the opportunity to work with ED nurses at other trusts to share learning and experience the benefits of training together. In addition a paediatric PDN was establishing team training and rotational posts for adult nurses to build their confidence and skills in paediatric care.

Opportunities for staff to spend time working with colleagues in other teams on a rotational basis had a positive impact on patient experience and staff practice. For example following a rotation with the psychiatric liaison team a foundation level doctor designed a new proforma for patients with a psychotic history who presented in the ECC. This would enable the team to more quickly assess patients with mental health needs and put enhanced care in place to manage risks.

The dementia strategy group had established terms of reference and a strategy that aimed to develop the trust into a dementia friendly organisation by 2020.
Maidstone Hospital

Medical care (including older people’s care)

Facts and data about this service

Maidstone and Tunbridge Wells NHS Trust was established in 2000 and provides a range of general hospital services and some areas of specialist complex care to around 560,000 people living in southwest Kent and East Sussex. The trust’s core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs, and it operates from two main clinical sites: Maidstone Hospital and the Tunbridge Wells Hospital at Pembury.

The medical care service at Maidstone Hospital provides care and treatment for Gastroenterology, Respiratory, Cardiology, Care of the Elderly (including stroke and transient ischaemic attack and Endocrinology, as well as offering some services within the community.

There is a Cardiac Catheter Laboratory at Maidstone Hospital focused on Electrophysiology studies, ablation and devices. There is a full cardio-respiratory and respiratory physiology support service offering diagnostic procedures. The service has 209 medical inpatient beds across eight dedicated medical inpatient wards, with additional beds situated in day care settings.

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

The trust had 37,867 medical admissions between April 2016 and March 2017. Emergency admissions accounted for 18,948 (50%), 1,332 (3%) were elective, and the remaining 17,587 (46%) were day case.

Admissions across the trust for the top three medical specialties were:

- General Medicine 13,634
- Gastroenterology 9,053
- Geriatric Medicine 7,497

(Source: CQC Insight)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Managers explained that a new web-based learning management system had been introduced to replace a spreadsheet record. We saw examples of both systems in use during our visit as some wards were still converting to the new learning management system.

Staff demonstrated the ease of which individual and team reports could be produced and described how the learning management system generated email alerts sent to the individual concerned and their line manager whenever a topic became ‘due’.

Subjects covered by all staff included child and adult safeguarding, information governance, infection prevention and control, fire safety, health and safety and trust values. Clinical and scientific staff had additional role specific mandatory training which included higher level
safeguarding training, responding to deteriorating patients, record keeping and more detailed infection prevention and control training.

Some subjects were offered ‘on-line’ through the learning management system, which offered the flexibility of access from any computer connected to the internet. This meant staff could complete certain topics after hours or at home if desired. Other topics required attendance at a classroom session.

Staff we interviewed at Maidstone Hospital said they received a suitable amount of training to ensure they had the skills to do their jobs. This included training in sepsis management and the use of screening tools such as pre-printed stickers showing triggers for referring patients to outreach support. We also found that staff received training to help make them aware of the potential needs of people with mental health conditions, learning disability and dementia.

Managers acknowledged training compliance rates for dementia awareness were lower than target (see below) and gave examples of actions undertaken to remedy this. These included the appointment of a dementia lead nurse and recruitment of dementia ‘champions’ from each ward area.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training with the exception of information governance that had a 95% completion target. A breakdown of compliance for mandatory courses between April 2017 and June 2017 for medical or dental and nursing staff in Medicine is shown below:

![Mandatory training completion](image)

Medical staff within the medicine core service were not meeting the trust target for five mandatory training modules, the lowest completion rate was for dementia awareness (including Privacy & Dignity standards) with 62% followed by medicine management training with 70%.
Nursing staff within Medicine did not meet the completion for three of 19 training modules; the lowest completion rate is for conflict resolution training with 50% followed by dementia awareness (including privacy & dignity standards) with 63%.

Maidstone Hospital had an 86% training completion rate.

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust had systems and processes in place to help staff identify and report concerns to protect their patients. Staff we spoke with had safeguarding training at the correct levels for their roles and were alert to any potential issues with adults or children. Female genital mutilation and sex exploitation awareness was incorporated into safeguarding training which was delivered as part of the annual mandatory training programme as well as induction courses for new staff.

In the wards we visited at Maidstone Hospital, we saw that training compliance rates met or exceeded the trust target. Staff described how they would identify a safeguarding concern and the processes used to report a concern or incident. We saw examples of safeguarding referrals and we noted the investigation documentation also included learning points following the investigation. Staff were able to identify the departmental safeguarding lead nurse to report concerns and obtain support. This indicated that staff identified the risks of abuse and were actively reporting it through correct channels.

The trust had recently formed a ‘safeguarding panel’ and we saw evidence that this been convened in October. Managers stated that this new arrangement enhanced the way the trust managed safeguarding enquiries and reduce any delays in learning being identified and shared.

Patients and relatives we spoke with on both sites said they felt safe on the ward and were always treated respectfully by staff.
Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.
A breakdown of compliance for safeguarding courses up to June 2017 for medical/dental and nursing staff in Medicine is shown below:

Medical staff within Medicine met the completion for four of the five safeguarding modules, it did not meet the 85% target for the safeguarding children level three module.

Nursing staff within Medicine met the completion for all five safeguarding modules. Maidstone Hospital had an 87% safeguarding training completion rate.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
All of the areas we inspected were visibly clean, tidy and free from clutter. We were told that there was daily housekeeping support provided to each area and we saw cleaning operatives working throughout the day. Housekeepers had a routine cleaning schedule to follow and kept account of their progress by completing regular cleaning audits and quality monitoring. We saw records of these on cleaning trolleys and we noted staff changing the colour-coded mops and cloths to suit the cleaning task.

We visited six wards at Maidstone Hospital and saw that beds, trolleys and medical equipment were clean and stored correctly. Wide use was made of ‘I am clean stickers’ which detailed the date and time the article was cleaned along with the name of the person who cleaned it. We saw these details had been completed in all cases, which meant staff could quickly identify items and equipment that was clean and ready for use. On one ward we noted stickers in use but not on bedside chairs, which meant staff there has less assurance these items had been cleaned.

Medical services had infection prevention and control policies readily available for staff to access on the trust intranet. Staff were aware of the policies and knew how to access them. These included waste management policies, which were monitored through regular environmental audits.

We saw that clinical and domestic waste bins were available and clearly marked in coloured bins for disposal in the correct manner. However, we noted examples of clinical waste (such as used gloves) being disposed of in the general waste bin. We brought this to the attention of the trust during our inspection.

The trust had arrangements in place to support the management of infection prevention and control. This included an infection prevention team with qualified infection control nurses and a doctor with infection control responsibilities. The team worked across the hospitals coordinating with other health-care professionals, patients and visitors to prevent and control infections. The infection control teams’ responsibilities included giving advice, providing education and training, monitoring infection rates and audit infection prevention and control practice.

All staff we observed during the inspection were ‘bare below the elbows’ in line with trust policy. Staff explained that the trust had banned the use of name badge lanyards on infection, prevention control grounds and had opted for ‘wipe clean’ plastic badges or identification card holders.

We saw ample supplies of personal protective equipment such as aprons and gloves in dispensers on walls and we saw these items being used. Body fluid spillage kits were readily available. Antimicrobial hand-rub dispensers were mounted on the walls outside each room or bay. These contained gel and we observed staff using the product as they moved around the premises.

We saw disposable curtains marked with the date changed. This complied with Hospital Building Note 00-09, infection control in the built environment and indicted that staff routinely changed curtains to help reduce the chances of germs passing from one person or object to another.

Sharps boxes were managed in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations). Clearly marked and secure containers were placed close to the areas where medical sharps were used. Instructions for staff on the safe disposal of sharps were displayed in clinical areas and the sluices. We saw clear guidance for staff on the action to take in the event of a needle stick injury. This was displayed in treatment rooms and other clinical areas.

There were adequate numbers of side rooms to allow any patient who presented a risk of cross infection to others to be isolated to reduce the risk. These rooms were clearly identified using a
system of magnetic signs that helped inform visitors and staff about any special precautions
needed. Similarly, posters about infection control were prominently displayed at ward
entranceways to encourage visitors to help in reducing the risk of cross infection by maintaining
good hand hygiene and not visiting if they are unwell.

Each of the medical wards and units we inspected displayed their infection prevention and control
audit results, so patients, visitors and staff had current infection control information available.

The directorate of emergency and medical services had reported 1 case of meticillin-resistant
staphylococcus aureus in the last year. The trust had a screening process for all inpatients and an
isolation and treatment protocol for any identified cases. During the same period, medical services
reported 18 cases of clostridium difficile.

The 2017 patient-led assessment of the care environment survey showed the trust scored 99.8%,
for cleanliness, which was better than the England average (98%).

Environment and equipment

The service had suitable premises and equipment and looked after them well. The areas we
observed supported the safe delivery of care. There was access to emergency equipment,
including portable oxygen, suction and automated defibrillators stored on purpose-built trolleys.
These were stocked and checked daily in accordance with guide sheets attached to each trolley,
which were collected by managers and audited monthly. All bays and rooms we visited had piped
oxygen and suction and every device we checked functioned correctly. This was consistent with
the emergency equipment checklists and indicated staff retained an active focus on ensuring
these items were ready for immediate use should an emergency occurring.

Rooms were well-lit, air-conditioned and supplied with sufficient equipment and furnishings.
Corridors, treatment rooms and toilets were spacious with doors wide enough to fit wheelchairs.

The wards and units were sited in relatively modern buildings and kept in good decorative order
using dementia-friendly contrast colour schemes. We saw good examples of clear direction signs
utilising colour codes and symbols.

The entryways had dropped kerbs to assist wheelchair users or those with limited mobility reach
the entrance. Disabled parking spaces and ‘drop off’ areas were provided close to entrances and
entrance doors were automated, again assisting people living with less mobility.

Beds, furniture and equipment were labelled with asset numbers and labels showing service
dates. Staff told us that the medical equipment was well maintained centrally by the engineering
service and none cited any problems in obtaining sufficient items for use. The ward stores we
visited appeared clean with plentiful shelving and items clearly labelled.

Fire safety equipment was available throughout the hospital and we saw evidence that fire
equipment safety checks had been completed by an external specialist contractor.

The 2017 patient-led assessment of the care environment survey showed the trust scored 96.8%
for ‘condition, appearance and maintenance’, which was better than the England average of 94%.

Assessing and responding to patient risk

We saw that comprehensive risk assessments were carried out on patient admission and kept in
the patient records. This included assessing the patient against the risk of falls, nutrition status,
skin integrity and pain. In the eight sets of patient records we examined, risk assessments had been regularly reviewed and updated.

Bed charts we saw were completed legibly and accurately and patient records showed that nursing staff escalated any concerns about deteriorating health and that decisions about changes to care or treatment plans were made by staff that were competent to do so. We saw ‘sepsis six’ management and screening tools in place such as pre-printed stickers showing staff the triggers for referring patients to the outreach support team.

Senior clinical staff stated that there were two daily nursing handovers and six multidisciplinary meetings a week where each patient was risk assessed. We observed one multidisciplinary meeting and saw effective risk-based discussions and decisions that supported what we had been told.

The trust used a national early warning system track and trigger flowchart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). The scoring system enabled staff to identify patients who were becoming increasing unwell and provide them with increased support.

Nursing staff told us they had good support from the doctors and the clinical outreach teams when a patient’s deterioration was observed.

In the notes we reviewed we found that the national early warning system scores had been calculated consistently and accurately. Staff explained that a new computerised system was in the process of being implemented that prompted staff to complete observations and record them on portable devices. The ‘live’ system automatically triggered alerts to senior nursing and medical staff when observations were missed or readings detected patient deterioration. We saw a demonstration of the software capabilities but were told the system was offline as part of the implementation development.

Patient moves per admission

This information is 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. The trust told us they are unable to provide accurate data regards ward transfers and clinical pathways within this data set.

Between August 2016 and July 2017, 371 patients moved during the night between (10pm and 8am) at Maidstone Hospital.

(Source: Trust Routine Provider Information Return P51)

Nursing staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Based on our observations during the inspection, there were sufficient staff to meet the patients’ needs. We saw that actual staff on duty matched staffing templates and this information was clearly displayed on the ‘green cross’ posters at ward entrances.

Lack of registered nurse staffing was a concern raised by senior staff and managers and was included on the directorate risk register. The trust had taken action to address the shortfall in staffing such as recruiting overseas nurses. We were told another recruitment drive was in
progress and at Maidstone hospital we heard from managers who had been interviewing overseas candidates using video conferencing facilities.

Managers stated that planned staffing was generally met, although bank and agency staff were often required. Bank use was encouraged by managers as staff were familiar with the ward processes and environment. Where outside agency staff were used, we were told that shifts were booked in ‘lines’ of up to a week. This meant the agency nurse worked a pattern of shifts on the same ward or unit, which helped ensure they were familiar with the processes used. We saw examples of correctly completed agency orientation sheets which confirmed this.

We saw arrangements for nursing staff to hand over the care of patients between shifts and we noted the use of printed handover sheets. We looked at these sheets and found they contained relevant information on the specific needs and risks of patients that supported the delivery of safe care.

The trust has reported their staffing numbers below for the period June 2017 for Medicine. There are 103.98 less WTE nursing staff within medicine then the trust planned to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing</td>
<td>498.38</td>
<td>394.40</td>
</tr>
<tr>
<td>Total</td>
<td>498.38</td>
<td>394.40</td>
</tr>
</tbody>
</table>

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

Vacancy rates

Between July 2016 and June 2017, the trust reported a vacancy rate of 19.0% in medical care of which Maidstone Hospital accounted for 22.7%

The trust has a target vacancy rate of 8.5% the overall vacancy rate for medicine and at both sites is worse than the trust target.

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

Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 1.1% in medical care. The rate for Maidstone Hospital was 0.7%

The trust target for turnover was 10.5% which medicine and both sites are performing better than target.

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

Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 3.9% in medical care. The rate for Maidstone Hospital was 3.7%

The trust's target sickness absence rate was 3.3% or lower. However, the trust average was 3.7% which matched the rate for Maidstone.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Bank and agency staff usage

Between July 2016 and June 2017, the trust reported a bank and agency usage rate of 89% in medical care; total of 18,629 shifts of which 35% covered by bank staff and 54% covered by agency, a total of 1,945 shifts were not covered.

- Maidstone Hospital: total of 7,080 shifts of which 38% covered by bank staff and 47% covered by agency, a total of 1,123 shifts were not covered.

The trust told us in their provider information request they had the highest bank or agency use on the following medical ward, ward 22, the reasons attributed to this was vacancies.

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

Medical staffing

Overall, we found that numbers of doctors at the right grades were suitable to meet the needs of patients.

Newly admitted patients received a timely review by a consultant trained in general internal medicine and we saw ward rounds taking place. A consultant on-call system operated and junior medical staff we spoke to told us they could access advice from a consultant and felt well-supported.

The trust has reported their staffing numbers below for the period June 2017 for Medicine.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>94.78</td>
<td>81.86</td>
</tr>
<tr>
<td>Total</td>
<td>94.78</td>
<td>81.86</td>
</tr>
</tbody>
</table>

There were 12.92 less WTE medical and dental staff within medicine rather than the trust planned to provide safe care.

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

Vacancy rates

Between July 2016 and June 2017, the trust reported a vacancy rate of 7.2% in medical care. The rate at Maidstone Hospital was 7.4%

The trust has a target vacancy rate of 8.5% the overall vacancy rate for medicine and at both sites was better compared to the trust target.

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

Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 1.1% in medical care. At Maidstone Hospital it was 0.8%
The trust target for turnover was 10.5%, medicine and both sites was performing better against this target.

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

Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 3.9% in medical care. At Maidstone Hospital it was 1.6%

The trust's target sickness absence rate was 3.3% or lower, and both sites were better than 3.3%

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

Bank and locum staff usage

Between July 2016 and June 2017, the trust reported a locum and agency usage rate of 9% in medical care;

- Maidstone Hospital: Total of 950 shifts of which 19% covered by locum staff and 92% covered by agency.

For medical care 12% of 1,836 shifts were covered by locum staff for the time period, 58% covered by agency and a total of two shifts was not covered.

The trust told us in their provider information request they had the highest bank or agency use on the following surgical wards, the short stay surgical unit and ward 31 which were at the Tunbridge Wells site, the reasons attributed to these were vacancies at both.

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

Staffing skill mix

Between June 2017 and 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 year 1-2) staff was the same.

Staffing skill mix for the 192 whole time equivalent staff working in Medicine at Maidstone and Tunbridge Wells NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>36%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>21%</td>
<td>22%</td>
</tr>
</tbody>
</table>
Records

Staff kept records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. Medical care services used integrated records which were shared by doctors, nurses and other healthcare professionals. Staff explained that the paper records were being merged with electronic systems and were positive about the changes being implemented.

In the patient notes we reviewed we saw a good standard of record keeping. The records contained all required information such as admission details, signature list and consent to treatment. The care records included multidisciplinary input where required for example, entries made by physiotherapist, occupational and mental health practitioner. Progress notes were complete, clear, legible, dated and signed.

Patients’ records were readily accessible to those who needed them and we found on this visit that they were stored securely in locked notes trolleys.

We saw that patients were risk assessed in key safety areas using nationally recognised tools. For example, we noted the use of waterlow scores to assess the risk of pressure damage. We saw that risk assessments were reviewed and repeated within suitable and recommended timescales.

On all wards we saw staff updating and referring to purpose-built marker boards that were mounted on walls at the nurses’ station or bay. We observed patient names written on these boards and occasionally other details. When we asked, managers told us it was trust policy to record surnames only, but we saw this was inconsistently applied. The board did not have covers which meant that the privacy of patients was not protected from casual observation by visitors or other patients.

Medicines

Overall, we found that medical services prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

The trust had current medicines management policies, together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Prescribers also had access to relevant resources on medicines management such as electronic and papers of the current British National Formulary.

We checked several resuscitation trolleys in medical services and noted that the trolley drawers were not secured by tamper evident tags. Although these had emergency use medicines in sealed boxes, these trolleys still contained intravenous fluids and infusions in drawers that could be opened by anyone. We felt this was a risk and brought it to the attention of the trust, who responded quickly and remedied this during the course of the inspection process.

The previous inspection report had highlighted concerns regarding competency checks for intravenous medicines for agency nurses. On this visit we saw that a local induction checklist was available and used to ensure agency nurses only undertook tasks when competent to do so.

We examined six prescription charts on wards in Maidstone and found these were legally valid and contained information about people’s allergies. There was one missed dose on these charts. Most charts had been clinically screened by a member of the pharmacy team.

During our visits we saw that medicines were stored securely in locked, wall mounted cabinets and kept in key-coded rooms away from visitors. Controlled drugs were stored, recorded and
handled in line with legislation. Spot checks on balances showed that contents of the cupboard matched the register. Medicines waste was handled correctly and staff knew to check with the pharmacist before crushing medicines. They had access to resources to help with this.

We saw reminders for staff on critical medicines (medicines which should not be omitted) and lookalike or sound alike medicines to promote safe administration.

On the ward we checked, we noted temperature records for the medicines fridge were missing entries. On the day of the inspection, we saw that a new fridge record chart was being introduced by the trust to help improve temperature recording. We found some medicines stored at ambient temperature, which should be stored in the fridge. Staff disposed of these immediately.

Opening dates were not always on liquid medicines to ensure they were used within the correct expiry date.

Staff knew how to report medicines incidents and demonstrated a good awareness of signs of sepsis.

A consultant microbiologist attended weekly ward rounds. We saw from prescription charts that antibiotics were reviewed regularly.

Staff told us that the trust dispensary was very busy and medicines did not always arrive on the ward in time; including medicines for people due to be discharged. This meant that the discharge had to be delayed until the medication was made available.

**Incidents**

The service managed patient safety incidents well. Staff recognised what constitute an incident and reported them. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported incidents using a commercial software package linked to the trust intranet and the people we spoke to confirmed they had received training and felt confident about using the system. We noted that the software would not allow an incident to be ‘closed’ until the duty of candour section of the file was completed. This facility gave the trust extra assurance that duty of candour was being followed by managers dealing with the incident report.

We saw evidence of learning from incidents that were shared across the trust through email alerts, announcements on the trust intranet and at local level during team and divisional meetings. For instance, we observed patients wearing anti-fall socks. Senior nurses stated this was the result of the directorate looking at ways to help reduce the number of patients slipping or falling, especially at night.

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

(Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 48 serious incidents (SIs) in Medicine which met the reporting criteria set by NHS England between August 2016 and July 2017.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting serious incident criteria with 28 (58% of total incidents).
- All other categories with seven (15% of total incidents).
- Abuse/alleged abuse of adult patient by staff with five (10% of total incidents).
- Pressure ulcer meeting serious incident criteria with four (8% of total incidents).
- Venous thromboembolism meeting serious incident criteria with three (6% of total incidents).
- Surgical/invasive procedure incident meeting serious incident criteria with one (2% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

We observed ‘green cross’ charts displayed outside each ward we visited. These displayed current ‘safety thermometer’ information about key indicators such as falls and staffing levels. The charts helped relatives and visitors to the hospital understand what the trust was monitoring and how each ward was performing against the targets set by the trust. This indicated the organisation had developed a positive focus on safety and was transparent about the levels of harm-free care achieved.

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 21 new pressure ulcers, 24 falls with harm and 29 new catheter urinary tract infections between August 2016 and August 2017 for medical services.
The prevalence rate of pressure ulcers and catheter acquired urinary tract infections has declined over the time period, with numbers falling to zero in August 2017.

Total falls reported were steady through the time period expect a peak in March 2017, however the most recent data reported no falls in August 2017.

(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. Managers checked to make sure staff followed guidance. New and updated guidance was evaluated and shared with staff.

We saw that staff were able to access national and local guidelines through the trust’s intranet. There were sufficient computer terminals provided on the wards we visited and we saw staff using
the resources. We noted there were links on the trust intranet to help access national guidelines if needed.

The standardised care pathways were based on current best practice and National Institute for Health and Care Excellence guidance. For example, the acute heart failure pathway and stroke pathways incorporated National Institute for Health and Care Excellence guidance. The trust routinely reviewed the effectiveness of care and treatment by using performance dashboards, local and national audits.

The minutes from various departmental and directorate-wide meetings showed that where audit results had been documented, these were discussed and plans developed to address any issues.

**Pain relief**

The trust had a pain management policy that staff could read on the intranet, and the policy included information on how to contact the specialist pain team. Staff we spoke to know how to contact them.

Patient charts included space for recording patients’ perception of pain and we saw visual pain charts on the stroke rehabilitation ward. These were designed to help patients who could not speak indicate their level of pain or discomfort.

Nurses assessed pain at set intervals to check if patients and this was recorded on ‘rounding’ sheets. Patients confirmed to us that if needed, pain relief medication was promptly brought by staff.

Staff told us that pharmacist and pharmacy technician availability on the ward was “generally good”.

**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 preferences.

The trust used nationally recognised tools to assess patients’ nutrition and hydration. We reviewed risk assessments while we examined patient notes and saw that overall, the nutritional assessments were up to date and additional support from the dietician service was available when needed. Some of the nutrition and fluid balance charts we reviewed were incomplete. This meant it was not always possible to assess if the patient had received adequate food and fluids.

Staff explained that dieticians monitored patients who received nutrition through a nasogastric or parenteral feeding tube. Parenteral feeding is the process by which a patient receives nutrients intravenously bypassing the usual process of eating and digestion. We did not see any patients undergoing this therapy on the wards or units we visited.

Staff offered patients three main meals and snacks were available if needed. There was a choice of food available and the hospital was able to cater for specialist diets.

We saw staff using coloured place mats to indicate people who needed assistance to eat their meals. In addition, the trust used a system of magnetised ‘pictograms’ to represent food or fluid restrictions as well as special dietary needs. These were mounted on display boards fixed to wall next to each bed in a bay or outside each separate room. These provided visiting staff and therapists with a visual reminder that the patient had a special requirement or need.
The 2017 patient-led assessment of the care environment survey showed the trust scored 92.84%, for food and hydration, which was better than the England average (89%).

**Patient outcomes - relative risk of readmission**

**Trust level**

Between May 2016 and April 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.

Elective admissions had a lower than expected risk of readmission overall, apart from general medicine

- Patients in general medicine had a higher than expected risk of readmission for elective admissions.
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions.
- Patients in cardiology had a lower than expected risk of readmission for elective admissions.

Non-Elective admissions general medicine and gastroenterology were similar to the expected value of 100.

- Patients in general medicine had a higher 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 gastroenterology had a lower than expected risk of readmission for non-elective admissions.

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**Elective Admissions – Trust Level**

![Elective Admissions Graph]

**Non-Elective Admissions – Trust Level**

![Non-Elective Admissions Graph]

*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 (01/05/2016 - 30/04/2017))

Maidstone Hospital

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

For Maidstone Hospital, all elective and non-elective admissions where in line with the England average apart from elective clinical haematology which was five times higher than the expected value of 100.

- Patients in general medicine had a lower than expected risk of readmission for elective admissions.
- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions.
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions.
- Patients in general medicine had a higher 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 gastroenterology had a lower than expected risk of readmission for non-elective admissions.

Elective Admissions - The Maidstone Hospital

Non-Elective Admissions - The Maidstone 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, Maidstone Hospital achieved grade A in latest audit, December 2016 to March 2017.
Maidstone Hospital

This site has scored highly in all quarters we have data for from October 2015 to March 2017 and it has improved its overall score to a grade A from B in the most recent quarter of December 2016 to March 2017.

### Patient centred Performance

<table>
<thead>
<tr>
<th>Domain</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
<td>B↑</td>
<td>A↑</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>D</td>
<td>D↓</td>
<td>C↑</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B↓</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
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<td>C</td>
<td>C</td>
<td>A↑↑</td>
<td>A</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C↓</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B↑↑</td>
<td>B</td>
<td>B</td>
<td>D↓↓</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>C↑</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Patient-centred Total Key Indicator Level</td>
<td>B</td>
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<td>B</td>
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### Team centred Performance

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<tr>
<th>Domain</th>
<th>Oct-Dec 15</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>B↓</td>
<td>B↑</td>
<td>A↑</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>C</td>
<td>C</td>
<td>D↓</td>
<td>C↑</td>
<td>C</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
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<tr>
<td>Domain 4: Specialist assessments</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
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<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A↑↑</td>
<td>A</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
<td>C↓</td>
<td>B↑</td>
<td>C↓</td>
<td>B↑</td>
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<tr>
<td>Domain 9: Standards by discharge</td>
<td>B↑↑</td>
<td>B</td>
<td>B</td>
<td>D↓↓</td>
<td>C↑</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>B↑↑</td>
<td>A↑</td>
<td>B↓</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Team-centred Total Key Indicator Level</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
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</tbody>
</table>

### Overall scores

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16-17</th>
</tr>
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<tbody>
<tr>
<td>SSNAP level</td>
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<td>B</td>
<td>B</td>
<td>A↑</td>
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<td>Combined Total Key Indicator level</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A↑</td>
</tr>
</tbody>
</table>

**Source:** Royal College of Physicians London, SSNAP audit

### 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 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 55 in patients with diabetes at Maidstone Hospital, 84.4% 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 two. This has dropped from the 2015 audit where Maidstone hospital scored 86.2%.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to Myocardial Ischaemia National Audit Project by hospital site (as opposed to trust).

NSTEMI is a type of heart attack. NSTEMI stands for Non-ST-elevation myocardial infarction. Between April 2014 and March 2015, 31.7% of nSTEMI patients were admitted to a cardiac unit or ward at Maidstone and 99.2% were seen by a cardiologist or member of the team compared to an England average of 55% and 96.6%. Whereas for Tunbridge Wells Hospital 58.8% of nSTEMI patients were admitted to a cardiac unit or ward at Maidstone and 96.6% were seen by a cardiologist or member of the team compared to an England average of 95.1% and 55%.

The proportion of nSTEMI patients who were referred for or had angiography at Maidstone Hospital was 70% and at Tunbridge Wells Hospital was at 73% to an England average of 79%.

<table>
<thead>
<tr>
<th></th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014/15</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Maidstone Hospital</td>
<td>120</td>
<td>120</td>
<td>120 (120)</td>
</tr>
<tr>
<td></td>
<td>99.2%</td>
<td>31.7%</td>
<td>70% (No data)</td>
</tr>
<tr>
<td>The Tunbridge Wells Hospital</td>
<td>119</td>
<td>119</td>
<td>111 (111)</td>
</tr>
<tr>
<td></td>
<td>96.6%</td>
<td>58.8%</td>
<td>73% (No data)</td>
</tr>
<tr>
<td>England: overall</td>
<td>45500</td>
<td>45500</td>
<td>38099 (38099)</td>
</tr>
<tr>
<td></td>
<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
</tr>
</tbody>
</table>

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

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 61%, which was worse the audit minimum standard of 90%. The 2015 figure was 83.5%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 22.8%, this is worse than the national level. The 2015 figure was 20%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 68.4%, this is better than the national level. The 2015 figure was 56%.
The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 71.4% this is better than the national level. The 2015 figure was 62%.

The one year relative survival rate for the trust in 2016 is 37.4% which is similar to the England average of 38%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

The trust have 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 14.8% this worse than the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 8.3% this worse than the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 56% this similar to the national aspirational standard of 100%.

The crude proportion of patients with a mobility aid in reach (if applicable) was 75% this similar to the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The trust had recruitment policies and procedures together with job descriptions for all grades of staff. Managers described how the trust completed recruitment checks to ensure new staff were experienced, qualified, competent and suitable for their post. All new employees undertook trust and local induction with additional support and training when required.

Agency staff had orientation packs delivered on their first shift and we saw completed examples matching staff names on rosters.

We saw electronic systems that assisted managers monitor the status of staff requiring validation and continuing registration with professional bodies. Registered nurses we spoke with told us the trust supported them in preparing for revalidation, which is a process all nurses and midwives must complete to renew their registration.

Management used the appraisal process to identify staff learning and development needs. Staff told us they had regular team meetings and were supported with their continuous professional development.

Nursing staff described having monthly one-to-one meetings with their ward managers. One nurse told us these happened “regularly and don’t get cancelled”. We saw examples of appraisal templates and completed forms.

We observed that staff were professional and competent in their interactions with colleagues, patients and their relatives/carers during our inspection.
A wide range of specialist nurses supported the nurses on the ward. For example, the dementia care team, palliative care team, safeguarding leads, diabetes care team and discharge coordinators.

Appraisal rates

Up to July 2017, 94% of staff within Medicine at the trust had received an appraisal compared to a trust target of 90%. Maidstone Hospital had a 93% appraisal rate.

A split by staff group can be seen in the graph below:

![Appraisal rates by staffing group for Medicine](source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We observed examples of good multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and GPs. Medical and nursing staff and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

At meetings, we observed positive and proactive engagement between all members of the multidisciplinary team (MDT). We found the ward rounds were well organised and well attended by representatives from the ward clinical team, therapists and operational managers.

Medical, nursing and therapy staff of all grades described the good working relationships between staff and directorates.

The wards used integrated patient records, which were shared by clinical staff and therapists. This improved communication and meant that care was better co-ordinated between healthcare professionals.

Seven-day services

Seven-day cover was not available for all support services such as psychiatric support, radiology and some therapy services. There was no access to dieticians or speech and language therapists at weekends. This had an impact on the care of patients particularly on the stroke ward, where dietary advice and support with eating affected recovery and discharge times.
Medical out of hours cover were provided by on-call, agency or locum staff supplementing the permanent members of staff. Consultant cover was available every day including weekends, with on-call arrangements for bank holidays.

Diagnostic services were available throughout the week and staff did not report any issues with obtaining diagnostic results out of normal hours.

Discharge lounges were open during the day, from Monday to Friday.

**Access to information**

The trust had introduced a number of new electronic systems since our last visit. These included clinical packages such as electronic prescribing as well as general software such as the learning management system. The trust was in the process of implementing electronic patient records during our inspection. Staff described the enhancements in positive terms.

At the time of our visit we saw mainly paper-based patient files. This meant there were sometimes delays when sharing information between hospitals and other providers who used electronic records and means of communication.

We saw that policies and clinical guidance was available on the intranet. Staff also had access to information from specialist nurses, such as the diabetic, stoma, and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.

There were systems in place to ensure the safe transfer of information when a patient moved between wards or hospitals.

All the staff we spoke with told us there was good communication and access to information between staff and between medical specialities.

Doctors told us they had prompt access to diagnostic results such as blood results and imaging. Staff said there was little or no delay in retrieving patient notes from the archives.

Site managers and senior staff routinely collected site data to inform the management of the hospital and the trust as a whole.

Management held ward and departmental meetings on a regular basis. The minutes from these meetings confirmed that information was shared including clinical updates and lessons learnt from incidents and complaints.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Across the medical directorate staff demonstrated a good understanding of the legislation and best practice regarding consent, the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment.

The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, the Mental Capacity Act 2005 guidance and checklists for use when dealing with cases.

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

The trust reported that between April 2017 and July 2017 mental capacity act (MCA) training had been completed by 98% of staff within Medicine.
The trust did not provide deprivation of liberty training as a separate module as this was part of the safeguarding level two module this was completed by 95% of divisional medical staff and 91% of nursing staff.
(Source: Trust Routine Provider Information Return P39)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Without exception, we saw all grades of clinical and support staff treating patients with kindness, compassion, courtesy and respect.

All staff wore dementia friendly badges that clearly stated their names and we saw displays showing key staff working in each ward or unit area as well as posters describing how to identify staff grades and specialities from their uniform colours. This meant patients and visitors could more easily identify who was attending them. We also saw nurses wearing ‘nurse in charge’ armbands, which assisted staff and visitors who wanted to ask questions or seek help.

Staff introduced themselves to patients and relatives and we saw that patient privacy and dignity was maintained at all times. For example, curtains were used consistently in the bays and we saw staff knocking before entering bathrooms, side rooms and treatment rooms.

Our observations were supported by feedback from the patients we spoke to. They said they felt safe and there was no difference in the quality of care received during the day or at night. Patients said that staff asked them if they had everything they needed, were comfortable, pain free and had adequate hydration.

We saw examples of survey leaflets distributed in the medical unit. Called ‘Did you get great care today?’ the trust used the services of an independent organisation that allowed patients or carers to provide feedback on their healthcare. The 2017 patient-led assessment of the care environment survey showed the trust scored 86.9% for ‘privacy, dignity and wellbeing’, which was better than the England average (83%).

The units we visited comprised of combinations of side rooms and bays. Side rooms were prioritised for patients presenting with infection risks, but were also used to avoid mixed sex breaches in the bays.

We noted toilet door signs could be designated for use by men or women by a sliding plate, which helped to preserve the dignity of patients when bed bays were reallocated to different genders. Managers explained that while people of different genders were “occasionally” admitted into the same bay, but this was “always resolved before the night shift”.

Friends and Family test performance

The Friends and Family Test response rate for Medicine at the trust was 30% which was better than the England average of 25% between August 2016 and July 2017.

Friends and family Test – Response rate between August 2016 and July 2017 by site.
The average response rate for the trust varies between nine percent and 164% there are some wards that have a low recommendation trends between July 2016 and July 2017 for example Charles Dickens Day Unit, it is also worth noting that data is only included for wards with total responses above 100 and the top 12 wards per site are shown.

(Source: NHS England Friends and Family Test)

**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 spoke to confirmed that staff explained care and treatment plans and they were provided with clear information.

We saw staff providing people with information about their medicines during their stay. Staff described examples of times they involved other specialists such as the end of life care team to ensure people had correct medicines prescribed and ready for discharge. For example, the trust
provided a chemotherapy triage phone line for people to call if they were experiencing problematic side effect from their medicines.

We observed staff consistently wearing name badges and we saw the widespread use of pictograms on magnetic boards outside rooms and bays. In addition, we saw displays showing key staff on each ward and posters describing how to recognise staff grades and specialities by their uniform. This indicated the trust actively considered ways to inform and involve patients and relatives about who was providing care and how this was being provided.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. The hospital had arrangements in place to provide support when needed, which included help from specialists such as end of life, diabetes and dementia nurses.

Patients also had access to physiotherapists and occupational therapists that provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.

We saw examples of thank you notes and cards written to staff expressing their gratitude and some of these had been placed on display in ward offices.

There was a non-denominational hospital chaplaincy service, which provided pastoral support for patients and their relatives, carers and staff. Three chaplains were employed by the trust and several church or mosque volunteers augmented the team. The chaplaincy were available 24 hours a day throughout the week and could be contacted by staff, relatives or carers through the hospital switchboard. Staff we spoke to knew this and we also saw service leaflets on display in wards and units.

The chaplain explained that all patients that wished to were encouraged and supported to attend the non-denominational Christian church service on Sunday and Islamic prayer services were also offered on Fridays. The chaplaincy team visited the ward at other time and provided spiritual and emotional support to patients, staff and relatives.

**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people. Patients were admitted to the medical wards at Maidstone Hospital via direct referral from their general practitioner, a ‘step down’ transfer from a critical care unit at the hospital or through the accident and emergency department.

The trust had an integrated discharge team and we saw that discharge information was monitored through daily board rounds and MDT meetings.

**Average length of stay**

**Trust Level**

Between June 2016 and May 2017, the average length of stay for medical elective patients at the trust was 4.7 days, which was higher than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 8.5 days, which is higher than the England average of 6.6 days.

Average length of stay for elective specialties:
• Average length of stay for elective patients in gynaecological oncology was higher than the England average.

• Average length of stay for elective patients in cardiology was lower than the England average.

• Average length of stay for elective patients in gastroenterology was lower than the England average.

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 similar to the England average.

• Average length of stay for non-elective patients in gastroenterology was higher than the England average.

**Elective Average Length of Stay – Trust Level**

**Non-Elective Average Length of Stay – Trust Level**

**Maidstone Hospital**

Between June 2016 and May 2017, the average length of stay for medical elective patients at Maidstone Hospital was 5.2 days, which is higher than England average of 4.2 days. For medical non-elective patients, the average length of stay was 8.6 days, which is higher than England average of 6.6 days.

Average length of stay for elective specialties:

• Average length of stay for elective patients in gynaecological oncology was higher than the England average.

• Average length of stay for elective patients in clinical haematology was higher than the
England average.

- Average length of stay for elective patients in gastroenterology was lower than the England average.

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 gastroenterology was higher than the England average.

**Elective Average Length of Stay - Maidstone Hospital**

**Non-Elective Average Length of Stay - Maidstone Hospital**

*Meeting people's individual needs*

The service took account of patients' individual needs. The trust employed specialist nurses to support the ward staff. This included dementia nurses and learning difficulty link nurses who provided support, training and had developed resource files for staff to reference. Wards also had 'champions' who acted as additional resources to promote best practice.

For instance, the 2017 patient-led assessment of the care environment survey showed the trust scored 92.79% for dementia care, which was significantly better than the England average of 76% and 94.53% for care of people with disabilities against an average of 82%.

Red trays were used on the wards to identify those patients who needed assistance with feeding. We saw that eating and drinking requirements were clearly displayed near each bed or room using magnetised signs.
Nurses used ‘intentional rounding’ to help ensure that patients’ needs were met. Nursing staff usually carried out the rounds at set times through the days and we saw completed records confirming this.

We saw pictorial aides available for use with people with communication difficulties. Each bed had a call bell in place and within reach of the patient. We saw these being answered promptly by staff. Throughout the hospital we saw leaflets and useful information on display to help patients and their relatives understand their conditions and the treatment options available. The printed information was only available in English. Staff told us that an interpreter service was available for those patients who needed assistance.

The general environment had been designed to provide assistance for those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and manual handling equipment. Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request. This meant that the hospital was able to care for patients with mobility difficulties.

**Access and flow**

People could access the service when they needed it. Overall, arrangements to admit, treat and discharge patients were in line with good practice.

Staff told us that patients were sometimes admitted to other parts of the hospital because of pressure on bed capacity. Outliers are patients admitted to wards outside of their speciality. This was a risk as the general environment was not always suitable and staff did not always have the experience and expertise to manage the ‘outlying’ patients’ conditions. On the day of our inspection there were nine outlier patients receiving care in areas outside of their speciality.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The trust’s referral to treatment time for admitted pathways for Medicine has been consistently better than the England average for the whole time period, in August 2016, it was at 97% for this group of patients being treated within 18 weeks versus the England average of 91%.

The most recent data for July 2017 showed 99% 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**

Five specialties were better than the England average for admitted RTT (percentage within 18 weeks).
### 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.

### Summary of complaints

We saw advice leaflets readily available on the wards and departments we inspected. Patients had access to the Patient Liaison and Advice service, who supported patients with concerns and complaints and provided information about NHS services.

Staff confirmed that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings and briefings. We reviewed a sample of team meeting minutes and saw that complaints were discussed and monitored.

Staff could access the complaints policy on the trust’s intranet and knew how to direct patients to make a complaint. Medical and nursing staff told us that they received feedback from any complaint they had been involved in.

Patients we spoke with said they would raise any issues or concerns with the ward staff in the first instance and were aware that a complaints process existed.

Between July 2016 and June 2017 there were 76 complaints about medical care across both sites. The trust took an average of 46 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be completed within 25 days or within 60 days for complex complaints. The top three subjects the complaints related to were all aspects of clinical treatment (44) admissions, discharge and transfer arrangements with 12 and communication / information to patients (written and oral) with seven.

- Maidstone Hospital: There were 41 complaints

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

### Is the service well-led?

#### Leadership

We saw examples of strong local ward and department leadership. The trust had managers with the right skills and abilities to run a service providing high-quality sustainable care.

Staff told us they felt well supported, valued and that that their opinions counted. At a local level, we saw that nurses in charge were clearly identified by the use of armbands, which helped ensure local leaders were visible to staff and visitors.

All ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their team faced in delivering good care.
Staff generally spoke in positive terms about the visibility of the senior management team. They told us that the chief executive and chief nurse visited front line services on a weekly basis. They said they felt free to raise any issues with them direct or through their line manager.

**Vision and Strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. We saw poster displays and other publications about the vision and values as we visited the wards. These were readily available for staff, patients and the public to view. In addition to information published for staff on the trust intranet, the trust published information about its mission, values and vision on its public website.

The trust’s started purpose was to provide safe, compassionate and sustainable health services and its vision to provide the highest, consistent, quality care to patients, whether in or outside hospital setting.

We saw values statements based on the word “PRIDE”, which meant “Patient First, Respect, Innovation, Delivery and Excellence”. Staff we spoke to were able to describe these statements and give examples that described an improving safety culture, better clinical leadership and governance.

**Culture**

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke to confirmed this and described in positive terms how they felt appreciated, supported and enjoyed their work.

Staff spoke in positive terms about the team working with medical and specialist support to provide care.

Staff said they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an ‘open culture’ in which staff could raise concerns without fear.

**Governance**

The trust operated a divisional governance model and ‘Triumvirate working’. This was a structure, which ensured that both clinicians and managers were involved in the management and planning of hospital activities at every level. The Triumvirate model usually consisted of a lead clinician, a senior nurse and a manager. Each of the triumvirate leadership teams had responsibility for designated wards and departments.

We reviewed the minutes of meetings, which demonstrated that regular team and management meetings took place. The minutes documented how information on incidents and complaints were investigated and any learning shared and good practice promoted

**Management of risk, issues and performance**

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

We found there were divisional risk registers in place. Managers we spoke with were aware of the risk registers and knew the main risks and the actions needed to reduce the risks.

**Information Management**

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The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust’s website provided safety and quality performance reports and links to other websites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage services, and collaborated with partner organisations effectively. Senior clinicians described how the trust was a member of the Kent & Medway NHS Emergency Planning Group and the South East London, Kent & Medway Trauma Network Emergency Planning Reference Group.

Managers told us that the trust was also a member of the Kent Resilience Forum, which brings together emergency services and other responders such as the NHS, utilities and the voluntary sector.

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys, complaints and the ‘How Are We Doing?’ initiative.

Stroke services organised ward based patient groups run in conjunction with charitable organisations. Patients and their families were given access to support groups and information resources to help them understand and adjust to stroke and traumatic brain injuries.

The “hello my name is …” initiative was widely practiced by staff and during our visit and we heard examples of staff using this when talking with patients. The initiative is aimed at raising awareness for staff to always introduce themselves to patients. Patients confirmed that staff always introduced themselves before any treatment or therapy.

The management team told us that any good ideas put forward by staff were discussed at weekly ward meetings and monthly team meetings. Useful suggestions and good ideas were then passed on to the clinical and quality boards. All the staff we spoke with felt informed and involved with the day-to-day running of the service and its strategic direction.

**Learning, continuous improvement and innovation**

The department was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
Facts and data about this service

The trust provides a range of general and specialised surgery including planned and emergency procedures. This included a range of specialities including breast, gynaecological, oncology, ophthalmology, urology, gastro-intestinal, orthopaedics, pain management, vascular (day case only) and ear, nose and throat. The site has specialist cancer and complex surgery units.

The trust has 20 main operating theatres across the two sites and each site has a day surgery unit. The trust has 12 surgical wards, which have 253 inpatient beds. Two of these areas are Short stay surgical assessment units totalling 40 beds and eye day care unit with 26 day case chairs.

(Source: Routine Provider Information Return – “Sites-Acute” tab)

The trust had 34,951 surgical admissions between April 2016 and March 2017. Emergency admissions accounted for 8,651 (24.8%), 21,494 (61.5%) were day case, and the remaining 4,806 (13.8%) were elective.

(Source: CQC Insight)

Is the service safe?

Safeguarding

Both permanent and agency staff we spoke to at both sites were able to describe when they should refer a matter for safeguarding and who they would report to. Staff described safeguarding referrals they had made in the past.

Safeguarding training completion rates

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

A breakdown of compliance for safeguarding courses between 01/04/2017 and 30/06/2017 for medical/dental and nursing/midwifery staff in Surgery is shown below:
Medical and Dental staff achieved the target of 85% for all safeguarding courses, except safeguarding children level 3, where compliance was 71%.

Nursing and Midwifery staff achieved the target of 85% for all safeguarding courses.

(Source: Trust Provider Information Request P18)

**Mandatory training**

The service provided mandatory training in key skills to staff and met its overall training target. However, it did not make sure target levels of staff completed individual training modules.

The trust set a target of 85% for completion of mandatory training across 18 courses and a completion of information governance at 95%.

A breakdown of compliance for mandatory courses between April 2017 and June 2017 for medical/dental and nursing/midwifery staff in surgical care is shown below:
Medical and Dental staff did not achieve the target of 85% for four mandatory training courses, the lowest completion modules were Dementia Awareness (including Privacy & Dignity standards) with 50% followed by Medicine management training with 60% completion.

However, senior staff explained the Dementia Awareness training rate was low because they were currently rolling out a new training program and the trust had measured training rates under the new program.
Nursing and Midwifery staff did not achieve the target of 85% for all training courses, the lowest courses were Dementia Awareness (including Privacy & Dignity standards), where compliance was 53% and Conflict resolution with 60% compliance.

Maidstone Hospital had an 86% mandatory training completion rate, there were six modules where this location did not achieve the target, the lowest Dementia Awareness (including Privacy & Dignity standards) with 53% completion rate followed by Safeguarding children level 3 with 67% completion rate.

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

However, as noted above, senior staff explained the Dementia Awareness training rate was low because they were currently rolling out a new training program and the trust had measured training rates under the new program.

There was a policy for sepsis management last updated in 2016. At the time of inspection, 95.5% of the general surgeries directorate and 95.5% of theatres staff had completed their sepsis training. This meant the directorate exceeded the trust target of 85% for completion of mandatory training. Staff we spoke to reflected and understanding of sepsis screening tools and care bundles and showed us the plastic sepsis information cards they carried with them.

We saw that mandatory training included training modules about dementia awareness. However, only 53% of staff in the directorate had completed the training. This could mean staff did not have the knowledge and understanding to treat patients living with dementia in line with agreed guidance. However, senior staff explained the Dementia Awareness training rate was low because they were currently rolling out a new training program this training rate did not reflect the number of staff who had received dementia basic awareness training as part of mandatory training.

All staff in the directorate, 100% had completed Mental Capacity Act training. This meant the staff would have an understanding of mental health conditions and their responsibilities for patients living with these conditions in line with agreed guidance.

We saw that staff were not required to have mandatory training specific to patients living with learning disabilities or autism.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We saw there were policies and processes in place to keep the hospital environment clean. We saw there were Standard Operating Procedures for cleaning clinical, non-clinical and specialist areas.

We saw monthly, weekly and quarterly cleaning audit results reflected all surgical departments and wards met the trust target of 90% or higher with the exception of one audit where a ward received 89.04% on a monthly audit. Two weeks later the area was re-audited and the result was above 90%. This meant both hospitals met the trusts cleanliness standards.

All of the surgical theatres and wards we observed appeared clean.

A patient at Maidstone noted their room was cleaned every day and that the cleaning was thorough including the rail and under their bed.

We saw the hospital had a Hand Hygiene Policy and Procedure that was in date. The hospital audited hand hygiene monthly. We saw results of monthly hand hygiene audits from April through
September 2017 across six wards and theatres. Departments scored 100% in all audits with the exception of one 91% result in one April audit. This meant hand hygiene audits across the theatre departments and wards at both hospitals showed good hand hygiene.

We saw that there were gloves and aprons available to staff throughout the surgical departments, wards and theatres. We saw staff members put on gloves before entering patient rooms on the wards which helped prevent the spread of infection. One patient noted staff put on gloves and aprons each time they came to provide care or treatment.

We saw that surgical trays were kept in the theatres preparations rooms. Staff told us that the equipment was decontaminated off site and they were not aware of any problems with the service. This ensured equipment would be clean and current.

The hospital has a system for managing the risk of Legionella (Legionnaires disease), a lung infection caused by Legionella bacteria. Legionella bacteria is spread when water supplies become contaminated with the bacteria which is more likely in larger, more complex water systems such as those found in hospitals. We spoke with one staff member who explained that hospital managed Legionella risk by flushing taps daily, submitting temperature readings weekly and testing the water for Legionella bacteria quarterly.

We reviewed the most recent Legionella quarterly tests. The September 2017 Maidstone tests showed Legionella bacteria were detected in one sink. As result infection control was informed, the sink was put out of use, remedial works were carried out and the sink was retested. We were told the hospital was waiting for results of the most recent test during the inspection period. This meant Legionella was present but the hospital was able to manage the risk to patients.

The trust provided data reflecting there had been 1 Clostridium difficile case at Maidstone in the 12 months between April 2016 and March 2017. Clostridium difficile is a type of bacteria that can infect the bowel and cause diarrhoea.

The trust provided data reflecting there had been no Meticillin-Resistant Staphylococcus aureus cases across the trust in the 12 months between April 2016 and March 2017. Meticillin-Resistant Staphylococcus aureus is a type of bacterial infection, which is resistant to many antibiotics and is capable of causing harm to patients.

The trust provided data reflecting there had been no Meticillin-sensitive Staphylococcus aureus cases in surgery departments across the trust in the 12 months between April 2016 and March 2017. Meticillin-sensitive Staphylococcus aureus is a type of bacteria in the same family as Meticillin-Resistant Staphylococcus aureus, but is more easily treated.

The trust provided data reflecting there had been two Escherichia coli cases at Maidstone in the 12 months between April 2016 and March 2017. Escherichia coli is a type of bacteria that can cause diarrhoea, urinary tract infections, respiratory illness, and other illnesses.

The trust provided data reflecting there had been no carbapenemase-resistant Enterobacteriaceae cases across the trust in the 12 months between April 2016 and March 2017. Carbapenemase-resistant Enterobacteriaceae is an antibiotic resistant bacterium capable of causing harm to patients. Notably, patients thought to be at risk of carbapenemase-resistant Enterobacteriaceae were managed as if they were infected unless tests proved otherwise.

We spoke to staff who worked in the pre-operative departments of both hospitals (while there was staff dedicated to each hospital the manager managed the pre-operative departments at both hospitals and staff could occasionally provide cover at either hospital). We saw that surgical patients tested for Meticillin-Resistant Staphylococcus aureus. If there was a positive test, elective
and non-emergency patients were treated for Meticillin-Resistant Staphylococcus aureus and required to have three clear tests before surgery.

Staff explained that any patients who had possible exposure to carbapenemase-resistant Enterobacteriaceae in the past 12 months would be screened. We saw this was in line with the hospitals Control and management of Carbapenemase-resistant Enterobacteriaceae and Carbapenemase-resistant Enterobacteriaceae Policy, which was in date.

If an urgent or emergency patient had a positive or unknown Meticillin-Resistant Staphylococcus aureus result or had been exposed to carbapenemase-resistant Enterobacteriaceae in the past 12 months, they would be treated as a patient with an infections disease. This would mean liaising with the consultant and infection control team; urgent testing, arranging for surgery in the last timeslot of the day and being treated in a private room.

However, we spoke with a staff member who told us the previous week two or three patients with infectious diseases required surgery in the same theatre on the same day. There was no clear process for the situation so it was escalated to the infection control team for advice, which was followed. Staff told us this was not recorded as an incident at the time. This meant there was no record in the department about how the multiple infections patients were managed.

On one ward we saw three patients with infectious diseases or suspected infectious diseases were cared for in private rooms. We saw that outside each room there were gloves in three sizes and yellow aprons or full body aprons for suspected carbapenemase-resistant Enterobacteriaceae for infection control.

All staff or visitors we observed entering the rooms donned the gloves and aprons before entering. They were expected to remove the gloves and aprons before leaving the rooms. Staff we spoke to about infection control including nurses and a porter were able to describe this process and why it was important.

We saw four staff members enter one room for a patient at risk of having Meticillin-Resistant Staphylococcus aureus. We saw that all four staff members donned gloves and aprons and removed them before leaving the room. However, one staff member left on their protective gear when they stepped into the hall for a new glove. This meant the infection could have been transferred from the protective gear into the hallway when the staff member stepped out, thus exposing other patients, visitors and staff.

We saw that the hospital has an endoscope reprocessing unit, where flexible endoscopes were reprocessed (decontaminated), separate from the unit where endoscopies were performed. The reprocessing unit was secured by a locked door. We saw that equipment followed a dirty to clean pathway, including separate rooms for clean and dirty scopes with separate entrances. This was in line with the Department of Health, Health Technical Memorandum 01-06: Decontamination of flexible endoscopes.

**Environment and equipment**

The service had suitable premises and equipment and looked after them well.

We looked at 73 supplies and pieces of equipment on the Maidstone Hospital theatres trolley, such as needles, syringes and airways, and saw they were sealed and in date.
We observed staff using sharps in a safe way. We saw staff using safe practice to put blades onto handles and saw staff in theatres department used a magnetic blade box. This meant staff minimised risks in their use and disposal of sharps.

We saw emergency equipment in the theatres including emergency eye wash equipment. There were adult and paediatric resuscitation and difficult airway trolleys available for theatres.

We saw that resuscitation trolleys on the wards and in theatres were unlocked and were not sealed with tamper evident seals. Trolleys need to be kept in a manner so they are both accessible and secure. In theatres they were kept in the department where only staff could access them but the trolleys on the wards were in a public space. This meant that staff or members of the public could remove or tamper with supplies from the trolleys and staff would not know the trolleys had been accessed.

Since the inspection the trust reported it has taken remedial action to ensure a tagging system is in place to provide tamper-evidence and secure the intravenous fluids contained within these trolleys at the trust. The hospital reported that for those trolleys that are not compatible with tamper tags, additional tamper evident containers have been placed. The daily checklist has been amended to include the tamper tag check. This means that it will now be evident if anyone has tampered with trolleys or their contents and staff can take action.

**Design, maintenance and use of facilities**

We saw in the theatre departments, doors to secure areas were locked and required passes or codes to enter. This meant unauthorised people could not enter the areas which could pose a risk to patients, staff, equipment and supplies.

Some theatres, for instance where orthopaedic surgery was performed, had lamina flow ventilation. This is a ventilation system which blows clean air constantly over the area where the surgery is performed to ensure a sterile environment.

We saw there was a preparation room, where equipment was prepared before surgery. This area did not have a lamina flow system but used a filtrated air system to ensure equipment remained uncontaminated.

We saw that the theatres department at Maidstone hospital was small for the amount of work performed. For instance, we saw that supplies had to be kept in the hallway rather than a storage cupboard. Staff told us they had reduced stock levels in the department to ensure stock was kept on shelves, not the floor. Staff told us they felt they still had enough stock and they felt the area was very small but this would be addressed in the future. This did not appear on the department risk register.

We saw there were holes in the hall walls and anaesthetic room doors of the theatre department. Staff told us it was common to see holes in the walls, they told us if holes were in the theatres walls, they referred them to the facilities department urgently and usually received a quick response. However, they told us the holes in the hallway walls had been there for a significant period of time, although they could not say exactly how long. Holes in walls and doors could be difficult or impossible to clean thus creating an infection control risk.

We saw on the Peale Ward patients could bathe in bathrooms located on the ward. However, we saw the showers could overflow. While we were on the unit we observed a shower overflowing during a patient’s shower. Four clinical ward staff members worked to clean the flood water which went into the hall and patient rooms. About 20 minutes after the flood was discovered, staff with a hoover attended to Hoover the wet floor. Staff told us that this was a known risk of using the
shower and flooding had occurred previously. Although staff addressed the overflow quickly, it could create a risk of slips and falls as well as the spread of infection.

**Maintenance and use of equipment**

We reviewed 11 pieces of equipment in theatres and noted all equipment was labelled with stickers reflecting that they had been services in the past year.

We saw that sinks in the wards were compliant with regulations to ensure that they minimised the spread of infection.

**Managing waste and clinical specimens**

We saw that in theatres at both hospitals waste was segregated and classified to keep people safe. We saw domestic waste was disposed of in bins with black bags and infectious waste in bins with orange bags. All bins we reviewed in theatres were empty. This meant the department was compliant with regulations requiring them to segregate waste and manage waste to minimise risk to staff and service users.

**Assessing and responding to patient risk**

We spoke to pre-operative nurses who explained how they worked with patients, anaesthetists, consultants and specialists to identify and address risks prior to surgery. These risks could include comorbidities such as diabetes, sleep apnoea, other diagnoses, weight, previous problems with anaesthesia and other issues.

If a patient was identified as high risk by the nurses based on responses to health questions or observations, the patient could be referred to the high risk clinic. At this clinic they would meet with the anaesthetist to address the risks.

We saw there was sepsis information available to staff which was posted in the breakroom and department. Staff we spoke to were able to demonstrate an understanding of sepsis signs and treatment. They showed us the sepsis information cards they carried as reminder about sepsis.

The World Health Organization Safer Surgery Checklist is a checklist to ensure all members of the theatres team take necessary steps to avoid incidents and injury associated with surgery.

We observed staff preforming the World Health Organization Checklist in theatres during our inspection. We saw they applied the checklist correctly. This meant, on the day of inspection, there were processes and systems in place to protect surgery patients from accidents or injury.

We saw the hospital audited compliance with application of the World Health Organization Safer Surgery Checklist in 3%-19% of cases, depending on the theatre. Audits across all theatres, excluding endoscopy, from April through October 2017 showed staff complied with the World Health Organization Safer Surgery Checklist in 99%-100% of audits. This showed theatres staff were completing the World Health Organization Safer Surgery Checklist and the trust performed better than its target of 90% compliance for all audits.

We saw the trust audited the endoscopy theatres World Health Organization safer surgery checklist compliance separately. These audits from April through October 2017 across both sites reflected compliance of more than 90% for all audits. This showed endoscopy staff were completing the World Health Organization safer surgery checklist and the trust performed better than its target of 90% compliance for all audits.
Staff told us the World Health Organization checklist used in the endoscopy theatres was
developed collaboratively and approved by a lead consultant to be signed by the lead endoscopist.

The trust used the Patient at Risk Score System track and trigger flowchart. The flowchart is
scoring system in which a score is allocated to physiological measurements (temperature, oxygen,
blood pressure, pulse, etc) to assess risk. The Patient at Risk Score System track and trigger
flowchart allowed staff to identify patients who were becoming unwell, before they became critical
and provide them with increased support.

**Nursing staffing**

Staff we spoke to in different departments reported differing levels of agency and bank staff usage.

Staff in the pre-operative department told us they used no agency staff and one regular member of
bank staff.

Staff we spoke to in the theatres departments told us vacant shifts were often filled by staff
performing overtime hours. This process was managed by band 7 members of staff.

Staff on the Maidstone Hospital Surgical Short Stay Unit told us they used agency staff
sometimes. The staff worked with permanent staff members and received an induction including
policies, access codes and contact information.

The trust has reported their staffing numbers below for the period April and June 2017. There is
a total of 158.09 WTE less staff in surgery across all staffing groups.

Qualified nursing & health visiting staff (Qualified nurses) had less than 74.59 WTE staff then
the trust planned for to provide safe care within surgery.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>400.07</td>
<td>325.48</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>400.07</strong></td>
<td><strong>325.48</strong></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 11.6% in surgical care at
Maidstone Hospital.

The trust has a target vacancy rate of 8.5% the overall vacancy rate for surgery was worse than
this trust target.

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

**Turnover rates**

Between July 2016 and June 2017, the trust reported a turnover rate of 1% in surgical care at
Maidstone Hospital.

The trust target for turnover was 10.5%; the turnover rate for surgery was better than the target.

*(Source: Routine Provider Information Request P18 Turnover)*
Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 3.4% in surgical care at Maidstone Hospital.

The trust’s target sickness absence rate is 3.3% or lower, Maidstone is slightly above this and both sites are better than the trust average which was 3.7%.
(Source: Routine Provider Information Request P19 Sickness)

Bank and agency staff usage

Between July 2016 and June 2017, the trust reported a bank and agency usage rate of 91% in surgical care;

- Maidstone Hospital: Total of 1,919 shifts of which 77% covered by bank staff and 19% covered by agency, a total of 107 shifts were not covered.

For surgical care 51% of 12,349 shifts were covered by bank staff for the time period, 40% covered by agency and a total of 1,053 shifts was not covered, accounting for an average 87 shifts a month.

The trust told us in their provider information request they had the highest bank or agency use on the following surgical wards, the short stay surgical unit and ward 31 which are at the Tunbridge Wells site, the reasons attributed to these were vacancies at both.
(Source: Routine Provider Information Request P20 Nursing – Bank and Agency)

The hospital reported that 107 shifts were not filled by any staff. We saw the hospital managed uncovered shifts by keeping record of: average fill rate of shifts; associated nurse sensitive indicators such as FFT scores, falls and pressure ulcers; comments about whether the risk level was expectable or rational for under filling; and fiscal indicators. The spreadsheets we provided were from summer 2017. However, their commentary indicated that some shifts were unfilled due to vacancies or staff absence rather than a risk analysis. This is a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18(1) which states sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

Medical staffing

The trust reported their staffing numbers for medical and dental staff with less than 18.95 WTE staff then the trust planned for to provide safe care within surgery.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>268.00</td>
<td>249.05</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>268.00</strong></td>
<td><strong>249.05</strong></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 32.4% in surgical care at Maidstone Hospital.
The trust has a target vacancy rate of 8.5%; Maidstone Hospital has a vacancy rate of 32.4%. (Source: Routine Provider Information Request P17 Vacancies)

However, the trust risk register reflected there was a lack of consultant anaesthetists at the hospital following changes to the rota to meet relevant guidelines. This was rated as a moderate risk level. Risks could include increased complexity in covering all aspects of the rota, reduced ability to cover additional activity, sickness and leave, increased locum use and increased costs. The risk register also identified a shortage of endoscopy clinicians that could impact the trust’s ability to meet endoscopy targets including for cancer and diagnostic pathways.

**Turnover rates**

Between July 2016 and June 2017, the trust reported a turnover rate of 1.0% in Surgical care at Maidstone Hospital.

The trust target for turnover was 10.5% which surgery was better against. (Source: Routine Provider Information Request P18 Turnover)

**Sickness rates**

Between July 2016 and June 2017, the trust reported a sickness rate of 0.5% in Surgical care; The trust’s target sickness absence rate is 3.3% or lower, the hospital was better than the target and the trust average which was 3.7%. (Source: Routine Provider Information Request P19 Sickness)

**Bank and locum staff usage**

Between July 2016 and June 2017, the trust reported a locum and agency usage rate of 99% in Surgical care;
- Maidstone Hospital: Total of 1,918 shifts of which 39% covered by locum staff and 61% covered by agency, a total of 22 shifts were not covered.

For surgical care at the trust 30% of 6,976 shifts were covered by locum staff for the time period, 69% covered by agency and a total of 70 shifts was not covered, accounting for an average six shifts a month. (Source: Routine Provider Information Request P2P Medical Locums)

**Staffing skill mix**

Between 01 June 2017 and 30 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 year 1-2) staff was higher.
Staffing skill mix for the whole time equivalent staff working at Maidstone and Tunbridge Wells NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>16%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Surgery was consultant led and there was a consultant for general surgery on call at all times. There were consultant led ward rounds twice a day. There was a consultant of the week who was on call for acute patients seven days a week and was to see all high risk patients within an hour.

Records
Staff kept clear and up-to-date records which documented care and were available to all staff providing care.

We reviewed ten sets of surgical patient records on the Peale Ward at Maidstone Hospital. We saw all records were thorough and included all expected documentation of pre-operative and operative information including diagnoses, care, risks and observations. All records were signed with the grade of staff and dated.

We saw the hospital audited 50 anaesthetic charts in January 2017. The audit showed that staff were not meeting the standards for record keeping set by the trust for any element of the audits. To meet the standards, at least 100% of records needed to be compliant; to partially meet the standards, 80% compliance was necessary. Compliance was partially met or not met within the audited sections as follows: Patient Information (83%), Pre-op Assessment (71%), Airway (89%), Intra Op (78%), Post Op (82%) and certain diagnostic tests for high risk patients (59%). This showed the records did not meet the trusts standards in any area.

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

The trust had current medicines management policies, together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Prescribers also had access to relevant resources on medicines management such as electronic and papers of the current British National Formulary.

Throughout the wards and theatres we observed medicines were stored securely and kept within their expiry dates.
We saw throughout the wards and theatres controlled drugs were stored, recorded and handled in line with policy. Spot checks on balances showed that contents of the cupboard matched the register.

We saw reminders for staff on critical medicines (medicines which should not be omitted) and lookalike/sound alike medicines to promote safe administration.

We saw throughout the wards and theatres medicines waste was handled in line with policy.

We found the intubation trolley in the theatres at Maidstone Hospital was tamper evident.

We saw at Maidstone Hospital the temperature of the medicines fridge was monitored regularly and within range.

However, the resuscitation trollies throughout the wards and theatres were not tamper evident. As described above, since the inspection the trust reported it has taken remedial action to ensure a tagging system is in place to provide tamper-evidence and secure the intravenous fluids contained within these trolleys at the trust.

Opening dates were not always on liquid medicines to ensure they were used within the correct expiry date. This meant they might be used when they were no longer as effective as expected.

Incidents

**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 to have happened for an incident to be a never event.

There were no never events at Maidstone hospital during the 12 month reporting period.

The service managed patient safety incidents well in some instances. Staff recognised incidents and reported them in line with policy. Managers investigated incidents but lessons were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and support.

Staff told us there was an incident reporting culture; they were encouraged to report incidents and there was a no ‘blame culture’ associated with reporting incidents. Staff were able to tell us the kinds of incidents that should be reported and give examples of when they had reported incidents.

Staff told us when they reported an incident on the reporting system; they could tick a box to request feedback. They told us when they ticked the box, they usually received the feedback.

The duty of candour, Regulation 20 of the Health and Social Care Act 2008, relates to openness and transparency. This duty requires services of health and social care services to notify patients (or other relevant person) of ‘certain notifiable safety incidents’ and provide reasonable support to that person. We saw that Duty of Candour Letters were sent when there had been a never event.

Staff told us sometimes lessons were shared by e-mail. We saw signs in staff areas sharing learning from incidents.

In the Maidstone pre-operative department we saw there was a ‘lesson of the week’ posted on the wall which shared information about an incident.

In the theatres department we saw staff looked at how other trusts rotated stock in response to an incident. Based on this they started to use an Omnicell machine (a secure medicines vending
machine) to store, rotate and order new stock.

We saw when root cause analyses were completed; the lessons were shared with those involved. In one case we saw a supervision and support plan for a staff member. In another case a policy was changed.

However, we saw that sharing was not always identified or shared and learning was not systematically identified, disseminated or audited.

We saw in the theatres department that incidents were recorded in a notebook. This created some confusion about when incidents had taken place, where and if they were logged and how lessons were shared.

Further, we saw that learning might be shared at a meeting, on a notice board or in notes. However, there was no set way to share all learning from incidents and there was no system to ensure that staff had seen the information or identify which staff might still need to be informed. This meant senior staff might not know who had been informed of learning or changes and staff might not know if they had missed information.

Lessons from incidents were not always complete or embedded. For instance, we saw signs in the theatre department about not using certain equipment; however the sign did not provide information about what equipment to use instead or further resources. When we asked staff they told us this information had not been provided. Staff told us they would receive e-mails about changes to practice but no further information or training. This meant staff might receive information about learning from incidents but not know how to apply or embed it.

Staff told us they were not regularly informed about investigation process or outcomes. We saw that incidents were on the agenda of the hospitals’ Theatre Monthly Team Meeting Minutes, but were not always discussed. This meant staff were not receiving regular information to keep them up to date.

Breakdown of serious incidents reported to Strategic Executive Information System

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents in Surgery which met the reporting criteria set by NHS England between 01 August 2016 and 31 July 2017.

The incident types broke down as follows:

- Surgical/invasive procedure incident meeting serious incidents criteria with three (30% of total incidents).
- Slips/trips/falls meeting serious incidents criteria with three (30% of total incidents).
- Treatment delay meeting serious incidents criteria with one (10% of total incidents).
- All other categories with one (10% of total incidents).
- Sub-optimal care of the deteriorating patient meeting serious incidents criteria with one (10% of total incidents).
- HCAI/Infection control incident meeting serious incidents criteria with one (10% 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.

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 seven new pressure ulcers, 16 falls with harm and 12 new catheter urinary tract infections between 01 August 2016 and 31 August 2017 for Surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Maidstone and Tunbridge Wells NHS Trust

<table>
<thead>
<tr>
<th>Total Pressure ulcers (7)</th>
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</thead>
<tbody>
<tr>
<td>0.5</td>
</tr>
<tr>
<td>0.4</td>
</tr>
<tr>
<td>0.3</td>
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<tr>
<td>0.2</td>
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<td>0.1</td>
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</table>

<table>
<thead>
<tr>
<th>Total Falls (16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
</tr>
<tr>
<td>1.0</td>
</tr>
<tr>
<td>0.5</td>
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<td>0.0</td>
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</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

We saw policies, guidelines and Standard Operating Procedures were evidence based, comprehensive and in date. These were available in paper format and online.

The hospital stored all policies and guidelines on an electronic system. Staff were able to demonstrate how they could access the policies and guidelines on the electronic system.

In the pre-operative department we saw a poster describing how treating anaemia prior surgery helped to reduce patient length of stay in elective surgery. Staff in the department told us they understood the poster and how they could affect patient length of stay.

We saw there were posters in the pre-operative department and the theatre break rooms providing treatment information sitting National Institute for Health and Care Excellence and other guidelines.

We saw the pre-operative department had received commendations for their implementation of changes to blood transfusion guidance.

Pre-operative department staff described how they used the surgery cancellation report to identify any risks or areas for improvement.

Medical records we reviewed documented eight out of ten surgical patients received Venous Thromboembolism assessment. Venous Thromboembolism is a condition where blood clots form in a vein which could cause injury, stroke or death. Patients at risk of Venous Thromboembolism received care in line with National Institute for Health and Care Excellence guidance.

In two records, patients with risk of Venous Thromboembolism did not have their Venous Thromboembolism assessment information completed in line with best practice. However both patients received antibiotics and prescribed stockings before surgery to protect them from getting Venous Thromboembolism. This meant guidance was being followed, although the rationale was not always recorded.

We saw standardised care pathways were based on current best practice and National Institute for Health and Care Excellence guidance.

The minutes from various departmental and directorate-wide meetings showed that where audit results had been documented these were discussed and plans developed to address any issues.

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 preferences.
Patients and staff told us patients were able to choose their food from various options and the kitchens catered for any special dietary requirements.

Patients reported receiving food shortly after returning to recovery, being offered hot drinks throughout the day and having a jug of water available. Some patients noted that hot meals were served for lunch rather than dinner, which they found odd.

One patient noted that food was ‘hit or miss’, but when they were constipated, more fruit was added to their plate. This is important because fruit contains dietary fibre which may help relieve constipation.

**Pain relief**

We saw that pain during surgical procedures was managed by the anaesthetist who met with patients before surgery to understand their surgery, history and individual needs as part of the pre-operative process. Anaesthetists used their knowledge and expertise to manage patients’ pain during the surgical process. The anaesthetists and consultants were available to discuss pain management after patients were on the ward and staff told us they were accessible.

Staff told us in some cases the doctor would provide a verbal order for the medication over the phone so that the patient would not need to wait. In this case the doctor would come to sign the order later in the day.

Patients on all wards were asked to use a scale of one to ten to classify their level of pain and we observed staff on the ward asking patients for their pain score and offering patients medication.

Patients at Maidstone reported that they had no pain or their pain was well controlled. One patient at Maidstone reported meeting with staff from the pain management team to discuss how best to manage their pain.

We reviewed 10 sets of notes across two wards, all these records reflected proactive pain observations and pain management. One set of records showed a patient had a pain score of four out of ten. The patient was treated and observed every 20 minutes until the pain score reduced to two out of ten.

However, the trust’s Guideline for the assessment of pain in adults and pain assessment tool did not provide clear guidance about when or how often pain should be reviewed and recorded after the initial assessment. This meant if a nurse was unsure about when to take pain observations, there was no clear guideline to which they could refer.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

Between 01 May 2016 and 30 April 2017:

All patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

Ear nose and throat patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
admissions when compared to the England average.

Urology patients at the trust had a similar expected risk of readmission for elective admissions when compared to the England average.

All patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

General Surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & Orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

ENT patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing elective admissions for different specialties](image)

**Non-Elective Admissions – Trust Level**

![Graph showing non-elective admissions for different specialties](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 represents the opposite. Top three specialties for specific trust based on count of activity.*

(Source: HES - Readmissions (01/05/2016 - 30/04/2017))

**The Maidstone Hospital**

Between 01 May 2016 and 30 April 2017:

All patients at Maidstone had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients Maidstone had a lower expected risk of readmission for elective admissions when compared to the England average.

Urology patients at Maidstone Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.

Ophthalmology patients at Maidstone had a lower expected risk of readmission for elective admissions when compared to the England average.
admissions when compared to the England average.

All patients at Maidstone had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at Maidstone had a lower expected risk of readmission for non-elective admissions when compared to the England average.

General Surgery patients at Maidstone had a similar expected risk of readmission for non-elective admissions when compared to the England average.

Ophthalmology patients at Maidstone had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions - The Maidstone Hospital**

**Hip Fracture Audit**

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.3% which was within the expected range. The 2015 figure was 8.3%.

The proportion of patients having surgery on the day of or day after admission was 76.3%, which was worse than the national standard of 85%. The 2015 figure was 80.5%.

The perioperative medical assessment rate was 98%, which failed to meet the national standard of 100%. The 2015 figure was 94.6%

The proportion of patients not developing pressure ulcers was 98.8% which falls in the top 25% of trusts. The 2015 figure was 95.7%.

The length of stay was 23.1 days, which falls in the middle 50% of trusts. The 2015 figure was 23.2 days.

(Source: National Hip Fracture Database 2016)

**Bowel Cancer Audit**

In the 2015 Bowel Cancer Audit, 80.3% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2014 figure was 75.9%.
The risk-adjusted 90-day post-operative mortality rate was 4.3% which was within the expected range. The 2014 figure was 1.6%.

The risk-adjusted 2-year post-operative mortality rate was 11.4% which was a positive outlier. The 2014 figure was 23.6%.

The risk-adjusted 30-day unplanned readmission rate was 9.6% which was within the expected range. The 2014 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 41.8% which was within the expected range. The 2014 figure was 39.6%.

(Source: National Bowel Cancer Audit)

**National Vascular Registry**

Data is not available for this metric.

(Source: National Vascular Registry)

**Oesophage-Gastric Cancer National Audit**

In the 2016 Oesopha-Gastric Cancer National Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 2.6%. This placed the trust within top 25% of all trusts for this measure.

The trust was not eligible for the 90-day post-operative mortality metric.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 37.6% this 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**

In the 2016 National Emergency Laparotomy Audit, Maidstone Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on one case.

The Maidstone Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on one case.

The Maidstone Hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on one case.

The Maidstone Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on one case.

The risk-adjusted 30-day mortality for the Maidstone Hospital was a negative outlier, based on two cases.

(Source: National Emergency Laparotomy Audit)

**Patient Reported Outcome Measures**

In the Patient Reported Outcome Measures 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 performance on groin hernias was worse than the England average. Groin Hernia – EQ-5D index showed slightly better performance than the England average.

No trust data was available for Varicose Veins.

For hip replacements, performance was slightly better than the England average.

For Knee replacements performance was about the same as the England average.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff in the theatres departments described orientation and training programs for new and existing staff. Staff told us new members of staff received an induction where they were able to rotate between different theatres for seven months and the department had a monthly training day which included medical devices training. Theatre Support Workers had Band 5 buddies for support. Staff told us both parties benefited from this system.

Staff told us they were working to increase the competency of staff by training four Band 4 theatres staff members to become associate practitioners. Associate practitioners are trained in one to two particular areas of clinical practice to provide certain types of care under the direction of a nurse. This upskilling could provide the theatres team with more skill and flexibility through internal training. Maidstone’s September team notes reflected that information about and benefits of this program were shared with the staff.
We saw training was different in different departments, although all staff we asked said they received training to meet their needs. In the preoperative department staff told us they had a yearly pre-operative study day where they had speakers updating them on topics such as National Institute for Health and Care Excellence guidelines, anti-coagulation, sleep apnoea and hypertension.

Staff described using a simulation machine located at Tunbridge Wells Hospital to support learning for theatres staff. This meant staff had the opportunity to practice scenarios in a realistic setting with no risk to patients; staff could review the scenario on video afterwards to gain further learning from the practice.

Revalidation is a Nursing and Midwifery Council process for nurses to revalidate their licences every three years. Nurses require support from managers or senior colleagues to complete the revalidation process. Staff we asked about revalidation told us that either they received support from managers and mentors or they had not gone through revalidation yet, but saw their colleagues had received support.

We saw information about revalidation posted for staff in staff break rooms. This meant staff had access to the information they needed to take steps toward their revalidation.

**Appraisal rates**

Between April 2017 and June 2017, 78% of staff within Surgery at the trust had received an appraisal compared to a trust target of 90%.

A split by staff group can be seen in the graph below:

![Appraisal completion graph](image)

Maidstone Hospital had an 81% appraisal completion rate this was below the trust target of 90% as well as the trust wide average of 88%.

*(Source: Routine Provider Information Request P43 Appraisals)*

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
Staff reported they knew how to contact members of other teams. Patients noted the good communication between staff, wards, consultants and the different departments.

Staff told us when they take a patient hand over they would get a brief overview of the handover information by telephone before the patient arrived and they would receive a full nurse to nurse handover in person when a nurse brought a patient to the ward.

Staff in the pre-operative department told us about how they worked with senior nurses, anaesthetists and consultants to ensure any concerns about patients were resolved before surgery.

Staff told us that pharmacist and pharmacy technician availability on the wards was generally good.

Staff told us that some multidisciplinary work was not as smooth as they would like. For instance the scheduling team did not always schedule preoperative appointments in a timely fashion. This could result in rushed tests, delays and surgery cancellations.

**Seven-day services**

Although there were inpatients at the hospital seven days a week, multidisciplinary services were not always available. The pharmacy team were available Monday through Friday during working hours, Saturdays 9:00 am until 4:00 pm and Sundays and bank holidays 10:00 am until 4:00 pm. Physiotherapists, occupational therapists, and dietary consultants were available Monday through Friday during working hours. This meant that patients who were staying in the hospital at the weekend did not have access to the same support as patients during the week.

Respiratory physiotherapists were on call for emergency services at all times.

Staff reported that emergency diagnostic services were available at all times. This meant emergency diagnostic support was available to in-patients at all times.

**Health Promotion**

The service monitored the effectiveness of care and treatment and used the findings to improve them.

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.

Staff told us they usually had access to information necessary to treat patients.

Pre-operative staff explained their process for using a tool to collect and evaluate incoming surgical patients’ information. Patients met with a pre-assessment nurse prior to surgery to discuss the surgery, health and risks. Patients received a copy of the questions they would discuss with the nurse prior to the appointment so that they could be prepared.

We saw that staff discussed lists prior to beginning surgery. Theatres staff told us they avoided handovers during surgery by ensuring that all staff present would be on the rota for the entire list. If a staff member could not be present for the entire list, they would be present in addition to the required number of staff members. However, we observed a situation where staff did need to
change in the middle of a list due to staff health. We were not able to observe the handover in this case.

Staff told us lists were not always accurate. We saw multiple incident reports showing theatres lists had errors. These showed the wrong procedure was listed or not all procedures were listed for each patient. This meant at the time of surgery the wrong procedure could be performed, the right equipment might not be available and not enough time might be planned for the surgery. As a result, patients could be injured and surgeries had been delayed or cancelled.

Senior staff told us that although this was a known issue, no solutions had been implemented and no one person was held accountable for each list. This meant the underlying issues had not been addressed and incidents were likely to continue.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that between April 2017 and June 2017 Mental Capacity Act training has been completed by 92% of staff within Surgery.

The trust did not provide deprivation of liberty training as a separate module, this was part of the safeguarding level two module, this was completed by 92% of staff within Surgery.

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

Pre-operative nurses told us they considered capacity in every case. If they had questions or concerns about capacity they escalated the issue to the pre-operative sister. When best interest meetings were needed, staff told us both the sister and the matron for safeguarding were involved in the process and decision.

Staff across departments described working with a family and staff at a best interests meeting to determine whether surgery was in the best interest of an adult patient with a learning disability. They worked together to determine that the patient did not need the planned surgery but left the door open for the family to return when and if the surgery became necessary.

Staff we spoke to demonstrated an understanding of the Mental Capacity Act, their roles under the Mental Capacity Act and the roles of doctors and social services with regard to the Mental Capacity Act and patient capacity assessments. We saw information about Mental Capacity Act, best interest decision and consent in staff break rooms.

We reviewed records for eight surgical patients. We saw they all included documentation of consent for every recorded patient contact.

Is the service caring?

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

**Friends and Family test performance**

The Friends and Family Test response rate for Surgery at Maidstone and Tunbridge Wells NHS Trust was 26% which was worse than the England average of 29% between 01 August 2016 and 31 July 2017. However, the Friends and Family response rate for Maidstone hospital was 38% which was better than the England average.

A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at Maidstone and Tunbridge Wells NHS Trust, by site.**

![Graph showing Friends and Family Test response rates](source: NHS England Friends and Family Test)

Patients told us that they were treated with dignity and respect. For instance patients told us staff always treated them with dignity and respect when speaking with them.

Some patients told us that when they were having a private discussion with nurses or doctors or receiving care, nurses always took care to close curtains and that they knocked on the doors of private rooms before entering.

Staff told us they weighed bariatric patients in private spaces to maintain privacy and dignity.

Other patients described getting up to shower or shave and nurses preparing clean night clothes or clothing for them.

Patients told us they had been visited by the consultant or anaesthetist and that these professionals made them feel important, ‘not like a number’, and safe.

One porter told us ensuring privacy and dignity was an important part of their job. They described maintaining patients’ dignity by making sure their bodies were covered and unexposed during transport. The porter said they left the room during patient handovers to ensure patients’ privacy.

However, we saw that dignity and privacy were not always respected. One patient told us there was no private area so when staff discussed confidential medical information, everyone could hear what was being said.
Emotional support

Staff provided emotional support to patients to minimise their distress.

Patients noted that staff were caring, genuine, friendly and kind. Patients also told us that staff made them feel safe and well looked after.

Staff in the pre-operative department told us they ensured that the same nurse saw repeat patients so the nurse had a relationship with the patient. The same nurse would meet and escort patients to theatre when the patient needed extra support.

However patients noted that staff were busy at all times. One patient told us, “you can’t expect too much - they have so many to care for”.

However, a young adult patient told us they were on a ward with patients who were much older. The patient told us they kept curtains open to feel less enclosed, but seeing older people unwell made them feel emotional and down.

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 told us they were involved in decisions about their own care and staff discussed care with them throughout their stay.

One staff member told us they checked understanding with patients and asked patients to feedback what they understood if the staff member believed they might need further clarification.

We observed staff treating a patient with a needle phobia. We saw staff explained each step clearly, were attentive and maintained eye contact. The patient was given time to ask questions and fully understand the procedure. This meant the patient had the information and support they needed to make decisions about their care.

However, one patient told us they did not know ‘what was happening’ with their care. They felt that the nurses changed often so no one knew what was happening with their case and they were not a priority.

Patients generally stated that they received good communications about care. One patient said ‘they have explained everything to me’. Although one family member told us that appointment letters were often incomplete.

Pre-operative staff described finding the best way to communicate with each individual patient. For instance, depending on the patient’s needs they might draw pictures or use a monitor to communicate information to patients.

However, a young adult patient told us, while staff provided them a lot of information, they did not always understand. They said nursing staff were good at asking if they understood and explaining when they didn’t, but medical staff did not do this.

Is the service responsive?

Service planning and delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.
People could usually access the service when they needed it. Lengths of stay were generally shorter than the national average.

**Average length of stay**

**Trust Level**

Between 01 June 2016 and 31 May 2017:

The average length of stay for all medical elective patients at the trust was 2.7 days, which is lower compared to the England average of 3.2 days.

The average length of stay for Trauma & Orthopaedics medical elective patients at the trust was 2.7 days, which is lower compared to the England average of 3.4 days.

The average length of stay for General Surgery medical elective patients at the trust was 3.5 days, which is higher compared to the England average of 3.3 days.

The average length of stay for Urology medical elective patients at the trust was 1.7 days, which is lower compared to the England average of 2.0 days.

The average length of stay for all medical non-elective patients at the trust was 6.4 days, which is higher compared to the England average of 5.1 days.

The average length of stay for General Surgery medical non-elective patients at the trust was 5.5 days, which is higher compared to the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics medical non-elective patients at the trust was 9.9 days, which is higher compared to the England average of 8.9 days.

The average length of stay for ear, nose and throat medical non-elective patients at the trust was 2.2 days, which is the same as the England average of 2.2 days.

**Elective Average Length of Stay – Trust Level**

**Non-Elective Average Length of Stay – Trust Level**

**The Tunbridge Wells Hospital**

Between 01 June 2016 and 31 May 2017:
The average length of stay for all medical elective patients at The Tunbridge Wells Hospital was 2.7 days, which is lower compared to the England average of 3.2 days.

The average length of stay for Trauma & Orthopaedics medical elective patients at The Tunbridge Wells Hospital was 3.0 days, which is lower compared to the England average of 3.4 days.

The average length of stay for ear, nose and throat medical elective patients at The Tunbridge Wells Hospital was 1.4 days, which is lower compared to the England average of 1.6 days.

The average length of stay for General Surgery medical elective patients at The Tunbridge Wells Hospital was 2.9 days, which is lower compared to the England average of 3.3 days.

The average length of stay for all medical non-elective patients at The Tunbridge Wells Hospital was 6.4 days, which is higher compared to the England average of 5.1 days.

The average length of stay for General Surgery medical non-elective patients at The Tunbridge Wells Hospital was 5.4 days, which is higher compared to the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics medical non-elective patients at The Tunbridge Wells Hospital was 9.7 days, which is higher compared to the England average of 8.9 days.

The average length of stay for ear, nose and throat medical non-elective patients at The Tunbridge Wells Hospital was 2.2 days, which is the same as the England average of 2.2 days.

**Elective Average Length of Stay - The Tunbridge Wells Hospital**

![Elective Average Length of Stay - The Tunbridge Wells Hospital](chart)

**Non-Elective Average Length of Stay - The Tunbridge Wells Hospital**

![Non-Elective Average Length of Stay - The Tunbridge Wells Hospital](chart)

**The Maidstone Hospital**

Between 01 June 2016 and 31 May 2017:

The average length of stay for all medical elective patients at The Maidstone Hospital was 2.7 days, which is lower compared to the England average of 3.2 days.

The average length of stay for General Surgery medical elective patients at The Maidstone Hospital was 3.6 days, which is higher compared to the England average of 3.3 days.
The average length of stay for Urology medical elective patients at The Maidstone Hospital was 1.7 days, which is lower compared to the England average of 2.0 days.

The average length of stay for Trauma & Orthopaedics medical elective patients at The Maidstone Hospital was 2.4 days, which is lower compared to the England average of 3.4 days.

The average length of stay for all medical non-elective patients at The Maidstone Hospital was 6.3 days, which is higher compared to the England average of 5.1 days.

The average length of stay for Urology medical non-elective patients at The Maidstone Hospital was 4.3 days, which is higher compared to the England average of 3.0 days.

The average length of stay for General Surgery medical non-elective patients at The Maidstone Hospital was 13.2 days, which is notable higher compared to the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics medical non-elective patients at The Maidstone Hospital was 28.3 days, which is notably higher compared to the England average of 8.9 days.

**Elective Average Length of Stay - The Maidstone Hospital**

![Elective Average Length of Stay - The Maidstone Hospital](image1)

**Non-Elective Average Length of Stay - The Maidstone Hospital**

![Non-Elective Average Length of Stay - The Maidstone Hospital](image2)

(Source: Hospital Episode Statistics)

**Meeting people's individual needs**

The service usually took account of patients' individual needs.

We saw that the hospital delivered services to take account for the needs of different people. Staff on the Surgical Short Stay Unit told us they only cared for patients who were expected to have a short recovery in the hospital and did not require high staffing ratios. Patients who needed a higher level of care would be cared for on the longer term wards unless they had a carer who could assist on the Surgical Short Stay Unit.

Staff told us they use the 'This is me' personal dementia folder to share information about patients living with dementia and facilitate patients sharing information about themselves.

Staff told us they did not use patient family members as translators. They told us they ensured patients who did not speak English had access to translators. Staff gave examples of arranging for
medical translators, using staff who spoke other languages as translators and rebooking pre-assessment meetings so that a patient could have a translator. One staff member whose second language was English described interpreting into their first language for patients on the ward. This could mean the nurse was able to more quickly and efficiently respond to patient needs, although it carries a risk that a staff member, untrained in interpretation, could make an interpretation error.

We saw that when the patient rang for help to go to the toilet, staff responded quickly.

We saw that a patient with hearing aids was provided with a small tub for them so that they were easily available and not lost.

Patients and staff told us that patients with special diets were catered for. They described special diets for a range of patients including diabetics, people with religious dietary requirements, vegetarians and vegans. One patient noted that they were diabetic, this was managed and staff checked on them regularly.

Staff told us when they worked with patients with learning disabilities; they welcomed the patients support network including family and carers.

One young adult patient told us their parent was allowed to visit out of visiting hours to help the patient to settle before going to sleep.

However, staff told us they were not able to provide written material in other languages or they did not know how to obtain them.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Between 01 August 2016 and March 2017 the trust’s referral to treatment time for admitted pathways for surgery was higher than the England average. From April 2017 the rate fell and was similar to the England average until July 2017.

![Graph showing referral to treatment rates](source)

(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. Of these, three of specialties were above the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>87%</td>
<td>75%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>88%</td>
<td>73%</td>
</tr>
<tr>
<td>Urology</td>
<td>81%</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.

Over the two years, the percentage of cancelled operations at the trust has been below the England average except in two periods Q4 2015/16 and Q1 2017/18, when it was notably higher than the England average.

Theatre cancellation reports reflect non-clinical reasons for cancellations in August through October 2017 included surgeons with illnesses, surgeon on leave without cover, no patient notes, no ward beds, patient refusal and patient did not appear.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Maidstone and Tunbridge Wells NHS Trust**

![Graph showing percentage of cancelled operations]

**Cancelled Operations as a percentage of elective admissions - Maidstone and Tunbridge Wells NHS Trust**

![Graph showing percentage of cancelled operations]

Between Q3 2015/16 the trusts performance was lower than the England average, from Q2 2016/17 to Q4 2016/17 the rate increased and was worse than the average. In Q1 2017/18 the performance was less than than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)
We saw in the theatres department there was a white board where staff recorded times the anaesthetist and surgeon were ready to start; actual time list began and finished, times all staff left and reason for delay if there was one. We saw three out of four boards had been completed the day prior to our visit. This meant staff understood the list timeline and any reason for delays were clear to all theatres staff.

Staff told us the emergency list would be organised so that patients who were not expected to stay overnight had time to be discharged on the same day.

We saw delays throughout the system kept patients in the hospital, or in the wrong department, longer than required for clinical reasons.

Staff told us pre-operative appointments were sometimes delayed. This could cause delays or cancellation of surgery. Incident reports verified that pre-operative appointment delays had caused surgery cancellations.

We observed a list where a patient’s surgery had been cancelled the day before because the pre-operative department did not have enough time to test the patient for infectious diseases or gather complete information.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them. However, lessons were not always learned from the results and there were long delays for responses.

Summary of complaints

Between July 2016 and June 2017 there were 88 complaints about Surgical Care. The trust took an average of 50 days to investigate and close complaints, this is did not comply with the complaints policy, which stated complaints should be closed within 25 days unless it’s a complex complaint in which the trust had a target of 60 days.

Maidstone Hospital: There were 28 complaints, 17 of these related to the subject all aspects of clinical treatment, and there were no other themes

(Source: Routine Provider Information Request P61 – Complaints)

Staff we spoke to told us they tried to resolve patients’ complaints on the ward as soon as a patient raised concerns. This meant concerns could be addressed and resolved or escalated during the patient’s care to minimise impact.

We reviewed five complaint files. We saw the trust took 55 to 183 days to respond to the complaints, none of which were marked as complex. No apologies were made for delay in responding and we did not see any holding letters explaining the delay. This meant patients were waiting long periods of time for responses without any acknowledgement from the trust.

We saw that in four of five files the trust apologised for the original incident, provided a clear response to the complainants’ concerns and provided contact details so complainant could revert to the trust with any further questions or concerns. In one response the trust did not apologise or provide a meaningful response to the patients concerns. This meant patients usually received meaningful responses to their concerns.

Staff told us learning from some complaints was shared at the meetings; we saw evidence of this in Maidstone Theatre Monthly Staff Meeting minutes.
Is the service well-led?

Vision and Strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action. At a trust wide level documents about vision and values were readily available for staff, patients and the public to view. This information was published for staff on the trust intranet, and the trust published information about its mission, values and vision on its public website.

We saw that the strategy for theatres was part of the larger strategy for the critical care department. The trust aimed to provide safe and effective critical care to the local communities. It was not clear that it was developed with involvement from staff, patients, and key groups representing the local community.

Staff we spoke to understood that a primary focus of the long term strategy was building to improve theatres capacity in the next couple years. Staff were waiting for these major changes and there appeared to be an understanding that they were in a period of inaction until major building works began. This was not reflected in the strategy.

For the surgical department the 2016-17 yearly strategy focussed on staffing (recruiting and retention) and staff reflected their understanding of this. The following years were to focus on theatres capacity and pre-assessment efficiency which staff did not appear to be aware of. Staff told us repeatedly the primary and immediate focus continued to be on staffing.

Governance

The trust had a Trust Clinical governance committee which met monthly. The committee’s aim was to review complaints, incidents, legal issues, Patient advice and liaison service and audit in one forum to bridge the information from all of these sources. The committee was informed by and fed information to Directorate Clinical Governance Committees to address governance at the directorate level.

The Surgery Directorate is a stand alone directorate, although anaesthetics, intensive care unit and theatres were part of the Critical care Directorate. Both Critical care and Surgery form part of the planned care division. Both hold directorate level clinical governance meetings and both are represented at Trust Clinical Governance committee. Two of the three sets of Clinical governance committee meeting minutes recorded that the surgery department was represented at the meeting. The third set of minutes reflected there was a representative, but they had not attended. This meant the department could feed directly into the top of the clinical governance system, even if they did not always attend meetings.

The Clinical Governance Committee was chaired by the Medical Director or (interim) Chief Nurse in their absence. The committee included managers or leads from clinical departments across the trust, legal, risk, complaints and Patient advice and liaison service departments. This meant the right people were present to discuss clinical governance and risk.

We saw that at the meetings the committee identified themes and trends. Trust wide learning was shared for dissemination through the Directorate Clinical Governance Committees. However, we did not see an action plan or responsibilities assigned for future actions. This meant it was not always clear from the notes, what future actions were required or who was responsible for them.
Staff in the theatres department told us that they had monthly directorate governance meetings where governance issues were discussed with staff.

**Management of risk, issues and performance**

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, it was not clear that all staff understood these systems. The department was making positive change toward risk management, but change was not yet fully employed.

We saw that there was a Critical care directorate risk register. This register included several departments including theatres and surgical wards. We saw that there were individual risk registers for departments, although staff in all departments we visited were not sure about specifics regarding the register.

We spoke to senior staff about perceived risks. We saw that in some cases staff understanding of risks aligned with the risk register, and that in some cases they did not. This meant that where staff were aware of risks they could mitigate the risks but in areas where staff were not aware of risks, they might not be directly addressing them.

Senior staff showed us how they could use the incident management system to review open incidents and get alerts. They told us these were discussed at risk meetings.

We saw that the Serious Incident Policy guiding the incident investigations was robust and comprehensive.

Senior hospital management worked directly with senior departmental staff to manage some risks. For instance, the trust had twice daily bed meetings, involving both hospitals’ management, to discuss the hospitals’ capacity and demand using a telephone link so that both hospitals were involved. Risks including patients with infectious diseases were also discussed at this meeting.

We observed senior hospital management and a senior representative for each department from each hospital attended the meetings. We heard staff that each department outlined their needs and capacity and discussed how they could help meet hospital-wide demand. This meant that managers from across the hospital understood individual department’s capacity and worked together to manage the demand.

The Maidstone Hospital Theatre Monthly staff meeting minutes reflected that department managers were preparing staff to take an influx of patients from Tunbridge Wells when it became necessary due to winter (or other) pressures.

**Leadership**

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, it did not appear staff had relationships with management beyond their own direct managers.

The hospital had a General Manager for Critical Care. The assistant general manager was the theatre manager and managed the theatres department, but had only been in post a short time at the time of inspection. The band 7 theatre staff deputised for the theatres manager, managed theatres employees and reported to the theatre manager.
The wards were managed by the ward sisters who supervised the ward staff. The ward sister reported into the Matron for Surgery.

Senior staff explained that there is always an executive staff member on site or on call. The on call executive staff members were able to make high level decisions including decisions about unexpected incidents, staffing, emergencies, etc.

Staff on the wards and in theatre told us they felt their immediate supervisors were visible, accessible and supportive. They reported that ward and theatre managers were very hands on and involved with the day to day working of the departments. Likewise, department managers reported they had close and supportive relationships with upper management, who they were involved with on a day to day basis.

We saw in department Monthly Theatres Staff Meeting notes that theatres department had a monthly meeting where information was shared and discussed. This included sharing learning and support and also highlighting good work by handing out thankyou cards and compliments at the meetings.

However, staff on the wards told us they did not have any relationship with or see upper management.

Culture

Staff we spoke to had mixed reviews about the culture and moral of the trust. Some staff told us they felt appreciated and supported and enjoyed their work.

Patients on the surgical wards at both hospitals reported that staff worked well as a team to provide care. One patient told us their recovery had progressed much more quickly than expected. ‘I put this down to everyone working in tandem- as a team'.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage required services, and collaborated with partner organisations effectively.

Trust was also a member of the Kent Resilience Forum, which brings together emergency services and other responders such as the NHS, utilities and the voluntary sector.

The trust had various opportunities for the public to engage including the Stakeholder Forum, League of Friends, Patient Experience Committee, Patient and Representative Working Group, feedback from the Friends and Family Test, inpatient surveys, complaints and the ‘How Are We Doing?’ initiative.

The trust engaged in the “hello my name is …” initiative which is aimed at ensuring staff always introduce themselves to patients. Patients confirmed that staff always introduced themselves before any treatment or therapy and we observed this in interactions.

We saw that the trust engaged with a wide variety of staff members through groups like the LGBT+ (Lesbian Gay Bisexual Transgender+) Network and cultural diversity network.

We saw there were engagement meetings with surgery staff and ward managers and Listening in Action Forums which engaged frontline staff in finding improvements for patient care.

Learning, continuous improvement and innovation
The trust did not demonstrate it was committed to improving services by learning from when things go well and when they go wrong.

However it promoted training, research and innovation which the staff took pride in. For instance, the pre assessment department used learning from incidents to change their practice. We saw that senior staff from the hospital published the study, Impact of Patient Blood Management Initiate on Length of Stay in Elective Surgery. The implemented learning from the study to change practices which resulted in shorter length of stay. The pre-assessment department posted information about the study outside the department office to share the findings.
Facts and data about this service

We carried out an unannounced inspection of the critical care unit at Maidstone Hospital as part of the new phase of our inspection methodology.

We last inspected the unit in 2015 and rated it as inadequate.

**Facts and data**
The trust has 18 Critical Care beds. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, Maidstone and Tunbridge Wells NHS Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult, 100.0%</td>
<td>Adult, 68.2%</td>
</tr>
<tr>
<td>Neonatal, 24.0%</td>
<td>Neonatal, 7.7%</td>
</tr>
<tr>
<td>Paediatric, 7.7%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England)

Maidstone District General Hospital has one Critical Care ward; the Acute Intensive Care Unit. This had 14 bed spaces, currently funded for nine critical care beds (used flexibly for level 2 and 3 patients) which totalled an Intensive Care Society (Intensive Care Society) nursing dependency of 7.

(Source: Trust Provider Information Request)

**Is the service safe?**

**Incidents**
The service managed patient safety incidents well. Staff recognised incidents and reported them in the correct manner.

The trust used an electronic incident reporting system to report their incidents. At our previous inspection there was a separate system that the intensive care unit were using to report their incidents which meant there was a risk that the trust could not have an overview of the incidents occurring, but staff told us they now only used the standard reporting tool used by the rest of the trust.
Maidstone Hospital reported 272 patient incidents between 1 September 2016 and 26 October 2017, of these, 227 (83%) were found to cause 'no harm' to the patient. This demonstrated a positive reporting culture within the unit.

We saw that incident feedback was completed by the site matron and was placed in a folder in the staff room for all staff to access. This also detailed how many incidents had occurred the previous months, and any trends or themes identified. Incidents were also discussed at a variety of meetings that staff of differing levels attended, from the intensive care unit team meeting to the Clinical Governance meeting.

**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 August 2016 and July 2017, the trust reported no incidents classified as never events for Critical Care.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in Critical Care which met the reporting criteria set by NHS England between August 2016 and July 2017.

(Source: Strategic Executive Information System)

**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, no falls with harm and no new catheter urinary tract infections between August 2016 and August 2017.

(Source: NHS Digital)

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.

The unit and equipment were visibly clean. The intensive care unit was considered a ‘very high’ risk area for cleanliness due to the vulnerability of its patients, and had weekly audits checking the cleanliness of the facilities, estates and nursing equipment used on the unit. Each section reviewed must score a minimum of 90% to be compliant.

We were only provided with the October 2017 cleanliness audit scores, however the scores for facilities, estates and nursing were all above 90%, indicating they were compliant with the
hospital policy.

We observed all staff in the intensive care unit were bare below the elbows and we observed them cleaning their hands before and in between patient contact, in line with infection control policies. All staff uniforms appeared clean and we observed staff wearing personal protective equipment such as gloves and aprons when the needed to.

There was hand sanitising gel at the entrance to the units, which we saw staff and visitors using on arrival to the unit. This helped to reduce the spread of infection to and from the ward.

The intensive care unit took part in hand hygiene audits to ensure staff were complying with a number of key aspects of hand hygiene, including washing hands between patient contact and ensuring that all staff were bare below the elbow. We reviewed the hand hygiene audits for the intensive care unit from April 2017 to September 2017 and saw this result ranged from 97% in April, 99% in May and June and 100% in July, August and September. These were all better than the trust target of 90%.

The unit acquired blood infection rates for the intensive care unit, as reported through the Intensive Care National Audit and Research Centre, were slightly lower (better) than in similar critical care units and better than all critical care units.

Intensive Care National Audit Research Centre data indicated that high-risk sepsis admissions to the unit were 6.7% during April to June 2017. This was higher than similar units.

Between November 2016 and October 2017, there no cases of unit acquired Methicillin Sensitive Staphylococcus infection or cases of Clostridium Difficile infection. The unit had two side rooms that could be used for isolating patients. This included those who may have had a suspected infectious disease, until this could be confirmed.

Staff received training in infection prevention and control as part of their mandatory training. The rate of training completion for infection prevention and control was 98% across the nursing staff, which was better than the trust target. For medical doctors across the critical care directorate, this was 90%, also better than the hospital target.

We saw an in date policy for the management of animal visitors to the trust. This stated that assistance dogs should be allowed to attend the hospital with reasonable adjustments to ensure equal access to services (‘Disability Discrimination Act - 2005 amended’ and ‘Equality Act 2010’).

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The intensive care unit at Maidstone Hospital was located on Level 1, Blue Zone, and was accessible by stairs or by lift. There was a waiting area within the unit which was locked, and visitors were required to use an intercom to identify themselves and who they were visiting. There was also a closed circuit television unit installed, which could be viewed via a monitor from one of the desk areas within the bay. However, the picture detail on this was poor and only in black and white. We observed staff struggling to identify who was waiting outside. Within the waiting area there was a poster asking visitors not to allow other visitors waiting at the door into the unit as this was a security risk. We observed visitors adhering to this.

Due to the setup of the bay areas, the buzzer intercom was only accessible in one of the bay areas. This meant that (as we observed on the inspection), one member of staff had to stay in the desk areas for the intercom, even when there were no patients present in the bay.

The unit was a combination of one six bedded area and two bay areas that can accommodate up to three patients each and two single side rooms. The bay areas were cramped, and although the floor had been marked to ensure that patient care was only delivered within the parameters of each area, it remained a challenging environment, both for staff and for visitors.
There was not enough space to store equipment on the Maidstone intensive care unit. One of the vacant bed areas in the unit was taken up solely by equipment. The unit was not at full patient capacity at the time of our inspection. However, it was unclear where the equipment would be moved to if the bed space was needed and this meant that the ward may not be able to accommodate all nine beds should they be needed. Whilst the area was visibly cluttered, the equipment itself was clean and had ‘I am clean’, dated labels on.

**Medicines**

The service prescribed, gave, recorded and stored medicines well.

We checked two prescription charts at the Maidstone intensive care unit. These were legally valid and contained information about people’s allergies. Prescription charts with antibiotics had reminders to ensure that prescribing was always in line with guidance. All charts had been clinically screened by a member of the pharmacy team at both sites.

The temperature of the medicines fridges was monitored regularly and within range.

Medicines were stored securely.

Controlled drugs at both sites were stored, recorded and handled in line with best practice and legislation. Spot checks on balances showed that contents of the cupboard matched the register.

We found one out of date medicine on each of the units; staff disposed of these immediately.

Medicines waste was handled in the correct way.

Staff knew how to report medicines incidents.

We did not find any evidence that resuscitation trolleys were tamper evident. Tamper evident trolleys and containers have replaceable tags that are broken when opened, so staff are aware if the trolley may have been accessed prior to them using the trolley. This is particularly important when the trolleys are in areas accessible to the public. Although some contained medicines in sealed boxes, these trolleys still contained intra venous fluids and infusions which were not tamper evident. However, following the inspection, the trust told us that a new tagging system was in place to provide evidence of tampering. Trolleys that were not compatible with the tags had additional tamper evident containers added. The daily checklist has been amended to include the ‘tamper tag’ check. This provided adequate assurance that any tampering with the trolley could be easily identified and action could be taken.

**Records**

Staff kept records of patients’ care and treatment. They were completed on paper records that were stored in a mobile cabinet on the unit which could only be accessed by key code.

We reviewed three sets of patient notes at Maidstone. In all of these notes, risk assessments and associated care plans for these were completed. However, in one out of these sets, time of decision to admit patient, summary of events leading to critical care admission and consultant review on admission could not be located.

Two prescription charts were checked; these were legally valid and contained information about people’s allergies. Prescription charts with antibiotics had reminders to ensure that prescribing was always correct.

A cross site records audit was undertaken in July 2017. This audit focussed on the daily record sheet completed by medical staff on both intensive care units. There were five criteria that the record were checked against, of which, only one of these met the expected standard of completion which was the patient management plans were clearly documented – this had 100% compliance.
Demographics and supportive treatments partially met the expected standard with 80% compliance, and cause of admission and patients physiology did not meet the expected standard at 68% and 45% respectively. The action plan stated this was to be discussed at a future governance meeting, with a planned re-audit date of 2018.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. The intensive care unit only accepted adults aged 18 and over, and therefore nursing staff only completed level one safeguarding children training. However, some medical staff had completed level two safeguarding children training in addition to this.

However, staff told us there had been one admission of a child onto the intensive care unit. This was an exceptional circumstance, but indicates that nursing staff did not have a sufficient level of safeguarding children training as a minimum of a level three is required for staff having direct contact with child patients.

A breakdown of compliance for safeguarding courses between April 2017 and June 2017 for support and nursing/midwifery staff is shown below:

![Safeguarding Training - Nursing](image)
We asked the provider for medical staff data for the intensive care unit doctors. Following the inspection, the trust provided us with trust wide overview of the medical staff safeguarding training compliance. The medical staff were performing better than the trust target in both adult and children safeguarding levels one and two. However, no medical staff had received level three safeguarding training. Although the ICU only routinely took adult patients, there had been once occasion where a child under the age of 18 had been cared for on one of the units. This meant that a minimum of level three safeguarding needed to be attained to ensure the safety of vulnerable children in line with national guidance.

We saw flowcharts mapping the process to follow when raising a safeguarding alert in the unit offices.

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust set a target of 85% (except for information governance training which carried a target of 95%) for completion of mandatory training.

A breakdown of compliance for mandatory courses between April 2017 and June 2017 for nursing/midwifery staff is shown below:
Critical care was not meeting the target for three modules and the lowest completion is for dementia awareness (including Privacy & Dignity standards) at 50%.

Maidstone Hospital had a 93% mandatory training completion rate, the lowest completion was for dementia awareness (including Privacy & Dignity standards) with 50%.

We asked the provider for medical staff data for the intensive care unit doctors. The trust was unable to break this down to intensive care unit level, however across the critical care directorate, the compliance rate ranged between 41% and 100%.

**Assessing and responding to patient risk**

We spoke with two consultants who told us that all deaths were discussed at the joint cross site meeting – each site had their own consultant lead for this. Following the inspection, the trust sent us documents detailing ICU deaths discussed between February and May 2017, indicating that all deaths were discussed as part of the ICU mortality review process. However, when we reviewed the trust-wide mortality and morbidity review meetings, we saw that only one ICU death had been discussed out of three sets of meetings.

The hospital used Patient at Risk scores. This was an early warning score tool used to help staff identify when patients may be deteriorating.

There was an outreach team that provided support for the management of deteriorating patients on the wards 24 hours a day, 365 days a year. This was in line with national guidance. This had changed since the previous inspection where they were only available during the day on weekdays. We spoke to members of the outreach team who felt they were an effective team and work together well. Patients discharged from intensive care unit were followed up for three consecutive days or a period deemed necessary considering the individual patient’s needs.
However, staff from the outreach team told us that sometimes when the intensive care unit or wards were busy, the outreach service was suspended. We requested data on this and saw that (trust wide) the outreach service from April to October 2017 had no uncovered hours. We also saw data that showed that From April to October 2017, 66 hours were spent in intensive care unit by the outreach team due to escalation. This equated to six shifts.

There was a Standard Operational Policy for the Management and Delivery of Critical Care in the Emergency Recovery Unit, however this was due for review in January 2017 which meant it was overdue review. This policy set out the roles and responsibilities of critical care staff in the event of a patient requiring admission to a critical care bed and none being available on the unit.

**Nursing staffing**

The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment.

The trust reported their staffing numbers below for the period April 2017 and June 2017.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post at June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>108.23</td>
<td>108.43</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>108.23</strong></td>
<td><strong>108.43</strong></td>
</tr>
</tbody>
</table>

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

At the time of our inspection of the Maidstone intensive care unit, there were nine beds, currently staffed for seven level three patients. On each day shift, in addition to nursing staff, one Clinical Support Worker worked. Clinical Support Workers would observe self-ventilating patients, assist nursing staff and re-stock equipment.

The outreach team at Maidstone was staffed with one outreach nurse per site, day and night. Sickness was covered by staff taking a bleep onto the intensive care unit and outreach staff would give telephone advice to wards that were concerned about patients. In these circumstances, it would be highlighted at the daily bed meetings that the outreach team were on the bleep.

Staff told us that there were permanent members of intensive care unit staff signed up to the bank system. When bank staff were not available to cover unfilled shifts, the matron or nurse in charge would go to agreed framework agencies for qualified intensive care unit staff. In rare cases where staff were still not available, the matron would conduct a risk assessment for going to non-framework agencies to obtain staff.

**Vacancy rates**

Between July 2016 and June 2017, the trust reported a vacancy rate of 5.3% in Critical Care which is better rate compared to a trust average of 11.4% and the trust target 8.5%;

- Maidstone Hospital: 6.4%

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
**Turnover rates**

Between July 2016 and June 2017, the trust reported a turnover rate of 0.5% in Critical Care compared to the trust average of 1% and the trust's target turnover rate is 10.5%;

- Maidstone Hospital: 0.6%

Critical care has a lower turnover compared to the trust target as well as the trust average for the 12 month period.

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

**Sickness rates**

Between July 2016 and June 2017, the trust reported a sickness rate of 2.7% in Critical Care;

- Maidstone Hospital: 3%
- Critical care has a lower sickness rate compared to the trust target 3.3% as well as the trust average for the 12 month period.

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

**Bank and agency staff usage**

Between July 2016 and June 2017, the trust reported bank and agency usage in Critical Care;

- Maidstone Hospital: had a total of 631 shifts, of which 79% were covered by bank staff, a further 15% covered by agency staff and a total of 37 shifts were not filled.

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

We spoke with staff who advised that the majority of the time that shifts need to be filled, they used either staff from Maidstone, or bank staff, and that they rarely used agency staff. 59% covered by bank, 21% covered by agency.

**Medical staffing**

The Intensive Care Society and the British Association of Critical Care Nurses guidance states that the consultant work patterns should deliver continuity of care. At our previous inspection, we saw that consultants only worked one day at a time, covering the intensive care unit Monday to Friday between 8am and 5pm, which was not in line with guidance. At this inspection, we saw that consultants worked three days at a time. This was an improvement from the previous inspection but was still not in line with best practice which stated consultants should work five days in a row to provide continuity of care. We spoke to a senior member of the medical team who told us that some staff found working five days in a row too tiring and intense. Whilst they encouraged staff to work more than three days in a row, if staff did not feel they could commit to this they would allow them to work a minimum of three days consecutively.

The consultant rota was fully recruited to with one vacancy being filled by a locum consultant. All of the new recruits were dual trained which meant they were trained in anaesthetics and intensive care medicine. We spoke to non-medical staff on the ward who told us that since the new rota and recruitment, consultants had been more available and more responsive.
At weekends, there was one intensive care consultant providing cover per site. This had improved since our last inspection where one consultant would cover both sites. This also meant that the consultant on call could be on site within 30 minutes, as recommended in the Core Standards of the Intensive Care Society and the British Association of Critical Care Nurses.

The Intensive Care Society and the British Association of Critical Care Nurses recommends that a ratio of one consultant to 14 patients should not be exceeded, and following the implementation of one consultant per site at the weekend and out of hours, this met the recommendation.

**Major incident awareness and training**

There was a trust wide major incident plan that provided a framework for staff to follow when a major incident was declared. Each department had an associated major incident action card which we saw displayed in the ward office. This demonstrated the cascade that occurred in the event of a major incident. We spoke to a Clinical Support Worker who told us about their role in a major incident and how they have had attended practices and scenario training.

In addition to this, there were guidelines for escalation of critical care capacity during major incidents. This included flowcharts for an increase demand on beds and the steps to take in this instance, and also referred back to the major incident action cards.

**Is the service effective?**

**Patient outcomes**

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

**ICNARC Participation**

The trust has two units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. More recent quarterly data may be available via the evidence grids. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Hospital mortality (all patients)**

For the acute intensive care unit at Maidstone Hospital the risk adjusted hospital mortality ratio was 0.7 in 2015/16. This was better than the national aggregate. The figure in the 2014/15 annual report was 0.9.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Hospital mortality (for low risk patients)**

For the acute intensive care unit at Maidstone Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.4. This was better than the England average. The figure in the 2014/15 annual report was 0.7.
The rate of readmission within 48 hours of patients being discharged at Maidstone Hospital was 1.2%, which was worse than other similar units (0.7%).

**Competent staff**

The service made sure staff were competent for their roles. However managers did not always ensure appraisals were completed. Following the inspection, the trust told us that the trust appraisal cycle runs from April each year. This meant that at the time of the data submission, the trust would have only been half way through their appraisal cycle.

Between April 2017 and June 2017, 55% of staff within Critical Care at the trust had received an appraisal compared to a trust target of 90%.

A split by staff group can be seen in the graph below:

Both sites and Critical Care overall were below the trust target of 90% as well as the trust average of 88%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

A member of staff described their induction to the unit They were given a four week supernumerary period to settle in and also a preceptor.

The core standards for intensive care recommends that 50% of nursing staff should have a post registration critical care qualification. 60% of staff at the Maidstone site had this qualification, This meant the unit met the standard. In addition to this, all new members of staff undertook the ‘foundations of intensive care’ course which was accredited by a local university.

We saw a set of specific competencies for clinical support workers working within the intensive care environment. These included being assessed for competency in describing the psychological needs of patients during critical illness and understanding the policy on using patient diaries and the benefit of using these for the patient post discharge.

Medical staff appraisals were completed on a yearly basis between September and January. The provider told us that all seven intensive care unit doctors based at Maidstone had an appraisal by October 2017.

**Evidence based care and treatment**

The service monitored effectiveness of care and treatment.
The National Institute for Health and Care Excellence provides national guidance and advice to improve health and social care.

National Institute for Health and Care Excellence guideline CG83, 2009 – rehabilitation after critical illness. This guideline states that patients with rehabilitation needs should be reviewed after their discharge from critical care. At our last inspection, there was no post discharge follow up for patients. At this inspection, we saw that follow up clinics had been instigated at both sites and there were dedicated nurses who took this on as part of their role in the unit.

National Institute for Health and Care Excellence guideline CG50 – Acutely unwell patients in hospital: recognition of, and response to, acute illness in adults in hospital (2007) – part of this guideline states that patients should not be transferred from intensive care unit at night (between 10pm and 6am.).

At Maidstone, between September 2016 and September 2017, we saw that for 477 patients discharged from intensive care unit, 35 (7%) were discharged at night. This had stayed the same from the last inspection which stated 7% of patients had been moved at night.

National Institute for Health and Care Excellence guideline CG135 - Organ donation for transplantation: improving donor identification and consent rates for organ donation (2011). This guideline states that organ donation should be considered as a usual part of ‘end-of-life care’ planning.

The intensive care unit at both sites participated in organ donation work and had specialist nurses in post. At the Maidstone site, there were 61 deaths, of which, four were able to donate organs. This gave an organ donation rate of 7%.

**Access to Information**

There was an electronic monitoring system where staff could look globally at observations from the desk in the centre of the unit. If a patient at risk score scored between three and five, would bleep. This electronic system allowed visibility.

Patient bedside notes were paper based, but staff could access electronic referral systems such as the picture archiving communication system which allowed staff to look at radiological imaging and reports.

Staff showed us the intensive care unit e-link web page which was available on the intranet. This was a page that all staff could access and locate policies and procedures in one place.

**Seven-day services**

The intensive care unit was open 24 hours a day, seven days a week.

At the weekend, an anaesthetist based in theatres was always on site, and one intensivist was on site. The intensivist would carry out two ward rounds per day. We reviewed sets of patient records that demonstrated there was consultant presence on both days of the weekend and that these were consecutive.

**Nutrition and Hydration**

We reviewed three sets of notes and saw evidence in all three that there was regular dietetic input.

The intensive care unit used the malnutrition universal screening tool to assess the nutritional needs of patients. Nutrition and hydration was managed effectively. We spoke to a dietician who had daily input with the patients and intensive care unit team.
Multidisciplinary working

Staff of different kinds worked together as a team, and there were formal processes to facilitate this.

At Maidstone there was a twice daily consultant ward round, and a lunchtime multidisciplinary meeting. Staff told us the physiotherapists normally attend on the ward round but we did not observe this on the inspection.

The intensive care unit had an outreach team which was a recommendation jointly of the Faculty of Intensive Care Medicine and Intensive Care Society core standards. This comprised of a team of senior nurses used within the hospital to provide advice and guidance for staff caring for patients on other wards who may be showing signs of deterioration or for patients who have recently been discharged from the intensive care unit. This service was available 24 hours a day, seven days a week, in line with the recommendations.

Staff told us that the pain team attended the unit regularly although we did not see them during the course of our inspection.

There was an Emergency Department Psychiatric Liaison Officer available to respond to referrals from the intensive care unit team, and review patients either as a routine referral (within 48 hours) or urgent referral (within 2 hours). They covered 8am to 8pm seven days a week. Outside of these hours, there was a crisis team.

In all of the sets of notes we reviewed, we observed there was regular dietician input.

A nurse from the intensive care unit attended the end of life care network meetings. The intensive care unit did not have an in house psychologist but did have an in house counsellor they could access on behalf of patients. They could also signpost patients and relatives to self-refer to a free counselling service.

Staff told us that pharmacist and pharmacy technician availability on the ward was generally good. Staff told us that the consultant microbiologist worked closely with staff on the ward to ensure people were prescribed the correct antibiotics.

Pain relief

A critical care pain observation tool which rates critically ill patients pain based on clinical observation had been introduced for use on patients who had a certain level of sedation. For patients who were awake or not sedated, a regular pain scale from zero to ten was used.

If the patient was in pain the majority of the intensivists had an anaesthetics background and could assist. Staff also had access to the chronic pain team and other specialist nurses such as tissue viability. We were told that these staff were readily accessible.

The trust sent us examples of pain assessment tools such as the Abbey pain scale which assesses pain in patients with dementia or cognitive impairment.

Nutrition and hydration

We spoke to a senior member of the dietetics team on the unit. They described how the dietetic input was in line with the Intensive Care Society guidelines (0.5 – 0.1 per patient). They spent their morning on the intensive care unit, and told us that felt very much part of the intensive care unit team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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The trust reported that between April 2017 and June 2017, mental capacity act Level 1 training had been completed by 99% of staff within Critical Care.

A staff member told us that they had scenario training around mental capacity. The safeguarding lead came from the other site and was able to give support and answer questions on the subject.

Staff gave examples of where they have looked after patients with learning disabilities (LD) and on one occasion where the father of a LD patient stayed overnight to help settle the patient.

Is the service caring?

Compassionate care

Staff interactions with patients were positive and respectful. We observed a consultant enter a patient room and introduce themselves to the patient and tell them what their role was. We spoke to a nurse on the unit who told us that they would be happy to bring their own relatives onto the unit and felt that they provided very high standards of care.

The environment and set up of the unit meant it was challenging to maintain patient’s privacy and dignity. The bed spaces were close together and although these could be segregated by disposable curtains on rails around the bed area, they were still in close proximity to the neighbouring patients. There also was not much room when relatives visited, so neighbouring patients could be disturbed.

We spoke to three patients relatives at Maidstone. They described the staff on the unit as ‘angels’ and ‘ever so kind’.

There was in excess of 25 thank you cards displayed on the wall outside the intensive care unit. These contained messages both from patients and relatives thanking staff for their support whilst on the unit.

Friends and Family Test were not available for either intensive care unit site. This was because the Friends and Family Test was only applicable if a patient was discharged directly home from the intensive care unit. Due to the nature of the patients on intensive care unit, it was likely that they would be transferred to another ward before being discharged home.

Understanding and involvement of patients and those close to them

Relatives could visit their loved ones between 11am and 8pm. However, the ward information board outside of the unit stated that “we try to be flexible so please ask” (if relatives wanted to visit outside these hours). We saw relatives visiting outside of these hours whilst we were on the unit.

We spoke to two relatives who told us the care was ‘superb’. They were kept informed about the plan for their relatives discharge.

The information board outside the unit also had information such as what a patient may need when coming into intensive care unit – for example, there were photographs of everyday items such as toothpaste, hearing aids, photographs etc. to help relatives and patients see at a glance a useful reminder of what they may need to bring with them.

There was a relatives information board outside the unit. This detailed various pieces of information in layman’s terms such as what ventilation meant and how patients were monitored. It also detailed the units layout and routine, including visiting hours and discharge information.

One relative we spoke to told us that the first time they visited they were upset by all the machines, but “staff took the time to explain them all to me and made me feel at ease”. They went
onto say: “they always explain what was happening and always happy to speak to you – even in the middle of the night.”

**Emotional support**

Both of the units used patient diaries. These were used for patients, relatives and staff to record key moments in their recovery or when they had visited. We spoke to a relative who told us about the diary and how they thought it was a positive idea. These could be reviewed, if the patient wished, in the follow up clinics run by the unit.

As part of the follow up clinic, patients were given the opportunity to complete a hospital anxiety and depression questionnaire. This produced a score which would give an indication of the risk of this. Depending on the outcome of the score, patients could either be referred back to the GP, or could be signposted to counselling advice.

The follow up clinic happened once a month and started in April 2016. Each patient was given a one hour follow up appointment. Letters would then be sent to the GP and anyone else who attended. Psychological assessments could be completed during the follow up appointment.

Staff gave us an example where they signposted a relative who was distressed, to the talking therapies service for advice. This was a free service that both patients and relatives could access for advice and support.

We saw interactive posters for support groups for patients that had been on the intensive care unit. These posters contained ‘z’ bar codes, that relatives could scan on their phone to interact with the information at a later date.

**Is the service responsive?**

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

The unit did not have a separate high dependency unit to care for patient’s on. When the unit had sufficient capacity, high dependency (level one) patients could be cared for on either of the units, and Clinical Support Workers could be utilised to support these patients.

Facilities for family members to stay on the ward were limited, primarily due to the lack of space available.

Relatives could visit their loved ones between 11am and 8pm. However, the ward information board outside of the unit stated that “we try to be flexible so please ask (if visitors wanted to visit outside these hours)”. We saw relatives visiting outside of these hours whilst we were on the unit.

The website informed patients of current roadworks nearby to one of the hospital sites which may cause them delay getting to, or leaving, the hospital.

**Meeting people’s individual needs**

During the inspection, we were told that a patient under 18 had been cared for on the unit. This was not a usual occurrence as the unit was designed to treat adults only. Staff described what measures they took to ensure that the child was cared for in the right way, which included liaison with the paediatric team and with the children’s hospital at a different site to ensure all stakeholders were kept informed of the child’s progress. However, at the time of our inspection, there was no standard operating procedure for dealing with children on the unit. This meant that staff may not have been fully prepared and equipped for dealing with a child on the unit. The
matron told us that they were looking at developing a standard operating procedure to help deal with any reoccurrences of this in the future

An interpreting service had been introduced to the trust since our last inspection and it was hospital policy to only used translators accessed through this service. The ward clerk on the Maidstone intensive care unit was the designated champion for this.

The website contained information on the ‘accessible information standard’ This advised patients of how they could access support of they had sensory or physical impairment, and receive information in a way which they could understand. However, we did not see any leaflets available in an alternative language or information about how to access information in another language on the units.

There was detailed information available on the website for patients called: Intensive care: a guide for patients and relatives. This contained both practical information about getting to the unit, what patients may need, and other information regarding a typical day on the intensive care unit and use of patient diaries.

The waiting room for relatives and visitors had a hot and cold drinks dispenser which was complimentary. There was a vast array of patient information leaflets available in the waiting room and posters signposting patients to different support groups and organisations.

Both sites had multi-faith chapels accessible to patients, visitors and relatives. There was a chaplain based at each site and these were supported by volunteers who could visit patients on request and provide support. The intensive care unit also had a spiritual and religious care directory that staff could access and provide information and or support to patients and relatives with.

We spoke with a nurse who was undertaking dementia training to become a dementia ‘champion’ after recognising the changing case mix and more elderly patients being admitted to the unit. Champions were staff who had elected to become experts in a particular area, and taken ownership of dissemination learning and best practice within their department.

Staff told us that the units used ‘this is me’ documentation, which was a support tool for patients with short or long term memory loss or communication issues. The this is me form includes details on the person’s cultural and family background; events, people and places from their lives; preferences, routines and their personality.

We saw that there were ‘twiddle-muffs’ available. These were double knitted hand muffs with different attachments that act as a stimulation activity for people with dementia.

There were books for children to read, including books that explained in children’s terms what being on the intensive care unit meant and also for helping to deal with the loss of a loved one such as a parent or other relative. They helped to help explain death and how to deal with grief and feelings of loss. There were also colouring books and pencils available for children to use when visiting the ward.

In addition to this, one of the staff members had visited hospices and palliative care teams as they felt there was not enough support available for children. As a result of this, the intensive care unithad started offering ‘memory’ boxes’ which were boxes that could be decorated and used to store items such as a hand print of lock of hair, reminding the relative of their family member. Hair locks could previously be provided to relatives, but these used to be wrapped in white surgical tape and placed in an envelope. The service offered these wrapped in ribbons and placed in a small decorated keepsake box. There were also small stuffed toys available in pairs – children
could then give one toy to their relative, and keep the other one. This was used to help the child still feel connected to their family member, even after death.

The intensive care unit at Maidstone was considering piloting the ‘swan’ scheme. This was a scheme where a swan icon is used on all paperwork and at the bedside to inform staff that a patient was approaching the end of their life. Staff were particularly keen on doing this at the Maidstone site due to the difficulty with privacy and dignity in the bay area of the unit.

There was a relatives room available in the unit. These were designed as a comfortable room for relatives to reflect away from the clinical environment. There were tissues, complaints process leaflets and information about creating your own memory boxes in this room.

There were two toilets on the intensive care unit, one of which contained a shower. The toilets were unisex and could be changed to display either male or female depending on who needed to access it.

Access and flow

Bed occupancy

Between September 2016 and August 2017, Maidstone and Tunbridge Wells NHS Trust had seen adult bed occupancy fluctuate, remaining worse than the England average for the entire reporting period except December 2016 and May 2017. Overall the trust had performed worse than the England average.

Adult Critical Care Bed occupancy rates, Maidstone and Tunbridge Wells NHS Trust.

![Graph showing bed occupancy rates](image)

Note: data relating to the number of occupied critical care beds was a monthly snapshot taken at midnight on the last Thursday of each month.
(Source: NHS England)

Delayed discharges

For the acute intensive care unit at Maidstone Hospital, there were 3,294 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 7.7%. This compares to the national aggregate of 5.3%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2014/15 annual report was 12.4%.
(Source: Intensive Care National Audit Research Centre (ICNARC))

Patients that had a discharge delayed up to four hours, ranged between 48% and 85% at Maidstone hospital in the last 12 months, and between 48% and 75% at Maidstone Hospital. This meant that the majority of patients fit for discharge were waiting up to four hours to be discharged to a suitable ward.
Non-clinical transfers

For the acute intensive care unit at Maidstone Hospital, there were 486 admissions, of which 0% had a non-clinical transfer out of the unit. Compared with other units this unit was slightly better than the England average. The figure in the 2014/15 annual report was 0%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

No patients were transferred to the intensive care unit or non-clinical reasons at either site during the past 12 months.

Non-delayed out of hours discharges to the ward

For the acute intensive care unit at Maidstone Hospital, 0.3% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was better than the England average. The figure in the 2014/15 annual report was 0.7%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

The intensive care unit at Maidstone Hospital cared for male and female patients together. Where possible, male and female patients were cohorted together, however this was not always possible.

The critical care department did not routinely report on mixed sex breaches as the care environment on an intensive care unit was significantly different to other areas of the hospital. It was not clear at the time of our inspection how mixed sex breaches were reported or monitored.

There was a follow up clinic for patients. Ward clerks sent letters out to patients who had been discharged for up to two months, inviting them in for an appointment. The band 7 had produced a report on the efficiency of the clinic between July 2016 and July 2017. Of 214 letters sent out to patients offering the service, 25 patient attended (12%).

A poster in the waiting area explained to patients that there may be a delay in them being collected to visit their patient, and apologised for this.

Learning from complaints and concerns

Summary of complaints

Between July 2016 and June 2017 there were no complaints about the intensive care unit.

The trust website had a section dedicated to how to complain and examples of anonymised complaint outcomes. However, none of the examples related to intensive care unit patients.

There was a box in the waiting room that relatives could post their feedback on.

The lead nurse for the follow up clinic shared feedback from the clinic with other intensive care unit staff. An example of this was where patients who were nil by mouth reported watching next door patients having cups of tea and advised staff to be mindful of this.

We saw multiple plaudits and letters thanking the nurse for both the care whilst on the intensive care unit and for the follow up clinic.
Is the service well-led?

Leadership

The lead matron for the critical care directorate covered both intensive care unit sites. The directorate encompassed intensive care unit, theatres, endoscopy, pain and pre assessment.

On each site, there was a site matron who both held critical care qualifications. The site matron for Maidstone had been in post for approximately five months at the time of our inspection. She told us she had good support and leadership from the directorate matron. Staff told us that both the lead matron and site matrons were visible on the units. Site matrons had a percentage of their time designated for clinical work, which meant staff saw them on the ground and they had the opportunity to work with the team in the clinical environment.

The intensive care unit outreach team worked cross site but were managed by the matron for the Maidstone site.

Site Matrons managed the band 7 nurses who in turn managed the band 6 and band 5 nurses.

Staff told us that the Lead directorate and site matrons were visible, but above that, staff rarely saw senior staff or members of the trust executive team.

Vision and Strategy

The intensive care units sat under the critical care directorate. The directorate also encompassed theatres, pre-assessment and the chronic pain team. The critical care directorate vision was ‘delivering safe and effective critical care and pain services, to the population of West Kent and East Sussex’.

Displayed outside both of the intensive care units was the vision for critical care staff. This was to: support and foster the highest quality of care to all patients and their families; train individuals who are passionate about adult critical care and who will become leaders in the field; foster an academic, diverse, educational environment that encourages ongoing professional development, evaluation and constructive feedback; lead the field of critical care nursing and medicine; advocate on behalf of patients and their families, emphasising prevention, treatment and research relating to adult critical illness.

The critical care directorate strategy encompassed clinical strategies across all three departments, and these were colour coded to demonstrate where they fitted in with the trust’s overarching strategy strands: caring organisation, sustainable services and improvement driven. For the intensive care unit, the clinical strategies for 2016/17 had been achieved with the objectives of setting up intensive care unit follow-up clinics and to meet recommended intensivist numbers. There were no objectives set for 2017/18 and the 2018 – 2021 objectives were to increase information technology to reduce paper in intensive care unit and to review intensive care unit staffing and provision. The clinical strategy was listed as improving patients care in intensive care unit and increasing the productivity of both intensive care units through technology. Also being alert to the pressures experienced in the TWH site and how to address these in light of current capacity and future demands on the service. However, there was no mention of future plans for the environment at the Maidstone site, which was a challenging environment to work in.

We spoke to staff who told us that one thing they would like to change about the unit was to get patients ready to go to the ward discharged from the unit more quickly.
Since our last inspection, the outreach service had been increased to 24 hours a day, 365 days a year from the previous five day week between 9am and 5pm, which now complied with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines.

**Culture**

We spoke to a CSW who told us that working on the unit was ‘superb’. They were given support to attend their studies, and to maintain their competencies.

A dietician told us that the staff on the intensive care unit were really experienced and the quality of care was fantastic. They felt it was a good team environment to work in.

The ward clerk said the unit was a very supportive environment. That staff were “all in it together” and would recommend it as a place to work and was proud to work there.

Staff told us they felt able to raise concerns and that the team was very supportive.

We spoke with a student nurse who was very positive about their experience on the unit and a nurse that had been recruited from overseas was very positive about the support and development offered by the department.

**Governance**

There was a trust-wide Clinical Governance Committee which met monthly. The committee was informed by the directorate level meetings such as the critical care board meeting and the clinical operations and delivery committee.

The Clinical Governance Committee was chaired by the Medical Director or (interim) Chief Nurse in their absence. The committee included representatives from clinical departments across the trust, including the legal, risk, complaints and PALS departments. We saw that there was regular attendance from an intensive care unit representative.

We saw minutes of the Clinical Operations and Delivery Committee and saw that both the Critical Care Lead matron and one of the lead nurses for intensive care unit was in attendance. Learning from incidents and SIs were a standing agenda item, along with a ‘safety moment’ of the month’ such as sepsis and associated National Institute for Health and Care Excellence guidance.

We saw minutes of the Critical Care Directorate board meeting. This was a cross site meeting where representatives of each of the critical care departments attended. This fed into the trust wide clinical governance meetings.

**Management of risk, issues and performance**

There was a risk register seen for the critical care directorate. Within this, there were four risks listed for the intensive care unit departments. The highest rated risks were out of hours, delayed discharges and outreach suspension. There was however, no risk listed for the poor environment at the Maidstone site, including the risk to patient confidentiality, privacy and dignity.

Each site also had a hazard profile which listed local risks and issues. These detailed local issues per intensive care unit site, including staff working in isolation in side rooms and risk of staff dealing with distressed relatives on a regular basis. These all had controls listed with links to the relevant guiding policy.

Senior staff showed us how they could use the electronic risk and incident management system to review open incidents and risks. They could also easily access mandatory training and other key data about their staff and service.
We saw evidence from meeting minutes that incidents and audit data such as Intensive Care National Audit Research Centre outcomes were discussed at a range of team meetings. White boards situated within the department displayed safety data such as safety thermometer data and audit outcomes such as the latest Intensive Care National Audit Research Centre data.

**Engagement**

There were team meetings that staff could attend. Staff told us that if they were unable to attend the team meetings, they would be sent the minutes. This included sharing learning and support and chances to raise issues.

There was a matrons’ workshop that was held for matrons across the departments to attend. We spoke to a site matron regarding this who told us it was a good opportunity to share best practice.

A regular Nursing Engagement and Leadership Forum was held weekly. This was open to all bands of nursing staff, students and clinical support workers. It occurred at the same time on both sites, with topics circulated the day before the meeting.

We spoke to members of staff who were attending training to be ‘champions’ in their chosen field such as dementia, end of life care, medical devices or health and safety. They told us how they were supported by their managers in this training.

Because of the nature of the critical care environment, there was no public involvement in how the department was run but patients and relatives were asked to comment on their care. However other than the displaying of thank you cards and feedback from patients at the follow up clinic, we did not see any evidence of analysis of feedback or any trend analysis to drive improvement.

The website contained information for patients and relatives visiting the critical care unit.
The trust has 46 inpatient paediatric beds across two sites – Maidstone Hospital and Tunbridge Wells Hospital. In addition to the inpatient beds across two sites, the trust also provides paediatric outpatient services at both sites.

Maidstone and Tunbridge Wells NHS Trust (MTW) also offers tertiary service paediatric orthopaedic surgery for the whole of Kent and parts of Sussex.

(Source: Routine Trust Provider Information Return (RPIR) – Beds tab)

The trust had 4,222 spells between July 2016 and June 2017.

Emergency spells accounted for 77% (3,240 spells), 12% (510 spells) were day case spells, and the remaining 11% (472 spells) were elective.

Riverbank Children’s Unit is a paediatric ambulatory and day-case ward consisting of 12 beds at Maidstone Hospital. Children and young people will be admitted to Riverbank for day-case surgery or having been referred to paediatrics from the emergency department, GPs or for further investigations. If the patient requires an overnight stay then they will be transferred to Hedgehog Ward at Tunbridge Wells Hospital.

Percentage of spells in children’s services by type of appointment and site, July 2016 and June 2017, Maidstone and Tunbridge Wells NHS Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Tunbridge Wells Hospital</td>
<td>3,699</td>
</tr>
<tr>
<td>The Maidstone Hospital</td>
<td>289</td>
</tr>
<tr>
<td>Neville Childhood Epilepsy Centre</td>
<td>234</td>
</tr>
</tbody>
</table>

Total number of children’s spells by site, Maidstone and Tunbridge Wells NHS Trust
This trust | 4,222
---|---
England average | 1,100,097
(Source: Hospital Episode statistics)

**Is the service safe?**

**Mandatory training**

We found staff had the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment. Staff told us it was their responsibility to ensure they were up to date with training and managers oversaw the training rates.

Mandatory training was a mixture of on-line training and face to face training. Modules included; safeguarding, information governance, infection control and prevention and fire safety. Additional modules were undertaken dependant on the staff member’s role. We saw training was appropriate for staff to deliver care in a safe way.

We saw evidence, which indicated staff were compliant with mandatory training. Staff told us they attended mandatory training days and completed online training packages in addition to this.

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

Breakdown of compliance for mandatory courses as of August 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division are shown below:

The below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services such as maternity, as well as those working in children’s services.

![Mandatory Training by module](chart)

Medical and dental staff in the Women’s and Children’s division met the 85% target for mandatory training compliance for nine modules. Medicine management training had the lowest completion rate with only 61% which equated to 211 of the 288 eligible staff members completing the training.
Nursing and Midwifery staff in the Women’s and Children’s division met the 85% target for mandatory training compliance for nine modules. Conflict resolution training had the lowest completion rate with only 46% which equated to 28 of the 61 eligible staff members completing the training.

Staff completed a comprehensive induction package on starting employment in children’s services. They were an additional staff member for the first three weeks of working in any area of the service and could shadow staff in the service during that time. Staff told us this was invaluable in understanding how each part of the service worked.

**Safeguarding**

Staff understood their safeguarding responsibilities and could describe the safeguarding policies and procedures.

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

A breakdown of compliance for safeguarding courses as of August 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division is shown below:

The below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services such as maternity, as well as those working in children’s services.
Women’s & Children’s division at the trust. Safeguarding children level 3 had the lowest completion rate with 61% which equated to 20 of the 33 eligible staff members completing the training.

In addition to this, 81% of nursing staff had completed safeguarding children level three training, which was an improving percentage from August 2017.

The 85% target was generally met for all of the safeguarding modules by medical and dental staff in the Women’s & Children’s division at the trust. Safeguarding children level 1 had the highest completion rate with 98%, this equated to 165 of the 168 eligible staff members completing the training.

Safeguarding training included training on female genital mutilation, childhood sexual exploitation and understood their duties to report this in line with guidance.

Staff had access to a named nurse for safeguarding and to a paediatrician with child protection experience and skills to provide immediate advice, assessment and a report if necessary.

Staff we spoke to had a good understanding of their responsibilities when reporting safeguarding concerns and how to keep children and their families safe from abuse and harm. Staff reported 28 incidents on the trust’s electronic reporting system from January to December 2017.

The named safeguarding nurse managed all paediatric services across both sites including children’s accident and emergency, neonatal services, specialist nurses and the community nursing team. She managed escalation to other agencies and was contactable by phone at all times. Staff could contact the lead for advice or to discuss difficult cases.

There was a named safeguarding doctor who discussed initiatives and audit report findings with the community paediatrician.

Child protection medical forms were discussed at peer review and audited and these were reported on to the governance committee.

The trust was not yet live on the Child Protection - Information Sharing project. However, this was to occur in soon after the inspection. Systems used this linking information technology across health and social care to help organisations to change business processes so that basic information could be shared securely between them.

Staff could flag, on the trust’s electronic booking system, if a child or young person was on a protection plan.
Staff completed proformas when children and young people were admitted to the ward. This would identify if a child was on a protection plan. If the child or young person had a named social worker, staff contacted the social worker to let them know they were an inpatient, keep them updated during their stay and inform them on discharge. Staff told us they had good working relationships with the social work team.

If a child did not attend their appointment in outpatients, this would be highlighted on the end of day report. The doctor completing the outcome sheets would review patients who did not attend and if necessary escalate this to the safeguarding team.

The service had safeguarding link nurses to liaise between the safeguarding lead and operational staff.

The safeguarding team would deal with children up to the age of 18. Patients up to the age of 16 years could be admitted to the paediatric ward. However there was no outreach service available for 16 and 17 year olds admitted to adult wards. The safeguarding lead was not routinely informed if a child was on an adult ward and relied on the wards informing them.

The trust acknowledged that it was not referring any domestic abuse to the Multi Agency Risk Assessment Conference. This is a victim focused information sharing and risk management meeting attended by all key agencies. The trust had no specific training on domestic abuse though it was an element of the safeguarding level 3 training that staff had.

The children’s directorate was unaware of the PREVENT training initiative and the National Health Service England directive of 85% of staff trained by March 2018.

**Cleanliness, infection control and hygiene**

The children’s and young people’s services controlled infection risk well. Staff followed effective systems and processes to prevent and protect people from a healthcare associated infection.

The Lead Infection prevention nurse led infection prevention and control at the trust.

Staff attended infection, prevention and control training and we saw training rates were above the target score of 95%. In addition to this staff completed aseptic non-touch technique training, this involves applying the strictest rules to minimize the risk of infection.

We visited outpatient clinic rooms, waiting areas, the ambulatory care and day case areas. All areas we visited were visibly clean and free from clutter. Staff completed daily cleaning checklists for rooms and equipment, we saw checklists were complete.

We saw audits of cleaning checklists which indicated the service was compliant in completing checklists. The outpatient area scored on average 98.5% from August 2017 to January 2018 and the Riverbank children’s unit scored on average 95.7% over the same period. Areas are audited depending on the level of infection risk they have, in the outpatient department this was significant and audits were carried out quarterly and in the Riverbank unit, the risk was high so this was monthly. This was in line with the national specifications for cleanliness. We saw cleaning staff using colour coded mops, cloths and buckets in line with policy and national specifications of cleanliness guidance.

We saw disposable curtains in treatment areas which had been changed within the last six months in accordance with hospital policy.
We saw sharps bins were available in treatment areas where sharps may be used. This demonstrated compliance with health and safety regulation 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.

**CQC Children’s Survey 2014 – Q26**

In the CQC children’s survey 2014, the trust scored 9.19 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

*(Source: CQC Children’s Survey, RCPCH)*

Infection, prevention and control standard operating procedures and policies we reviewed were up to date and accessible by staff on the hospital intranet. This assured us the units were following evidence-based procedures whilst preventing the spread of infections.

We observed staff adhered to the infection control policies, including ‘bare below the elbows’, hand hygiene, long hair tied up and correct use of personal protective equipment such as gloves and disposable aprons.

We saw hand hygiene results which indicated in August, September, October, November and December, the Riverbank unit scored 100% when they were audited against patient contact.

There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 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 handwashing sinks. Sanitising hand gel was readily available throughout the hospital.

Staff flushed all taps in the children’s services areas daily and emailed to indicate this had been done. At the weekend, a member of the estates team would complete this task. This reduced the risk of legionella infections.

Alcohol hand cleaning gel dispensers was available at all entrances to areas and we saw staff and visitors use them.

**Environment and equipment**

We saw the design of the Riverbank unit led to a child friendly atmosphere. Children had contributed to decoration of the unit and staff consulted local children in future plans for changes to the play room area.

The design and maintenance of children’s services assisted in keeping children safe. The entrances to the services were swipe card only and visitors had to ring a bell to be admitted. Only paediatric staff or staff assigned with specific access to the paediatric unit could access with a swipe card. A general trust swipe card did not give clearance. This gave the department control on who was entering the department.

We saw clinical rooms; clean and dirty utility rooms and the kitchen were keypad entry only. Keypads were of a height adults could reach, but a small child would be unable to.

We saw a range of specialist equipment for children, to carry out examinations, consumables and a wide variety of toys to provide distraction techniques.
Equipment was serviced regularly and we looked at many pieces of equipment, all had stickers to indicate they had been service in the last 12 months.

Electrical equipment had electrical safety tests completed regularly and we saw stickers on equipment which indicated this was the case.

We saw each consulting room in the outpatient area was equipped with a treatment couch and trolley for carrying the clinical equipment required. Rooms had equipment in to provide physical measurements, in privacy. This was line with Hospital Building Note (HBN) 12 (4.18) which recommends a space for physical measures to be provided so this can be done in privacy.

A variety of disposable items of clinical equipment was available in treatment rooms. All items we checked were in date.

**CQC Children’s Survey 2014 – Q2, Q7, Q25**

In the CQC children’s survey 2014 the trust scored 9.11 out of ten for the question ‘Did you feel safe on the hospital ward?’ This was about the same as other trusts.

The trust scored 9.24 out of ten for the question ‘Did you feel that your child was safe on the hospital ward?’ This was about the same as other trusts.

The trust scored 8.98 out of ten for the question ‘Did the ward where your child stayed have appropriate equipment or adaptions for your child?’ This was about the same as other trusts.

A list of all scores from the survey which fall under the safe domain are listed below.

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Did the ward where your child stayed have appropriate equipment or adaptions for your child?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>8.98</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26. How clean do you think the hospital room or ward was that your child was in?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>9.19</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>53. For most of their stay in hospital what type of ward did your child stay on?</td>
<td>S3</td>
<td>0-15 Adults</td>
<td>10.00</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>7. Did you feel that your child was safe on the hospital ward?</td>
<td>S3</td>
<td>0-7 Adults</td>
<td>9.24</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>2. Did you feel safe on the hospital ward?</td>
<td>S3</td>
<td>8-15 CYP</td>
<td>9.11</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Resuscitation trolleys were available in the main outpatient waiting area and the day case area and were easily accessible to all staff. Both trolleys were tamper evident. All trolleys had daily checklists. The checklists were completed daily for the last two months. We saw equipment was available for children of all sizes and all disposable equipment on the trolley was in date.

The outpatient area was specifically designed with children in mind, had a wide variety of toys and books available and had a television which was playing child friendly films at the time of inspection. The outpatient department was for children only.
In the theatre recovery area there were dedicated bays for children which were screened off from the adult recovery area. This was in line with the royal college of surgeons, standards for children’s surgery recommends: to minimise any distress that children and young people should not be cared for alongside adults in recovery areas and parents should be allowed to visit their child in recovery.

We reviewed the management of waste and clinical specimens and found these to be correctly segregated, stored, labelled and disposed of in line with HTM 07-01, control of substance hazardous to health and Health and Safety at work regulations.

**Assessing and responding to patient risk**

We found a wide range of risk assessments, screening tools and record charts were used to minimize risk to patients. Effective policies and procedures were in place to manage a patient in an emergency.

Every child had a Paediatric Early Warning Score which is a tool to identify if a child was becoming more unwell. This form had a system which guided staff to the appropriate action. We reviewed a selection of the forms and saw that staff escalated any concerns in the correct manner from these recordings.

Managers audited the completion of paediatric early warning scores and in the most recent audits in August 2017 and January 2018, scored 100%.

There was an escalation policy. Any child requiring transfer to another hospital for any reason including critical care was transferred to a nearby trust with these facilities through a contracted retrieval service. Staff had a good understanding of the process, which was in line with the policy.

The service had a sepsis policy and clinical guidance for sepsis in infants and children which referred to relevant national and professional guidelines.

The trust used a paediatric sepsis screening tool and antibiotic protocol. All staff received training on induction and attended a two yearly update. Staff we spoke with were aware of how to assess and manage sepsis.

All children attending as day cases were pre-assessed. This was done either by attendance to the pre-assessment clinic or by a telephone assessment depending on the nature of the child’s treatment.

A registered nurse always escorted children to and from theatre and carried a grab bag with them in case of emergency.

Staff had training to respond to patients in an emergency. We saw 86.2% of medical staff had attended basic life support. Eighty four percent of nursing staff were trained in paediatric basic life support. In addition to this, 69% of nursing staff were trained in emergency paediatric life support.

Any patients seen in the ambulatory unit who required inpatient care were transferred to the Tunbridge Wells Hospital at Pembury. A multi-disciplinary team, which included a paediatrician, carried out a risk assessment to decide if transport was possible with parents in a car or whether an ambulance transfer was required. If a patient’s care needs could not be provided for at the Tunbridge Wells hospital at Pembury could be transported to another hospital by the retrieval team. This was in line with the paediatric transfer policy.
The trust had a child abduction plan, approved in January 2015. The plan formed apart of major incident training. We received information which indicated 72.6% of staff had attended major incident training. Staff we spoke with were aware of the process.

**Nursing staffing**

The service had sufficient numbers of staff to provide safe care and treatment to children and young people.

Managers calculated staff rota’s using royal college of nursing guidance. Staff were rostered depending on the planned activity for the day case unit and the numbers of beds on the ambulatory care unit.

Bank staff were the trust’s own staff and agency staff completed a comprehensive induction prior to working in any of the children’s services department.

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in children’s services for the period January 2017 to June 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 17</td>
<td>102.61</td>
<td>107.80</td>
</tr>
<tr>
<td>February 17</td>
<td>99.94</td>
<td>107.81</td>
</tr>
<tr>
<td>March 17</td>
<td>102.56</td>
<td>107.80</td>
</tr>
<tr>
<td>April 17</td>
<td>102.04</td>
<td>107.15</td>
</tr>
<tr>
<td>May 17</td>
<td>101.95</td>
<td>107.83</td>
</tr>
<tr>
<td>June 17</td>
<td>101.14</td>
<td>107.80</td>
</tr>
</tbody>
</table>

As at June 2017, there are 6.66 WTE less staff in post than the trust had planned to provide safe care.

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

**Vacancy rates**

Between July 2016 and June 2017 the trust reported an average vacancy rate of 7.1% for nursing and midwifery staff in children’s services;

- Maidstone Hospital: 0%
- Tunbridge Wells Hospital: 7.2%
- Other: 10.7%

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

**Turnover rates**

Between July 2016 and June 2017, the trust reported an average turnover rate of 0.9% for nursing and midwifery staff in children’s services.

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

**Sickness rates**

Between July 2016 and June 2017 the trust reported an average sickness rate of 4.0% for nursing and midwifery staff in children’s services, which is above the overall trust target of 3.3%
for sickness rates.  
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Medical staffing

There was a paediatric registrar and house officer onsite on the unit at all times. A consultant paediatrician was available 24 hours a day, seven days a week.

For all paediatric lists, there was a paediatric anaesthetist. When a paediatric anaesthetist was not available, such as in an emergency, an anaesthetist with paediatric skills and competency was used. A paediatric consultant was available at all times. This was consistent with Standards for Children’s surgery – The Royal College of Surgeons, 2013 Standards for Children.

The trust has reported the following planned and actual staffing figures for medical & dental registered staff working in children’s services for the period January 2017 to June 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 17</td>
<td>42.35</td>
<td>43.80</td>
</tr>
<tr>
<td>February 17</td>
<td>42.35</td>
<td>43.80</td>
</tr>
<tr>
<td>March 17</td>
<td>43.85</td>
<td>43.80</td>
</tr>
<tr>
<td>April 17</td>
<td>43.65</td>
<td>44.25</td>
</tr>
<tr>
<td>May 17</td>
<td>43.45</td>
<td>43.65</td>
</tr>
<tr>
<td>June 17</td>
<td>43.65</td>
<td>42.45</td>
</tr>
</tbody>
</table>

As at June 2017, there were 1.2 WTE more staff in post than the trust had planned to provide safe care.  
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

Between July 2016 and June 2017 the trust reported an over establishment by 0.4% for medical and dental staff in children’s services;
- Tunbridge Wells Hospital: -0.4%
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

Between July 2016 and June 2017, the trust reported an average turnover rate of 1.1% for medical & dental staff in children’s services.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

Between July 2016 and June 2017 the trust reported an average sickness rate of 3.9% for medical & dental staff in children’s services, which is above the overall trust target of 3.3% for sickness rates.
**Staffing skill mix**

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

**Staffing skill mix for the 40 whole time equivalent staff working in Children’s services at Maidstone and Tunbridge Wells NHS Trust**

![Chart showing staffing skill mix]

(Source: NHS Digital)

**Records**

All the records we reviewed in all the paediatric departments had multidisciplinary medical records, completed by everyone associated with their care. We reviewed five sets of medical records on. All of these had the relevant information recorded such as patient details, diagnosis and management plan, observation charts and assessment of nutritional status where applicable. Staff were therefore able to obtain the correct information and provide the plan of care to the patients. They were comprehensive and easy to read. Records were kept securely in lockable trolleys.

All test results were accessible on the computer system and recorded in the medical records along with risk assessments and specific condition care plans.

Both hospital sites used the same system and records were easily transferred between sites when this was required.

There were flags on the electronic system which alerted staff to whether children attending the hospital were under child protection known to social services or the hospital safeguarding team.

Children with complex or long term medical conditions carried health passports, which contained information about medication they may be on.

An electronic discharge notification was sent to a child or young person’s GP on their discharge. This was a summary of care received. Staff also sent a more detailed discharge letter.

Staff encouraged parents to bring in personal child health records (red books), to ease information sharing from hospital to health visitors.

The mental health community team assessed children with mental health needs and this was also recorded in the multidisciplinary record.
Medicines
Medications were stored securely including medication fridges that were locked. Fridge maximum and minimum fridge temperatures were checked daily and this was recorded to ensure that medicines were stored in accordance with manufacturers’ recommendations.

Controlled drugs were stored in accordance with legislation and there were regular stock checks of controlled drugs. Staff carried out an additional check of controlled drugs daily and we saw records to indicate this was the case.

Local topical anaesthetic creams cause numbness to the area where they are applied. They were applied to children and young people who required a cannula to be inserted into their vein for the administration of an anaesthetic or blood sampling. Topical creams and oral painkillers such as paracetamol and ibuprofen were covered under a patient group direction. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

Since the last inspection in 2015, training and sign off, of competencies for staff to administer these drugs had improved and was only administered by staff with authorisation to use the direction in line with the trust’s policies.

Staff had access to national formularies such as the British National Formulary for Children and a local electronic formulary detailing the preferred antibiotics for specific infections.

The service followed neutropenia guidelines that were accessible by computer and were up to date. Children were administered antibiotics within an hour of diagnosis and this was overseen by specialist oncology nurses, one of which was always on duty.

There was also a paediatric sepsis guideline and antibiotics were administered within an hour. This process was a Performance of Commissioning for Quality and Innovation target that is a national framework for locally agreed quality improvement schemes. Commissioners monitored the achievement of local quality improvement goals and targets, this goal had been met for the last quarter.

Paediatricians reviewed medication on ward rounds and clinical areas were supported by daily visits from a paediatric pharmacist. The pharmacist showed us how they reviewed drug sheets and how they denoted any questions or instruction on the record for the attention of the attending paediatrician. There was good communication between the pharmacist and clinicians and this demonstrated that dosages, length of time of treatment, contraindications and drug interactions were monitored by the pharmacist and acted upon. The pharmacist also monitored antimicrobial prescription.

Medication records recorded children’s weight and allergies.

Advice was provided to carers about any medication on discharge. This included the patient passport which documented what medication had been administered and when it was next due. There was space for carers to continue to record medication at home so that the carer could monitor regularly required medication and analgesia, to provide the most effective recovery.

Incidents
The staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses.

Staff told us they were encouraged to report incidents and there was a no ‘blame culture’ associated with reporting incidents.
Incidents were recorded on the trust’s electronic system and there were systems in place to investigate and take action. Staff could request feedback. In addition to this, staff received feedback at staff meetings and we saw minutes of meetings to indicate this was occurring.

National patient safety alerts were shared via email and action would be taken dependent on the subject of the alert. For example, the pharmacist would deal with any relating to medicines and informed staff of the outcome of any action.

From January to December 2017, 303 incidents were reported in the children’s and young people services.

**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 children’s services.

*Source: Strategic Executive Information System (STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England between September 2016 and August 2017.

The breakdown of incident type was:

- Pending review (a category must be selected before incident is closed) with one (50% of total incidents). We saw a root cause analysis of this incident, which clearly identified change made because of this incident and the subsequent investigation findings.
- Medication incident meeting Serious Incident criteria with one (50% of total incidents).

*Source: Strategic Executive Information System (STEIS)*

All child deaths were discussed at the child death overview panel which provided a report to the trust mortality surveillance group. We saw themes and trends were highlighted and learning and actions produced. An example of change as a result of an investigation was that a paediatric representative had been put in place on the end of life steering group and pain group.

The duty of candour is a regulatory duty relating to openness and transparency. It 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. Staff we spoke with had a good knowledge of the duty of candour and, senior staff were clear about their responsibilities in relation to the duty of candour.

**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, falls with harm or catheter urinary tract infections between August 2016 and August 2017 for children’s services.
(Source: NHS Digital)

There was a paediatric safety thermometer in use in all paediatric departments.

**Is the service effective?**

**Evidence-based care and treatment**

The provider used evidence based guidance to assess and care for patients. Trust policies were evidence based and referenced professional and national guidance. These were all on an electronic system which all staff could access. All care pathways were also on this system and could be printed off for individual patients.

The service carried out a number of audits, which had resulted in a change in practise and had re-audited to see the impact of the change. For example: An audit of safeguarding children; Investigation children with fractures on skeletal survey; audit of paediatric early warning scores; audit of the management of febrile neutropenia patients; audit of paediatric transfers to tertiary centres; and an audit of safeguarding children; medical letters. In the last audit, inconsistencies in child protection reports led to the implementation of a proforma.

Audits to demonstrate compliance with National Institute of Health and Care Excellence (NICE) guidelines were carried out. For example: An audit of the management of deliberate self-harm in children who present to the Emergency Department clinical guideline (CG) 16 and diabetes service compliance with NICE 2015 Guidelines: Prospective Audit/ NICE NG18 & 19; Diabetes (type 1 & type 2) in children and young people: diagnosis and management including diabetic foot problems.

Sepsis screening and the management of paediatric patients was in line with national guidance. There were sepsis guidelines and inpatient sepsis was one of the Commissioning for Quality and Innovation national goals that the trust was measured on. The trust met this target in the last quarter.

All children diagnosed with sepsis were administered antibiotics within an hour. If these patients were in Maidstone hospital they had antibiotics administered before transfer to the Tunbridge Wells Hospital at Pembury paediatric inpatient ward. There were also neutropenia guidelines which meant antibiotics were provided within an hour and were managed by the lead oncology nurses who are available 24 hours a day, seven days a week. This was in line with National Institute Health and Care Excellence, NG52; Sepsis: recognition, diagnosis and early management.

No paediatric patients detained under the Mental Health Act were nursed at Maidstone hospital.

**Nutrition and hydration**

A variety of food was available for children on the ward to suit all age groups. Staff could contact the kitchen for any specific dietary requirements.

Care plans included nutrition and hydration assessments and staff could refer children to a paediatric dietician, who was located within Riverbank unit, to assess and manage any specific dietary needs.
Children were starved from two to four hours depending on the procedure and in line with national guidelines. If children were delayed, going to theatre, staff would ensure they continued to receive fluid. Nutrition was also considered and staff could sucrose to ensure children’s sugar levels were maintained in patients before surgery to assist their recovery.

**Pain relief**

Pain management was evidence-based and provided guidance on managing varying levels of pain including the use of sucrose, paracetamol and pain relieving drugs.

Children admitted to the day case unit had pain assessments. Staff used a behavioural pain assessment tool, which looks at facial expressions and postures for non-verbal patients; a self-reporting tool, which was pictures of faces ranging from a happy face to a sad face and visual analogue tool. A visual analogue scale is a tool to help patients identify a level of how they are feeling and would, for example be a score of one to 10.

We looked at a selection of records and saw staff routinely assessed children’s pain levels.

There were patient group directions in place for the use of paracetamol and ibuprofen and administration of local anaesthetic prior to cannula insertion. Staff had the appropriate training and had a competency assessment before being able to administer medications under a patient group direction.

Maidstone Hospital had a play therapist five days a week. The play therapist provided distraction techniques and prepared children for any potential painful procedures. We saw the treatment room was well equipped with toys, book and bubbles to provide distraction.

**Patient Outcomes**

The service regularly reviewed the effectiveness of care and treatment through local and national audits. In May 2017, the service carried out an audit of paediatric endoscopy. The audit was to look at performance in terms of indications for the endoscopy and safety in performing upper and lower gastrointestinal endoscopy. The audit also looked at waiting times and the service assessed the results in line with national averages for paediatric endoscopy.

The trust completed the British Thoracic Society (BTS); National Paediatric Community Acquired Pneumonia Re-Audit in 2017 and the Irritable bowel Disease Audit in January 2017.

The trust participated in the National Paediatric Diabetes Audit, annually in line with the healthcare quality improvement partnership.

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows in the 2015/16 diabetes audit for Maidstone Hospital performed similar to the England average. There were fewer patients having an HbA1c value of less than 58 mmol/mol compared to the England average and the mean HbA1c was similar the England average.

All audits compared results against expected standards in line with guidance or national averages. If the standard was not met or the score was worse than the national average, an action plan was drawn up to address the issues, which we saw in each care.
Readmission rates for surgical patients were better than the average of other hospitals in the region. Maidstone and Tunbridge Wells had a 4.4% readmission rate which was better than the regional average of 6.5%.

**Competent staff**

We saw staff were competent to perform their roles, attended regular supervision training and had regular appraisals. Leadership development training was available to staff, which was encouraged by managers.

**Appraisal rates**

Between April 2017 and July 2017, 87% of staff working within services for children and young people (88% for staff in paediatrics and 87% for staff in neonates) within the Women’s and Children’s division at the trust had received an appraisal compared to a trust target of 100%.

The 81% appraisal rate applies to nursing and midwifery registered staff.

The 96% appraisal rate applies to medical & dental staff.

The 95% appraisal rate applies to NHS infrastructure staff

The 88% appraisal rate applies to support to doctors and nursing staff.

The appraisal rate for staff working in children’s services in Maidstone Hospital was 88%

(Source: Trust Provider Information Request P46)

All patients were cared for by registered paediatric nurses. There were also 11 specialists nurses for specific conditions such as diabetes, gastrointestinal conditions, oncology, asthma, epilepsy, cystic fibrosis and endocrinology.

We saw comprehensive competency documents for medication management, patient group directives, insertion of cannulae into veins and assessment tools which staff had to complete before sign off, by a senior member of staff. We saw training records to show staff had training to cover the scope of their work.

Learning needs for staff were identified through their annual appraisal and when new skills were required. For example, since the increase in mental health patient admissions, mental health training and conflict resolution training had been provided. A clinical educator supported staff in their roles and developed training, specific for staff working in children’s and young people’s services.

There was documental evidence to show that appraisals and revalidation was taking place. Staff had regular clinical supervision sessions, which could be both one to one or in a group.

Agency staff received an induction and the service regularly used the same agency staff as they knew they had completed the induction. Agency nurses were also required to complete a drug assessment, prior to being allowed to give drugs.

All children referred to the ambulatory care unit with an acute medical problem were seen by a consultant prior to discharge. The unit had access to a consultant during its opening hours. Specialist paediatricians were available for telephone advice.

**Multidisciplinary working**

There was evidence of good multidisciplinary working both within the trust and with external stakeholders.
We observed staff working well together during our visit. They also worked well with multidisciplinary teams within the hospital and with other outside services in order to provide the best care possible for their children and young people.

Our review of five medical records, confirmed there were effective multidisciplinary working practices, which involved nurses, doctors, physiotherapists, and pharmacy. Staff told us they felt supported by and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe.

**CQC Children’s survey 2014 – Q36**

In the CQC children’s survey 2014, the trust scored 8.48 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts.

(Source: CQC Children’s Survey, RCPCH)

Qualified play specialists were available in all areas where children and young people would be seen and treated. Play specialists were available during the opening times of the unit and outpatient department.

The service had established links with children’s social service teams and staff could access advise from paediatric services at other hospitals.

When children and young people were transferred from the service, information was shared with relevant community health professionals to ensure consistent coordinated person centred care was delivered.

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment.

When children were discharged a letter was sent to the patient’s general practitioner by direct email to ensure the GP was fully aware of diagnosis, treatment and what medication had been prescribed in a timely manner.

Staff gave children a children’s passport when they were discharged. This was a record of what medication they were on, when it was last administered and when next due. There was also space for parents to continue the medication record to ensure medication was provided timely and correctly and to manage pain as effectively as possible.

**Seven-day services**

There was seven day access to diagnostic services such as x-ray, ultrasound, computerised tomography, magnetic resonance imaging, echocardiography, endoscopy and pathology.

The unit had access to pharmacy advice 24 hours a day seven days a week.

**Health promotion**

Staff identified children, young people and their families who may need additional support, for example, children and young people living in vulnerable circumstances and children and young people at risk of developing long term conditions. Staff were able to signpost patients and their carers to support services or directly refer them to services.

Throughout the Riverbank unit and children’s outpatient department, there were posters and literature advertising and supporting national public health initiatives.
Staff routinely asked parents about smoking and alcohol intake and could refer to smoking cessation advice if required.

We saw posters and leaflets promoting, vaccinations, Health Start initiatives which provide advice on nutrition, ‘Smoke free’ posters, ‘Change for Life’ advise on lifestyle and posters advising on how to recognise meningitis and sepsis.

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

Staff demonstrated an understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005, with regard to children over 16 years and the Children Acts 1989 and 2004.

Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff understood and assessed children for Gillick competency and where appropriate signed consent forms, counter signed by their parents.

Fraser Guidelines were set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985) and apply specifically to contraception. They are used to decide whether a girl of 16 or under can be given advice or treatment without the consent or knowledge of her parents.

Staff we spoke with had a good understanding of Gillick competence, Fraser guidelines and gaining consent from children. They gave us numerous examples of where they spent time to fully explain procedures to children, before gaining consent, giving them time to consider their decisions and advising them to discuss with their parents, when this was appropriate.

**Other CQC Survey Data**

**CQC Children’s Survey Data**
The trust performed about the same as other trusts in all of the questions relating to effective in the CQC children’s survey 2014

**CQC Children’s Survey questions, effective domain, Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Subgroup</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Did a member of staff agree a plan for your child’s care with you?</td>
<td>E1</td>
<td>0-15 adults</td>
<td>8.56</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41. Do you think the hospital staff did everything they could to help ease your child’s pain?</td>
<td>E1</td>
<td>0-15 adults</td>
<td>8.23</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34. Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>E3</td>
<td>0-15 adults</td>
<td>8.20</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>36. Did the members of staff caring for your child work well together?</td>
<td>E4</td>
<td>0-15 adults</td>
<td>8.48</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33. Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>E5</td>
<td>0-15 adults</td>
<td>7.33</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Is the service caring?

Compassionate care

We observed staff actively engaging with children and their families. We saw compassionate and caring interaction and staff were skilled in talking and caring for children and young people.

Care from nursing and medical staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth. We saw staff respond to call bells in a timely manner.

Parents we talked with spoke highly of the support they received from staff. This was particularly important to the parents of children with ongoing conditions which meant regular visits to the paediatric services across all departments.

Staff referred to children’s bed areas as ‘safe spaces’ so no procedures were carried out there, to minimize anxiety, whilst they were in the unit.

We observed the play therapist investing time with a child to help keep them settled while their parents were away.

Staff gave us an example of supporting a child having a procedure carried out regularly, who was becoming increasingly anxious. They told us they found out the child’ favourite thing was fairies and ensured there was a of fairy dust from the main entrance to the bed. A fairy letter had been left on the bed, encouraging the child to have treatment. This led to reducing the child’s anxiety about the procedure.

CQC Children’s survey 2014

The trust performed about the same as others in the England average for 13 out of 14 questions relating to compassionate care in the CQC children’s survey 2014. The trust performed better than other trusts for ‘was your child given enough privacy when receiving care or treatment’.

CQC Children’s Survey questions, compassionate care, Maidstone and Tunbridge Wells NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Overall… (please circle a number)</td>
<td>C1</td>
<td>0-15 adults</td>
<td>8.28</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>KLOE</td>
<td>Sub-group</td>
<td>Trust Score</td>
<td>RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td>-----------</td>
<td>-------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>35. Were members of staff available when you or your child needed attention?</td>
<td>C1</td>
<td>0-15 adults</td>
<td>8.12</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>8. Was your child given enough privacy when receiving care and treatment?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.72</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>9. Did you think there were appropriate things for your child to play with on the ward?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.27</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>10. Did staff play with your child at all while they were in hospital?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>5.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>11. Did new members of staff treating your child introduce themselves?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.27</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40. Do you feel that the people looking after your child listened to you?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.42</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41. Do you feel that the people looking after your child were friendly?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.87</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42. Do you feel that your child was well looked after by the hospital staff?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.75</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43. Were you treated with dignity and respect by the people looking after your child?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.14</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9. Were you given enough privacy when you were receiving care and treatment?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18. Do you feel that the people looking after you listened to you?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.05</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19. Do you feel that the people looking after you were friendly?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.44</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>20. Overall… (please circle a number)</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>8.28</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

**Key:**
- Better than other trusts
- About the same as other trusts
- Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)

**Emotional support**

**CQC Children’s survey 2014**

The trust performed about the same as other trusts for all three questions relating to emotional support in the CQC children’s survey 2014.

**CQC Children’s Survey questions, emotional support, Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Did a member of staff tell you what to do or who to talk to if you were worried about your child when you got home?</td>
<td>C3</td>
<td>0-7 Adults</td>
<td>8.01</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Children were admitted by a children’s nurse or nursery nurse to the ward who escorted the parent and child to the operating department. The child and a parent were then transferred to the care of a theatre practitioner and the parent was allowed into the anaesthetic room until the child was inducted. Parents could wait in a waiting area, return to the ward or go to get refreshments. Staff would contact parents when the child was coming out of theatre, so they could wait in the recovery area and be there when the child woke up.

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

Feedback forms were available for children, young people and their families to complete. They had a section where parents and children could comment on what was good and what could be done better. These were used to review services and make improvements.

**CQC Children’s survey 2014**

The trust performed about the same as other trusts for all 19 questions relating to understanding and involvement of patients and those close to them in the CQC children’s survey 2014.

**CQC Children’s Survey questions, understanding and involvement of patients, Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Did hospital staff tell you what was going to happen to your child while they were in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.32</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>27. Did members of staff treating your child, give you information about their care and treatment in a way that you could understand?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.96</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29. Did you have confidence and trust in the members of staff treating your child?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.87</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>30. Were you encouraged to be involved in decisions about your child’s care and treatment?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.54</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31. Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.21</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32. Did staff ask if you had any questions about your child’s care?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.12</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38. Did a member of staff tell you what would happen next after your child left hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.79</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Age Group</td>
<td>Percentage</td>
<td>Comparison</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>43. Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure?</td>
<td>0-15 adults</td>
<td>9.01</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>44. Before the operation or procedure, did a member of staff answer your questions about the operation or procedure in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.15</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>45. After the operation or procedure, did someone explain to you how the operation or procedure had gone in a way you could understand?</td>
<td>0-15 adults</td>
<td>8.87</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>47. Did a member of staff give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.29</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>48. Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>7.20</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
<tr>
<td>50. Did hospital staff talk to you about how they were going to care for you in a way that you could understand?</td>
<td>8-15 CYP</td>
<td>8.83</td>
<td>About the same as other trusts</td>
<td></td>
</tr>
</tbody>
</table>
In the CQC children’s survey 2014 the trust scored 8.56 out of ten for the question ‘Did a member of staff agree a plan for your child’s care with you?’ This was about the same as other trusts other trusts.

(Source: CQC Children’s Survey, RCPCH)

Young people could access transitional care from 11 years of age. Transitional care gave adolescents and parents empowerment and supported to make decisions about their future care. Parents were encouraged to be involved in the care of their babies and children as much as they felt able to. Parents were encouraged to visit and spend time with their children by staff.

Parents told us staff kept them well-informed throughout their child’s treatment. Parents were allowed in the anaesthetic room and in the recovery area once the child had regained consciousness.

Parents were encouraged to provide as much care for their children as they felt comfortable but were also able to take a break with the assurance their child would be well cared for.

Children and parents we spoke with felt they had been involved in care and decisions made around their child’s treatment. Parents and children were very positive about the care received. One parent commented they ‘were really well informed and very impressed with the service” and commented ‘this would be so stressful without the support of the staff”.

**Is the service responsive?**

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

Riverbank Children’s Unit was a paediatric ambulatory and day-case ward consisting of 12 beds at Maidstone Hospital. Children and young people would be admitted to Riverbank for day-case surgery or having been referred to paediatrics from the emergency department, general practitioners or for further investigations. If the patient needed an overnight stay then they will be transferred to Hedgehog Ward at Tunbridge Wells Hospital.

Children and young people who attended the units for ambulatory care or day case surgery were lower risk patients. Children or young people at risk of developing complications following surgery or who were more unwell would be sent to the Tunbridge Wells Hospital at Pembury.

There were pre-assessment clinics for children scheduled to be admitted for elective surgery.

There were dedicated children theatre lists at Maidstone hospital. If children or young people were scheduled on speciality list, they would be scheduled first on the list.

Pharmacy were available Monday to Friday during working hours, Saturdays 9:00 am until 4:00 pm and Sundays and bank holidays 10:00 am until 4:00 pm. Physiotherapists, occupational therapists, and dieticians were available Monday to Friday during working hours.

The Riverbank unit was redesigning its playroom area at the time of inspection and had involved children in its redesign. Children had contributed to the decoration of the unit.

The outpatient area was for children only and its design, layout, furniture and decoration reflected this. It unit had its own reception and waiting area.

Parents had access to the kitchen in order to prepare themselves refreshments, this was key pad access.
The trust performed about the same as other trusts for three out of four questions relating to responsiveness in the CQC children’s survey 2014. The trust performed better than others for ‘How would you rate the facilities for patients or carers staying overnight?’

**CQC Children’s Survey questions, responsive domain, Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15</td>
<td>Adults</td>
<td>9.48</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39. How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15</td>
<td>Adults</td>
<td>8.17</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>2. Did the hospital give you a choice of admission dates?</td>
<td>0-7</td>
<td>Adults</td>
<td>2.52</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>3. Did the hospital change your child’s admission date at all?</td>
<td>0-7</td>
<td>Adults</td>
<td>9.04</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

**CQC Children’s Survey Data – Q53**

In the CQC children’s survey 2014 the trust scored 10.00 out of ten for the question ‘For most of their stay in hospital what type of ward did your child stay on?’ The measure is if children spent most of their time of a children’s ward rather than an adult ward. This was about the same as other trusts.

(Source: CQC Children’s Survey, RCPCH)

**Meeting people’s individual needs**

Parents were able to visit at any time on the paediatric wards and translation services were available for patients and parents who did not speak English as their first language should this be required.

A play therapist was available four days a week and we observed the play therapist working with children. They also ran sessions for children experiencing emotional difficulties. For example there was a session for children with needle phobia that had proven to be very helpful. This was particularly helpful for those children regularly attending ambulatory care for regular injections, blood tests or intravenous therapy.

The comprehensive assessment of children, including a history of any past or current mental health problems alongside the assessment of their physical health needs also meant that the paediatric unit managed a number of patients with emotional needs specifically around care such as needle phobia. The play therapists also ran sessions with children with other phobias that were affecting their life such as toilet phobias etc.

There were a number of leaflets available to patients and parents on the unit.

When children reached an age where to move from paediatric to adult care this was managed, taking into account their personal circumstances and needs. For example paediatric oncology patients were not transferred to adult care until their treatment was completed.
The introduction of a play therapist was a marked improvement and staff and children we spoke to commented very favourably on the difference this had made to their hospital experience and how they managed their current treatment or long term conditions.

For the last three years when children are approaching transition to adult care the service have used the “ready steady go programme” for over 11 years old with a long-term condition. The programme is designed to help children and carers to gain the knowledge and skills to manage their condition.

**Access and flow**

Children attended the ambulatory care unit in three ways. They could be referred from the paediatric emergency department or ambulatory care unit or from their general practitioner.

The unit was challenged by the volume of children referred from general practitioners with diagnoses such as a cold, a headache or tonsillitis and by the volume of children returning by appointment for treatment. The service was working with general practitioners to support them in assessing whether children and young people needed to be admitted or could be looked after in their own homes.

Children were admitted for theatre in the morning for the morning list and at 12.00 hrs for the afternoon list. There were dedicated children lists but if children were scheduled on a mixed list they were prioritized to be first on the list.

Children were admitted to the Riverbank day care unit via consultant planned booking.

Children admitted to the unit with an acute medical problem were seen by a paediatric doctor within four hours of admission.

General practitioners assessing or treating children with unscheduled care needs had access to immediate telephone advice from a consultant paediatrician.

The service provided a consultant paediatrician-led rapid access service so that any child referred for this service could be seen within 24 hours of the referral being made.

The acute service was supported by a community children’s nursing service. As the community nurses were a part of the acute children’s nursing team, pathways were common from hospital to home and care within the community.

**Neonatal Critical Care Bed Occupancy**

The critical care bed occupancy is at zero percent for the whole time period between July 2016 and June 2017.

(Source: NHS England)
Learning from complaints and concerns

Summary of complaints

Between July 2016 and June 2017, there were ten complaints about children’s services. The trust took an average of 51.1 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be completed within 25 days. Complex complaints have a completion target of 60 days.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Information was available for patients to access on how to make a complaint and how to access the Patient Advice and Liaison Service. A dedicated member of staff in the clinical area, including the matron and clinical director, reviewed all formal complaints received and concerns raised with Patient Advice and Liaison Service. All concerns raised were investigated and there was a centralised recording tool to identify any trends emerging. Learning from complaints was disseminated to the team to improve the patient experience.

Information was readily available for patients who wished to make a complaint, but who needed support to do so.

We reviewed a spreadsheet that recorded all complaints about the children and young person’s service from October 2016 to October 2017.

There was evidence that the complaints were managed appropriately and people were treated compassionately and supported. In addition to this, there was evidence the complaint was investigated thoroughly and was formally recorded.

The unit provided forms for children and parents to answer questions in accordance with the ‘Friends and Family’ test for children in an accessible way.

Is the service well-led?

Leadership

There had been significant improvement in the children and young person’s core service since the last inspection.

We found a strong leadership team, driven to improve services, who encouraged and managed change well.

The matron reported to the Associate Director of Operations for women’s, children’s and sexual health and professionally supported by the Head of Midwifery. The Associate Director of Operations and the Head of Midwifery reported to the Chief Operating Officer.

The ward managers reported to a matron who directly line managed the ambulatory unit managers, neonatal unit managers, advanced nurse practitioners, community team manager, clinical educator and specialist nurses. A business case had been put in to employ another matron.

The directorate organisational structure was that each ward and outpatient area had band 6 nurses that reported to two ward managers. There was one for ambulatory and day care across both sites and one for inpatient care at the Tunbridge Wells Hospital at Pembury.

Staff told us the matron was very visible across the directorate and the chief nurse attended paediatric directorate meetings.

The service leads demonstrated an understanding of their challenges around growing volumes and changing demands within the health economy and had reviewed the competence
requirements of their staff to meet this demand. This was evident in their discussions with commissioners to work in partnership to address the issues of changing demand and needs in the community.

**Vision and Strategy**

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

We saw poster displays and other publications about the vision and values as we visited the wards. These were readily available for staff, patients and the public to view. In addition to information published for staff on the trust intranet, the trust published information about its mission, values and vision on its public website.

The trust’s started purpose was to provide safe, compassionate and sustainable health services and its vision to provide the highest, consistent, quality care to patients, whether in or outside hospital setting.

We saw values statements based on the word “PRIDE”, which meant “Patient First, Respect, Innovation, Delivery and Excellence”. Staff we spoke to were able to describe these statements and give examples that described an improving safety culture, better clinical leadership and governance.

There was a children’s strategy in place and staff we spoke to demonstrated their commitment to improving child health experiences and outcomes.

There was evidence of the staff’s commitment to the mental health and emotional wellbeing of children and their carers in day to day activity within the service.

**Culture**

Staff we spoke with told us they were supported and felt valued. They thought highly of the matron who they said was very visible supportive and kept them well informed.

There appeared good communication between matron level and associate directors but evidence of some disconnection above this level in regard to trust wide and national strategies.

The culture was centred on the needs and experience of children and their carers and this was evident in some of the initiatives introduced both on the wards and neonatal unit.

Staff we spoke to both on inspection and in focus groups were proud of the trust and how it had risen to the challenges they faced.

There appeared an open and honest culture with staff prepared to say when things went wrong and what needed improving.

Staff were appraised and had opportunity to discuss their development needs. Most were satisfied with how their development needs were being met and gave us examples of how this was being achieved. They understood the limitations the trust had due to financial pressures and were supportive of the trust. A number of staff within focus groups did feel there was a disparity in that doctors had protected training time where nurses did not.

There had been an increased awareness in the well-being and safety of staff. The trust had a counselling service available to staff and we saw examples where this had proved useful in any areas were staff may have been traumatised by a work event. The staff also praised the security staff for their support.

**Governance**

176
The governance structure was led by the chief nurse. Reporting to the chief nurse was the trust ethicist, the associate director for quality governance, and deputy chief nurses.

The patient safety manager, health and safety advisor, trust solicitor, complaints and patient advice and liaison services manager, audit and innovation lead and the research and development manager reported to the associate director for quality governance.

A monthly integrated performance report from the directorate was provided to the Quality and Safety Committee and we saw minutes of these meetings.

The directorate was represented at the board who received reports on safeguarding of children.

The associate director of nursing maternity, women and children’s services along with the associate director of operations for children, women and sexual health led the children’s and young person’s service and they reported to the chief operating officer (COO).

**Management of risk, issues and performance**

The management of risk issues and performance was standardised throughout the trust. Performance dashboards for each division were standard across the trust and divisions produced monthly reports which went to the board.

Staff could raise a risk to the risk lead in their area, who would put it on the electronic risk register.

Senior staff members were aware of the risks related to mental health and emotional wellbeing in relation to the service. This has been documented on the risk register.

There was a good understanding of potential risks such as seasonal fluctuations and changing demands in the health economy. There was also a good awareness of the financial challenges the trust had.

Winter management plans included children and young people services with escalation policies and processes to provide more beds and staff as required. This also applied to summer pressures where incidents relating to effects of a heat wave had been implemented as demand rose due to being on the coast and in surge of holiday makers.

Reports on antimicrobial prescribing and sepsis management were escalated to the board through the trust’s governance framework.

There was a systematic programme of clinical and internal audit to monitor quality.

**Information Management**

We saw that information was cascaded upwards though the reporting lines and meetings to the senior management team and we saw minutes of meetings to this effect. There was evidence of information being shared with clinicians and other operational staff.

However, there appeared to be a break in the flow of information from the executive team reaching associate director level and beyond. We noted a number of national initiatives and information which we were aware had been circulated to chief nurses that at directorate level they were unaware of.

The directorate regularly reported on mental health to the board.

**Engagement**

Feedback from children, young people and parents was actively sought through surveys.
The Riverbank unit had a “Did your child get great care today” or “Did your baby get great care today” form for parents to complete or alternatively they could rate and review their child’s care online.

There were two types of forms for children to complete that had written a pictorial answers for children. All had a section where parents and children could comment on what was good and what could be done better. These were used to review services and make improvements.

The leadership team were aware of the challenges to children and young people services.

**Learning, continuous improvement and innovation**

The children’s’ services carried out regular audits and completed action plans in response to audit results.
The Tunbridge Wells Hospital at Pembury
Urgent and emergency care

Facts and data about this service

We carried out an unannounced inspection of the emergency department at the Tunbridge Wells Hospital at Pembury as part of the new phase of our inspection methodology.

We last inspected the unit in October 2014 and rated it as requires improvement.

Details of emergency departments and other Urgent and Emergency Care services

- Maidstone Hospital
- The Tunbridge Wells Hospital at Pembury

Activity and patient throughput

Total number of urgent and emergency care attendances at Maidstone and Tunbridge Wells NHS Trust compared to all acute trusts in England.

- There were 167,829 attendances between July 2016 and June 2017 at Maidstone and Tunbridge Wells NHS Trust as indicated in the chart above.
- Children attending A&E accounted for 23% of all attendances.
- Attendees arriving by ambulance accounted for a further 23% of all attendances.

(Source: NHS England)

Urgent and Emergency Care attendances resulting in an admission

179
The percentage of A&E attendances at this trust that resulted in an admission fell between 2015/16 and 2016/17. In 2016/17, rates were higher than the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td></td>
<td>29,283</td>
</tr>
<tr>
<td>Discharged*</td>
<td></td>
<td>96,035</td>
</tr>
<tr>
<td>Referred*</td>
<td>35,352</td>
<td></td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,520</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>138</td>
<td></td>
</tr>
<tr>
<td>Left department</td>
<td>5,253</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>452</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>796</td>
<td></td>
</tr>
</tbody>
</table>

^ Includes: to A&E clinic, fracture clinic, other OP, other professional

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training across 13 courses and a completion for information governance at 95%.
A breakdown of compliance for mandatory courses between April 2017 and June 2017 for medical/dental and nursing staff in Urgent and Emergency care is shown below:

Medical and dental staff did not reach the trust target of 95% for information governance with a training completion rate of only 41%. The trust target of 85% were met and exceeded for four of the remaining 13 modules. Blood transfusion had the highest completion rate of 96% while conflict resolution training was not completed by any medical and dental staff member. Low completion rates were reported for dementia awareness (including privacy & dignity standards) (50%) and medicine management (54%).

Maidstone Hospital had a 76% average mandatory training completion rate, below the trust target of 85%.

Tunbridge Wells Hospital had a 72% average mandatory training completion rate, below the trust target of 85%.
Nursing staff did not meet the trust target of 95% for information governance with a completion rate of 89%. The trust target of 85% were met and exceeded for nine of the remaining 13 modules. Conflict resolution and dementia awareness (including privacy & dignity standards) had the lowest completion rates of 76% and 53% respectively.

Tunbridge Wells Hospital had an 82% average mandatory training completion rate, set against a trust target of 85%

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

Safeguarding

Safeguarding training completion rates

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

A breakdown of compliance for safeguarding courses between April 2017 and June 2017 for medical/dental and nursing staff in Urgent and Emergency Care is shown below:
Safeguarding adults level 1 (89%), safeguarding children level 1 (90%) and safeguarding children level 2 (85%) all had completion rates meeting exceeding the trust target of 85%

Safeguarding children level 3 and safeguarding adults did not meet the trust target with completion rates of 81% and 64% respectively.

Tunbridge Hospital had an 84% safeguarding training completion rate, just below the trust target of 85%.

Safeguarding adults level 1 and 2, safeguarding training level 1 and 2 all had completion rates above the trust target of 85%. Safeguarding children level 3 had the lowest completion rate of 79% and did not meet the trust target of 85%.

Tunbridge Wells Hospital had an 83% safeguarding training completion rate, below the trust target.
Staff routinely reported children seen in the department to their health visitor and school nurse. This information was on display at the reception desk. Staff sent all paediatric casualty cards to the children and young person’s safeguarding lead for review.

The administration team completed the details of each accompanying adult who brought a child to the department. The team had implemented this following feedback from clinical staff to help ensure safeguarding. We saw during our observations staff in the paediatric ED confirmed the identity of each person who accompanied a child.

Nurses we spoke with demonstrated detailed knowledge of safeguarding escalation policies as well as how to identify signs a patient or visitor was a safeguarding concern. Staff nurses said they felt confident to in speaking with the senior clinical team about any safeguarding concerns they had, including suspected abuse or female genital mutilation (FGM).

A safeguarding children and young people policy and practice guidance document was available to staff on the intranet and provided guidance and pathways for responding to suspected child sexual exploitation and FGM. However this document was out of date and was due to be reviewed in October 2016. A safeguarding adults at risk of harm policy and procedure was in date and due for review in August 2018.

Cleanliness, infection control and hygiene

The department participated in the national monthly Saving Lives audit. This involved auditing up to four elements of hand hygiene practice, use of personal protective equipment and continuing care bundles for central venous catheter, peripheral lines and urinary catheter care against trust standards. Between November 2016 and October 2017 the emergency department (ED) performed variably with an overall score of 87%. This was an average result and reflected a wide range of monthly compliance between a low of 40% for peripheral line insertion standards in August 2017 to 17 occurrences of 100% achievement. There were 12 instances of missing data, which means the overall average result was limited.

A domestic assistant was based in the ED from 10am to 6pm seven days a week. We spoke with one member of the team who demonstrated good knowledge of infection prevention and control and the safety systems in place to ensure chemicals were used safely.

Environment and equipment

The department participated in the national patient-led assessment of the care environment (PLACE). PLACE enables assessors who have experience of the hospital environment to review the ED against five areas: cleanliness; privacy; condition, appearance and maintenance; dementia and disability. Each category relates to adaptations in the environment that improve accessibility for people. In the 2017 PLACE scores, the ED performed highly in four of five categories:

- Cleanliness 99%
- Privacy, dignity and wellbeing 88%
- Condition, appearance and maintenance 96%
- Dementia 98%
Disability 95%
In each category the ED performed better than the national average and significantly better in the
dementia category (22% higher) and the disability category (13% higher).

The director of infection prevention and control used a weekly environmental care dashboard to
assess the ED against national standards for clinical areas identified as at very high risk of poor
environmental cleanliness. Between November 2016 and November 2017 the ED achieved an
average of 97%, which met the minimum target of 95%.

Construction work was taking place in the ED to provide a new clinical decisions unit (CDU). We
saw construction staff managed risks appropriately such as in the provision of secure dust sheets
to stop contamination in clinical areas. We also saw the ED team were proactive in escalating
concerns about the construction area to the manager.

The design of the majors area meant it was not possible for staff to see all patients in treatment
bays from the clinical stations. This presented a risk that staff would not always immediately notice
if a patient was deteriorating or needed help. To address this staff ensured patients with the
highest level of need, including mental health needs, were cared for in the bays that were visible
from the nurse and doctor stations.

Assessing and responding to patient risk

Emergency Department Survey 2016

The trust scored “about the same” as other trusts for all of the five Emergency Department
Survey questions relevant to safety. Low scores were recorded for: “How long did you wait
before you first spoke to a nurse or doctor?” and “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?” Both questions received a score of 6.2 out of a possible ten.

<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</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>handed over to the emergency department staff?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.2</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</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.7</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>9.7</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 recommends that the time patients should wait from
time of arrival to receiving treatment is no more than one hour. The trust met the standard for all
months over the 12 month period between September 2016 and August 2017.

Performance against this standard showed an even trend over the period. A slight increase in waiting times can be seen over the winter months of November and December 2016, and again in June and July 2017. Performance over the 12 month period was consistently better than the England average.

**Time to treatment between September 2016 and August 2017 at Maidstone and Tunbridge Wells NHS Trust**

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![Graph showing time to treatment between September 2016 and August 2017 at Maidstone and Tunbridge Wells NHS Trust](source: NHS DIGITAL: A&E quality indicators)

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

**The Tunbridge Wells Hospital at Pembury**

Between October 2016 and September 2017 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at The Tunbridge Wells Hospital at Pembury.

The average percentage for journeys with a turnaround time over 30 minutes was 54%. Over the winter months of November and December 2016 and January 2017 percentages increased to above average. An increase in turnaround percentages can again be seen in May and September 2017. Over the period more than half of all journeys consistently had turnaround times over 30 minutes.

Over the period an average of 110 journeys had a turnaround time over 60 minutes. Numbers increased significantly, from 65 in October to 171 in December 2016, showing an increase over the winter period from November 2016 to January 2017. Numbers decreased after this period, reaching a low point of 44 delayed journeys over 60 minutes in March 2017. After March 2017 numbers increased again reaching its highest point of 181 delayed journeys in June 2017. Overall, although there were variances delayed journeys over 60 minutes followed an increasing trend from 65 in October 2016 to 151 in September 2017.

**Ambulance: Number of journeys with turnaround times over 30 minutes - The Tunbridge Wells Hospital at Pembury**
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.

From August 2016 to July 2017 the trust reported 364 “black breaches”, with an upward trend over the period. Over the period an average of 30 black breaches were reported per month. The number of “black breaches” reported showed an increase over the winter months of November and December 2016, reaching the highest number reported in January 2017, with 78 “black breaches” reported. Numbers decreased after this period but escalated again in May 2017 with 55 breaches reported. Insufficient capacity was cited as the reason for 93% of all breaches reported; a further 5% were reported as “cases unknown”.

Comment from trust: “There is some discrepancy between the data presented by SECAMB and the Trust. This has been discussed at the WK A&E Delivery Board and there is to be a joint action plan between SECAMB and the Trust to be in place by September 2017.”

Number of black breaches reported per month
Staff triaged patients to the most appropriate area of the ED based on their level of risk. For example the rapid assessment point (RAP) enabled clinical staff to quickly assess each patient’s level of risk and keep them in an area of observation whilst awaiting a decision to admit. The RAP had capacity for five patients, including one patient in a side room that could be used for isolation. During times of high levels of demand when the RAP was full, the nurse in charge used a standard operating procedure to open an escalation area in a corridor. The nurse in charge or the matron would become responsible for these patients and coordinate transfers as quickly as possible with the bed manager. The escalation area was used for patients who were medically stable.

The trust had taken action to ensure they followed updated 2016 Resuscitation Council guidance that resuscitation medicines be kept locked away. For example, medicines kept as part of resuscitation trolleys and kits were stored in tamper-proof or tamper-evident containers that were tagged and checked daily by staff. However, the ED had a consistently poor performance record in monthly resuscitation trolley audits. For example between March 2017 and August 2017, none of the four resuscitation trolleys in the resuscitation bay met the trust’s minimum standards. This related to missing monitor leads. The resuscitation team carried out a project in August 2017 to trace missing leads and in November 2017 all four trollies met the trust standard for equipment. However trollies in ED majors and minors that were rated compliant in August failed against trust standards when they were audited in November 2017. Between January 2017 and November 2017 expected audits were not carried out on 45 occasions.

A nurse practice educator carried out a monthly audit of practice of triage nurses. This reviewed adherence to triage standards including establishing and documenting 10 key criteria such as the presenting complaint, allergies and observation.

Nurse-led triage was available 24-hours seven days a week and this nurse carried out an initial clinical assessment of each patient who arrived in the department without paramedic transport. However from looking at the results of triage nurse audits it was not evident triage nurses always escalated serious conditions or deteriorating patients effectively. For example in April 2017 an audit noted a triage nurse did not refer a patient who presented with symptoms of a stroke to the stroke team and incorrectly calculated a Manchester triage score.

All doctors working in the ED had up to date advanced trauma life support, paediatric life support and/or advanced life support training and all nurses and clinical support workers (CSWs) had
basic life support training. CSWs completed a hospital life support programme that provided additional instruction for those working in acute settings.

All ED nurses completed paediatric life support training based on their grade and level of responsibility. For example staff nurses and senior staff nurses completed paediatric immediate life support training. Senior nurses completed the European paediatric advanced life support course.

Staff used the paediatric early warning scores system to trigger an escalation of care for deteriorating children.

Staff carried out a risk assessment for venous thromboembolism for each patient seen in the ED.

A triage audit in September 2017 in the paediatric ED found variable completion of risk assessments to trust standards. For example 74% of patients had a PEWS score calculated and 88% had a safeguarding risk assessment.

Nurse staffing

The trust reported their staffing numbers below for the period April 2017 and June 2017.

There is a difference in the number of staff in post compared to what was planned by the trust, for the most recent month of June 2017, the data shows there were 46.85 less nursing staff in post then what the trust planned for to provide safe care.

The numbers below are for qualified nurses described by the trust as either qualified nursing midwifery staff or qualified nursing and health visiting staff.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>210.71</td>
<td>171.54</td>
</tr>
<tr>
<td>May 2017</td>
<td>209.71</td>
<td>173.60</td>
</tr>
<tr>
<td>June 2017</td>
<td>218.5</td>
<td>171.64</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>638.92</strong></td>
<td><strong>516.78</strong></td>
</tr>
</tbody>
</table>

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

Vacancy rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a vacancy rate of 15.7% in urgent and emergency care:

- Maidstone Hospital: 16.9%
- Tunbridge Wells Hospital: 16.9%
- Other: -3.3%

There is an over establishment of nursing staff associated to the other site category, which is why there is a minus figure related to vacancy.

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

The figures submitted by the trust were different to the vacancies the senior team understood they had and the matron said they had a 29.5% vacancy rate for band five nurses.
Turnover rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a turnover rate of 0.7% in urgent and emergency care;

- Maidstone Hospital: 0.7%
- Tunbridge Wells Hospital: 0.7%
- Other: 0.6%

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

Sickness rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a sickness rate of 4.5% in urgent and emergency care;

- Maidstone Hospital: 3.8%
- Tunbridge Wells Hospital: 4.9%
- Other: 5.9%

The location named as other has the highest sickness rate amongst nursing staff.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

Between July 2016 and June 2017, the trust reported a bank and agency usage rate of 94% in urgent and emergency care;

- Maidstone Hospital: 92%
- Tunbridge Wells Hospital: 93%
- Other: 96%

For qualified nurses there was a total of 6,978 shifts over the 12 months up to June 2017, of which bank staff were used to cover 40% of shifts, agency staff were used to cover 3,675 shifts and a total of 506 shifts (on average 42 a month) were unfilled within this time frame.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

A team of four paediatric nurses provided care in the paediatric emergency unit and worked cross-site at Maidstone Hospital. Emergency nurse practitioners worked in the minors unit from 8am to 12am seven days a week.
Two nurses were assigned to the resuscitation bay each shift but this was sometimes reduced to one nurse if help was needed with a transfer. Staff we spoke with said this was the most common staffing concern in the department.

We observed a nursing handover and looked at the records of seven handovers. We found in each case staff identified patients with safeguarding, mental health or complex needs and prioritised them for clinical review. The senior team also used this system to escalate staff shortages and to book bank or agency staff to resolve this.

**Medical staffing**

The trust reported their staffing numbers below for the period April 2017 and June 2017.

There is a difference in the number of staff in post compared to what was planned by the trust, for the most recent month of June 2017, the data shows there were 40.65 less medical and dental staff in post than what the trust planned for to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2017</td>
<td>197.87</td>
<td>144.40</td>
</tr>
<tr>
<td>May 2017</td>
<td>197.86</td>
<td>147.00</td>
</tr>
<tr>
<td>June 2017</td>
<td>187.25</td>
<td>146.60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>582.98</strong></td>
<td><strong>438.00</strong></td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a vacancy rate of 19.4% in in urgent and emergency care;

- Maidstone Hospital: 16.6%
- Tunbridge Wells Hospital: 21.9%

There is a higher medical and dental vacancy at Tunbridge Wells hospital compared to Maidstone Hospital.

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

**Turnover rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a turnover rate of 1.7% in in urgent and emergency care;

- Maidstone Hospital: 1.7%
- Tunbridge Wells Hospital: 1.6%

There is a higher medical and dental vacancy at Maidstone Hospital compared to Tunbridge Wells hospital.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)
**Sickness rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

As at June 2017, the trust reported a sickness rate of 0.1% in urgent and emergency care;

- Maidstone Hospital: 0.1%
- Tunbridge Wells Hospital: 0.1%

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

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From July 2016 to June 2017, the trust reported a bank and locum usage rate of 100% in urgent and emergency care;

- Maidstone Hospital: 100%
- Tunbridge Wells Hospital: 100%

For medical and dental staff there was a total of 11,333 shifts over the 12 months up to June 2017, of which locum staff were used to cover 87% of shifts, agency staff were used to cover 1,447 shifts, and a total of 20 shifts were unfilled within this time frame.

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

**Staffing skill mix**

As at July 2017, the proportion of consultant staff reported to be working at the trust were the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 46 whole time equivalent staff working in Urgent and Emergency Care at Maidstone and Tunbridge Wells NHS Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th></th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>30%</td>
<td></td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>0%</td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>41%</td>
<td></td>
<td>31%</td>
</tr>
<tr>
<td>Junior</td>
<td>29%</td>
<td></td>
<td>25%</td>
</tr>
</tbody>
</table>
A team of 11 consultants worked in the ED and cross-site at the emergency care centre at Maidstone Hospital. A team of 30 other doctors, including clinical fellows, middle grade doctors, specialist registrars and foundation year 2 doctors provided 24-hour medical cover in the department. Three associate specialists and locum consultants

Consultant cover was provided 14 hours per day between 8am and 10pm Monday to Friday and nine hours per day Saturday and Sunday. A paediatric consultant was based in the children’s ED from 2pm to 10pm.

A GP was based in minors seven days a week from 12pm to 11pm.

A team of emergency department practitioners were in training and working in a supernumerary capacity.

Records

In June 2017 the ED team introduced a new auditing tool that would help them to audit the quality of patient records against the trust’s note-taking standards. This was based on audit results published in January 2017 that indicated only 66% of patient records completed by doctors met the standard. This was a significant deterioration from the 82% standard achieved in the previous audit. In response, auditors used a clinical governance meeting to identify areas for improvement. For example, staff were encouraged to challenge colleagues whose writing was illegible and new guidelines were sent to locum doctors.

Monthly clinical governance meetings were used to discuss the results of rolling quarterly audits for the quality of patient records. Areas for improvement for the next audit in January 2018 were for clearer and more consistent documentation of tests results and the outcome of investigations.

We saw from looking at the results of monthly triage nurses audits that there was room for significant improvement in documentation. Between March 2017 and November 2017 nurse triage records were 72% compliant with trust standards. This was an overall average and reflected a range from 47% in June 2017 to 96% in April 2017. Out of the nine audits that took place, eight failed to meet the minimum trust standard. There was no trend of improvement between months and results varied significantly between nurses. In addition common themes had not been addressed by the auditing team.

The psychiatric liaison team used a different patient records system to the ED team. This meant ED staff could not access a patient’s crisis plan if they were known to the liaison team and instead relied on the liaison team being available to visit the patient. The ED team used a risk assessment to initially assess patients against their level of risk for issues such as self-harm or suicidal intent. However in two records we looked at staff had not fully completed the care plans and there was no evidence in the ED’s paper notes system that the patients had been referred to the liaison team.

Medicines

The urgent care divisional team included medicines errors in monthly clinical governance reports. We saw the number of errors was noted and a senior clinician or member of the pharmacy team discussed with staff the contributing factors and any learning to be actioned.

Nurse prescribers were able to prescribe medicines for certain conditions using patient group directions (PGDs). We found PGDs to be up to date and that nurses referred to them appropriately. In February 2017 an audit observation of a triage nurse noted they checked PGDs...
thoroughly before prescribing and recommended a check for contra-indications with other medicines patients may take be completed in each instance.

Short staffing in pharmacy meant there had been no weekend dispensing service for one month. Instead prescribing staff issued FP10 prescriptions where needed and patients took these to another pharmacy if the medicine was not available in the ED.

**Incidents**

**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.

From September 2016 to August 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from September 2016 to August 2017.

Of these, the most common type of incident reported was.

- Treatment delay meeting SI criteria with 10 (43% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with six (26% of total incidents).
- Slips/trips/falls meeting SI criteria with four (17% of total incidents).
- Abuse/alleged abuse of adult patient by staff with two (9% of total incidents).
- VTE meeting SI criteria with one (4% of total incidents).

(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)
An incident information board for staff highlighted the latest reported incidents and learning from these. This also noted incidents that had not been formally reported using the electronic reporting system and reminded staff of their responsibility to use this by providing case notes as examples.

In September 2017 the senior team added open incidents to the divisional risk register because there were 400 unresolved incidents between both sites. The risk indicated that learning may be delayed or missed and the senior team did not have capacity to make significant progress with investigations and closure. The trust incident team and patient safety team had implemented a series of one-day sessions to help the ECC team complete their incident investigations.

From looking at the outcomes of incidents it was not evident staff were always aware of trust policies or care pathways. For example one incident noted a patient was transferred from the hospital to another trust with blood and without a nurse or doctor with them. This was against trust policy and there was no evidence transfer documentation had been completed or that the site manager was aware the transfer had been arranged.

**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 one new pressure ulcer, two falls with harm and seven new catheter urinary tract infections between September 2016 and September 2017 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Maidstone and Tunbridge Wells NHS Trust

![Safety Thermometer Graph](image)
Is the service effective?

Evidence-based care and treatment

The trust participated in the national Department of Health essence of care audit, which established the service in the ED against 10 quality benchmarks. The latest results for the ECC related to March 2017 to October 2017. In the continence and elimination and medicines management categories, the ED achieved an A score, which indicated there was substantial evidence to demonstrate that the standard had been achieved. In seven categories the ED achieved a B score, which indicated there was clear evidence to demonstrate that the standard had been achieved. In the hygiene and mouth care category, the ED achieved a C score, which meant there was some evidence to suggest the standard was being achieved.

The trust managed a document version control system that meant staff had access to the most up to date policies and national guidance online.

Staff used a safeguarding and mental health risk assessment tool for patients who were at risk of self harm or presented a risk to others. This was in line with National Institute for Health and Care Excellent clinical guidance 16 in relation to self-harm and used the mental health triage scale to ensure assessments were evidence-based.

An audit and service review was a standard part of monthly clinical governance meetings. We saw from looking at the minutes of meetings that staff used this time to remain up to date on policy changes and the outcomes of audits. For example in October 2017 the team reviewed the outcome of an acute urinary retention audit. This highlighted overall good practice with a need for more proactive prescribing and screening.

The trust’s dementia operational policy and procedure was in date and due to be reviewed in 2019. A dementia strategy group had ratified a dementia strategy for 2017 to 2020. Staff accessed these policies and others using the intranet, which we saw was easily accessible.

Staff used the sepsis 6 pathway and a ‘red flag sepsis’ pathway to ensure patients received timely and appropriate care. The ECC team worked with the critical care outreach team in the management of patients with sepsis in line with guidance from the UK Sepsis Trust.

Extended scope physiotherapists met quarterly with consultants to review clinical studies as part of a drive to ensure practice met the latest best practice.

Nutrition and hydration
Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.8 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was the same as other trusts.

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

We saw staff offered patients drinks and snacks where appropriate including hot meals, tea, coffee, water and juice. Staff provided a water jug for each patient who was in the department in a trolley or bed bay for longer than four hours.

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.1 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was the same as other trusts.

The trust scored 7.7 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

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

The results of monthly triage audits indicated there was room for improvement in the consistency of establishing and recording pain scores. Between March 2017 and November 2017 in a sample of 200 records the triage nurse documented a pain score in 59% of patients.

A triage audit in September 2017 in the paediatric ED found 70% of patients had a pain score and 70% had been offered analgesia.

Patient outcomes

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 RCEM audit for severe sepsis and septic shock, the Tunbridge Wells Hospital was in the upper quartile compared to other hospitals for eight of the 12 measures and was in the lower quartile for none of the 12 measures.

The measures for which the site performed in the upper quartile were:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival (100%)
- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED (100%)
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to): Within one hour of arrival (91.3%)
  - Standard 4: Serum lactate measured: Within one hour of arrival (90%)
  - Standard 5: Blood cultures obtained: Within one hour of arrival (89.6%)
  - Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival (81.3%)
• Standard 7: Antibiotics administered: Within one hour of arrival (79.2%)
• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival (83.3%)

(Source: Royal College of Emergency Medicine)

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

Tunbridge Wells Hospital

In the 2015/16 RCEM audit for vital signs in children, Tunbridge Wells Hospital was in the upper quartile compared to other trusts for five of the six measures.

The measures that performed in the upper quartile were:

• Standard 1a: temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score,
• Standard 1b: capillary refill time recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest.
• Standard 2: 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.
• Standard 3: There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present).
• Standard 5: Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 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

Tunbridge Wells Hospital

From the 2015/16 RCEM Audit for Lower Limb Immobilisation in Plaster Cast, Tunbridge Wells Hospital performed:

• In the upper 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 100% in 40 cases.
• In the upper quartile for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation’, with a score of 78% in 50 cases.

(Source: Royal College of Emergency Medicine)

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

In the 2015/16 Procedural Sedation in Adults audit, was in the upper quartile for no measures, the lower quartile for two measures and the middle quartiles for the remaining five measures.

The measures that performed in the lower quartile were:

- Standard 1: Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading, b) Prediction of difficulty in airway management and c) pre-procedural fasting status
- Standard 5: 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) ECG

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant Sign Off (2016/17)

The 2016/17 Consultant Sign Off Audit monitors the proportion of patients of various groups who were reviewed by a consultant in emergency medicine prior to discharge from the ED. For each group, the RCEM standard is that 100% of all patients receive a review from senior medical staff on discharge.

- Of all patients aged over 30 admitted for chronic chest pain in the 2016/17 audit, 36% were seen by a consultant and 93% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.
- Of all children under 1 year of age admitted with a fever in audited in 2016/17, 70% were seen by a consultant and 100% were seen by an ST4 or above.
- Of all patients making an unscheduled return to the ED in 2016/17 with the same condition within 72 hours of discharge, 60% were seen by a consultant and 100% were seen by an ST4 or above.
- Of all audited patients over 70 years of age who were admitted with abdominal pain, 60% were seen by a consultant and 100% were seen by an ST4 or above.

Unplanned re-attendance rate within 7 days

From September 2016 to August 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average.

The trust have been consistently worse than the national average since September 2016 and the trust performance was 10.2% compared to an England average of 7.8% whereas most recently in August 2017 the figure is still high with a trust performance was 10.0% compared to an England average of 7.8%.
Unplanned re-attendance rate within 7 days - Maidstone and Tunbridge Wells NHS Trust

(Source: NHS Digital - A&E quality)

From looking at the results of triage audits we saw staff did not consistently record patient outcomes. For example in an audit of triage notes from June 2017, none of the 20 patients included had a documented outcome. This included patients who presented with significant levels of need such as a drug overdose and a needlestick injury. An audit of 200 triage records between March 2017 and November 2017 indicated a consistent lack of focus on patient outcomes. This reflected poor standards of documentation, inconsistent initial assessment and no evidence of contacting specialty teams.

Between June 2017 and October 2017 the ED performed variably in the results of sepsis audits. For example 92% of patients had been screened for sepsis and 84% had been prescribed antibiotics.

Where patients attended the ED under the influence of alcohol or drugs, the psychiatric liaison team reviewed them after they were deemed to be medically fit. This meant there could be a delay in review until the patient became sober.

**Competent staff**

**Appraisal rates**

From April 2016 to March 2017, 87% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 100%.

A split by staff group can be seen in the graph below:
Tunbridge Wells Hospital had an 86% appraisal completion rate, by staffing group only qualified nursing staff had achieved 100% appraisal completion.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

We saw the ED team had a proactive approach to improving staff training and clinical competencies as a result of audits. For example an audit of record-keeping in January 2017 highlighted a need for more defined criteria for senior clinician review for high risk conditions. This particularly applied to trainee doctors and the trust induction was updated to reflect this.

New nurses and CSWs in the department spent time with different teams including the psychiatric liaison team, the paediatric ED team and the major incident team.

Senior nurses used the outcomes of audits and observations to tailor supervisions to individual staff needs. For example in April 2017 a triage nurse received additional competency support for improving their response to deteriorating patients and improving documentation following a failed audit review. As part of their supervision a senior nurse identified significant improvements in practice.

Doctors had protected time for teaching and education based on their grade. For example middle grade doctors and registrars had monthly teaching sessions and foundation level doctors had weekly teaching.

Clinical nurse specialists from the psychiatric liaison team provided staff training in providing care for patients with mental health needs, including those with learning disabilities or dementia. All clinical staff undertook training in completing mental capacity assessments with patients.

A practice development nurse (PDN) had developed an education programme to help clinical support workers (CSWs) develop their skills and competencies. This included support to access the nursing associate training course. In 2017 five CSWs had achieved a level three diploma in clinical healthcare support. This reflected the focus the senior team placed on education and development. In addition the PDN was working with the resuscitation team to develop a teaching plan for life support training to ensure this was standardised across the team. The PDN worked with the simulation suite team to plan and deliver practical training and simulated scenarios. The nursing team at Maidstone Hospital could observe this by videolink. Recently this had included trauma training with a local trauma network team.
The PDN had facilitated joint teaching and learning sessions between nurses and foundation level one doctors to establish a multidisciplinary approach to delivering care and treatment. In addition weekly protected teaching time was made available to all clinical staff. Emergency nurse practitioners had access to dedicated teaching and learning time.

Staff had access to a wider range of teaching through a network partnership with other EDs. For example they could attend an evidence-based emergency practice course at another hospital, which enabled colleagues from the other trusts to participate in this hospital’s ED foundation course.

The PDN had organised a triage study day, including paediatric triage, to improve practice.

A paediatric PDN was working to improve opportunities for adult nurses to develop their skills and competencies in care and treatment for children. This included creating rotational posts and holding focus groups to identify the important areas of focus for nurses.

Clinical support workers were supported to undertake training in extended areas including venepuncture to NVQ level 3, cannulation, urinalysis and carrying out ECGs.

**Multidisciplinary working**

Mental health community services were provided by other organisations and the trust’s psychiatric liaison team worked between the ED team and community teams to ensure patients were seen by the most appropriate professional.

Speech and language therapists provided support and communication tools where patients had difficulty communicating due to a learning disability or mental health need.

The psychiatric liaison team worked with ED staff to complete a physical health checklist for patients who were due to be admitted to an inpatient ward or the acute mental health unit. This enabled the team to plan in advance for coordinating care and treatment for patients with complex needs.

A dementia practitioner worked with dementia link nurses to coordinate care for patients.

Social workers were part of the integrated discharge team and staff had access to them on call 24-hours, seven days a week.

Physiotherapists were based in the department Monday to Saturday. Four extended scope physiotherapists worked cross-site as autonomous practitioners and independent prescribers to provide care for patients with strains, sprains and rehabilitation needs.

A high impact therapy (HIT) team of physiotherapists and occupational therapists provided support for patients in majors, minors and the clinical decision unit. The HIT team also supported patients over the age of 75 as part of the fast track elderly care pathway as well as patients who were referred to an inpatient rehabilitation pathway.

**Seven-day services**

All areas of the ED operated 24-hours, seven days a week with the exception of the paediatric ED and the GP service.

Consultant cover, including a paediatric consultant, was provided seven days a week.

The HIT team provided a seven day service from 8am to 8pm.
Radiology services were available adjacent to the ED including 24-hour, seven day x-ray and computed tomography (CT) scanning. Ultrasound services were provided during the daytime seven days a week.

Although the paediatric ED was not open 24-hours, two children and young people’s registrars were available in the hospital 24-hours, seven days a week.

**Health promotion**

Staff did not routinely document if they offered health promotion or advocacy services to patients awaiting assessment by the psychiatric liaison team.

Details of a local common ailments scheme were on display at reception and provided guidance on where patients could obtain advice other than the ED, such as their local pharmacy.

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

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

The trust reported that from April 2017 to July 2017 Mental Capacity Act (MCA) training has been completed by 95% of staff in within Urgent and Emergency Care.

(Source: Trust Provider Information Return P14/P49)

We looked at the records of two patients who staff had referred to the psychiatric liaison team. In both cases there was no documented evidence of a capacity assessment or consent. Staff nurses told us they were trained to carry out capacity assessments but there was room for improvement in how this was monitored and implemented on a shift-by-shift basis.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The trust’s urgent and emergency care friends and family test performance (% recommended) was generally better than the England average from September 2016 to August 2017.

Most recently in August 2017 the trust performance was 91.9% compared to the national average of 88.0% Since December 2016 the trust has seen an increase in performance and it has steadily remained between 92% and 94% for the rest of the time period.

**A&E Friends and Family Test Performance - Maidstone and Tunbridge Wells NHS Trust**
The ED had a dignity tent as part of the chemical, biological, radiological and nuclear defence (CBRN) equipment. Staff told us they used this in other circumstances to maintain patient dignity, such as if someone collapsed in the car park.

Staff had improved dignity for patients cared for the clinical decisions unit (CDU). For example comfort items such as blankets were provided and quiet space was available for conversations or meetings.

**Emotional support**

**Emergency Department Survey 2016**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all 24 questions relevant to caring.

<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>4.0</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>8.5</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>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.3</td>
<td>About the same as 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</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</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>7.9</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>8.4</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>7.3</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>8.9</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>7.9</td>
<td>About the same as 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>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.8</td>
<td>About the 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>5.4</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>8.2</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>8.0</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>8.9</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>9.3</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>4.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</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>5.6</td>
<td>About the same as 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>5.9</td>
<td>About the same as 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>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

Paediatric nurses had delivered training to adult nurses in emotional support after a child’s death. In addition the team had developed a bereavement box that included items such as a teddy bear and the ability to make footprints.

A hospital counselling team was on call to support relatives after a bereavement and a bereavement booklet was readily available.

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

We observed the reception team and the arrivals process for patients. We saw in each case the team worked to maintain confidentiality despite the open-plan design of the area. In addition they modified their communication and approach to each individual and demonstrated the ability to work adaptively. For example we saw the reception team interact with children and young people who were upset or anxious and their understanding of how they felt helped to calm them down.

We spoke with the parents of a child who was being treated in the paediatric ED. They told us, “The wait was really short and we’ve been kept really well informed. Everyone has been lovely.”

**Is the service responsive?**

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

Between November 2016 and November 2017 48 adult patients and 33 child patients were admitted to the hospital from the ED on a psychiatric pathway. Of the adult patients 23% of patients presented with a drug overdose and 23% presented with suicidal intent. Of the child patients, 48% of patients who were admitted presented with suicidal thoughts or self-harm. In the year leading to our inspection, the psychiatric liaison team saw an average of 50 patients each month who needed an assessment and 98% of these had been seen within two hours.

Emergency nurse practitioners (ENPs) supported the delivery of the minors service from 8am to 12am, which enabled the service to see and treat minor injuries. In addition dedicated
physiotherapy cover was available in the unit from 8am to 6pm daily and nurse and clinical support worker cover was available at all times.

The paediatric ED was open from 10am to 10.30pm. This reflected a recent reduction in hours of two hours per day due to short staffing. If children were still in the paediatric ED at 10.30pm, they were transferred to another area if the paediatric ward did not have a bed available. If a child was admitted to ED overnight, staff cared for them in the resuscitation area until the paediatric ED opened. Although this meant patients were transferred between areas, it reflected a lack of capacity to deliver a 24-hour paediatric service and meant patients’ needs were met as appropriately as possible.

A psychiatric Liaison team was available in the hospital between 8am and 8pm and were available to review patients within two hours of referral. Outside of these hours staff told us they often experienced lengthy delays in obtaining mental health support and they would admit patients to a medical inpatient ward to provide care until the liaison team started work.

Staff used a specific triage pathway for patients with mental health needs who arrived by ambulance. This meant the rapid assessment team assessed the patient within 15 minutes of arrival to identify their immediate needs and to put in place a one-to-one nurse to patient ratio to keep them safe. We saw from looking at two patient records that staff completed 15 minute observations on patients who had a mental health risk. However this was not always initiated in a timely manner. For example in one record we saw the patient had been in the department for four hours before staff commenced the observations.

Staff maintained a noticeboard in the waiting area that included details of the current wait time for each ED service as well as information relating to current health risks, such as seasonal flu. The sign also included information on how the department maintained confidentiality. Staff had produced an information leaflet that provided guidance on why waiting times differed and why patients were not seen on a first-come, first-served basis. We saw these were readily available and staff proactively offered them to patients when wait times increased.

The senior team were developing a new minors pathway for patients who accessed the service by ambulance. This would include presentations such as minor injuries and low-risk chest pain where an ECG was normal. This would reduce pressure on the rapid assessment point (RAP) service and ensure patients were still seen appropriately.

The Home First team worked from a central local referral unit to ensure patients due for discharge were home by 6pm. A member of staff from this service provided a ‘meet and greet’ to each patient when they arrived home and started their care package the next day. The HIT team liaised with the community team to ensure essential elements of care such as access to day centres and home modifications were put in place.

Local patients had access to specialty services through a referral pathway from their GP. This meant their GP could refer them to a specialist in the hospital and the ED team triaged each patient on arrival.

**Meeting people’s individual needs**

**Emergency Department Survey 2016**

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

<table>
<thead>
<tr>
<th>Question</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>7.2</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>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

From looking at the results of monthly triage nurse audits, it was not evident nurses consistently identified or responded to patient’s needs beyond their immediate presentation. For example we saw one patient in May 2017 re-attended the department with injuries sustained as a result of domestic violence. However there was no evidence the triage nurse acted on this and instead documented that clinicians should refer to the patient’s GP notes. An audit in June 2017 noted a triage nurse had not documented any details about a patient who presented with a drug overdose or notified the specialist team.

The medical team provided a virtual fracture clinic, which had reduced delayed assessments.

Staff used a designated observable bay for patients living with dementia who may find the ED environment distressing.

The nurse in charge completed a two hourly quality round to manage risks to patients and ensure individual needs were met. As part of this system staff ordered a hospital bed for patients who had been in the department for over four hours and ensured they had a call bell within reach. We reviewed a sample of quality round checklists and found staff were responsive to individual needs including in escalating delays in care or transfer. However the nurse in charge was responsible for caring for patients who had to be accommodated in the corridor escalation area, which meant they could not complete quality rounds during that time.

Staff had access to a learning disability passport that helped them to understand the needs of individual patients. This tool also helped in handovers from paramedics to ECC staff or when transferring a patient to an inpatient ward.

Staff used a dedicated mental health assessment room for patients with elevated risk. This room was minimally furnished so as to reduce the risk of a patient making dangerous use of furniture and there were no ligature points in the room. There was no alarm call system fitted although staff could clearly see into the room at all times. The nearest toilet for this room had ligature points and could pose a risk to patients who used this without supervision.

The security team were trained to adapt their communication techniques to individual patient needs. For example when a patient who did not speak English presented in a confused state and with significant anxiety, a security officer calmed them down with positive tone of voice and reassuring body language.

Nursery nurses worked alongside paediatric nurses to provide play and distraction to infants and children. Toys and games were available in the department.
Access and flow

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 A&E.

The trust did not meet the standard from October 2016 to September 2017.

The trust breached the standard 12 times from October 2016 to September 2017.

Between October 2016 and September 2017 performance against this metric showed a trend of improvement.

The trust performance has improved since January 2017 it has been below the 95% standard for the entire time period, and only recently been better than the national average since June 2017, most recently it is in line with the England average as of September 2017.

Four hour target performance - Maidstone and Tunbridge Wells NHS Trust

(Source: NHS England - A&E Waiting times)

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

From October 2016 to September 2017 Maidstone and Tunbridge Wells NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than to the England average. Performance against this metric showed a trend of improvement over the period.

The trust performance has improved since January 2017, it has been consistently worse than the England average. The trust percentage at its peak in December 2016 was above 32% compared to the England average of around 20%, whereas now the trust percentage is around 16% and the England average is around 12%.

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Maidstone and Tunbridge Wells NHS Trust
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, two patients waited more than 12 hours from the decision to admit until being admitted.

<table>
<thead>
<tr>
<th>Month</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>426</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
<td>616</td>
<td>0</td>
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<tr>
<td>Dec-16</td>
<td>950</td>
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</tr>
<tr>
<td>Feb-17</td>
<td>674</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>473</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>523</td>
<td>0</td>
</tr>
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<td>285</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>538</td>
<td>0</td>
</tr>
</tbody>
</table>

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment
From October 2016 to September 2017 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was similar to the England average.

From October 2016 to September 2017 performance against this metric showed a trend of improvement. Most recently in August 2017 the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 3.0%, compared to the England average which was 3.0%.
From October 2016 to September 2017 the trust’s monthly median total time in A&E for all patients was consistently higher the England average. Performance against this metric showed a trend of decline.

In August 2017 the trust’s monthly median total time in A&E for all patients was 172, which is worse than that of the England average which was 144. The trust has consistently been worse than the England average for the whole time period.

(Source: NHS DIGITAL - A&E quality indicators)
The RAP was intended to relieve the pressure on the majors and minors areas by providing additional capacity. A middle grade doctor was based in RAP from 8am to 12am. Outside of these hours the doctor in minors covered the unit and a nurse led care. Staff did not admit patients to the RAP overnight but patients already in this area could be kept under observation. Although this area was planned to be a short-term escalation area it had been open continually for three months leading to our inspection. We saw safe staffing levels were always maintained and the member of staff in charge managed capacity in line with a standard operating procedure. This meant if patients were stable and no cubicles were available, up to four patients could be cared for in an escalation area in a corridor.

A senior nurse acted as a flow coordinator on each shift and liaised with the duty bed manager to assist with patients waiting to be admitted. A surgical assessment unit was based on site and staff could transfer patients there for orthopaedic or ear, nose and throat assessments.

An ENP and consultant carried out a daily board round at 7am to identify patients who could be seen by social services or the outpatients teams to reduce pressure on inpatient beds.

The department offered a priority check-in service from 8am to 12am for patients who arrived by ambulance.

The nurse in charge used the quality round checklist to identify if any patients had remained in a seated area, rather than a bed or trolley for over six hours. They shared this information with the wider hospital team at board rounds, which took place four times daily, to identify how to move them to a more appropriate area.

The psychiatric liaison team were responsible for discharging patients from the ED to an appropriate community bed if needed. Staff told us this process usually took about four hours but if there were significant delays or the patient’s mental state deteriorated, an escalation pathway was in place that enabled the operations manager and duty director to intervene.

**Learning from complaints and concerns**

From July 2016 to June 2017 there were 62 complaints about urgent and emergency care services. The trust took an average of 34.9 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 days or 60 for more complex complaints. 55 of the 62 related to all aspects of clinical treatment.

Tunbridge Wells Hospital: There were 33 complaints, taking on average 50 days to close complaints within this service; the main themes were around delayed investigation and treatment due to waiting times.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

We looked at the outcomes of two formal complaints made to the department. Although both complaints indicated an investigation had taken place that included the staff involved, it was not evident there was learning or a definitive outcome that helped to improve standards. For example one complaint related to the attitude and communication of a doctor with a young person. The outcome of the complaint identified the doctor was excessively tired, which may have contributed to their approach to the patient. Another complaint related to a wound that was not cleaned or dressed in the ED and which subsequently led to an infection. The trust’s response noted they could not identify if the lack of cleaning of the wound contributed to the infection.
Is the service well-led?

Leadership

An urgent care director led urgent and emergency services, supported by an associate director of nursing, a general manager, a lead matron for the emergency department (ED) and three matrons. A clinical director was the overall lead for medical care in the ED and a lead consultant had been in post for four years.

All of the staff we spoke with were positive about leadership in the department and said they felt able to approach the senior team at any time. Medical staff noted there had been an improvement in clinical leadership and consultant support.

Vision and strategy

The ED team had contributed to a vision and strategy for the department that was in addition to the trust’s overall vision. The vision had four key areas that focused on early intervention and critical decision-making, access to appropriate specialties, minimising patient recalls and stabilising the staff team.

Construction work was taking place in the ED to create a six-bedded clinical decision unit. This along with the introduction of GP-led triage was the immediate vision and development plan for the department. In addition a new frailty unit was planned for 2018, which would reduce the need to transfer elderly patients to Maidstone for specialist care.

The psychiatric liaison team members we spoke with said they did not know if the trust had an overriding mental health care and treatment strategy.

The practice development nurse (PDN) role was new to the department and this individual worked with their counterpart at Maidstone Hospital to develop the scope of the role. For example they worked with PDNs at other trusts in the local area to share teaching and learning at four-monthly meetings.

Culture

Staff described a positive and supportive working culture in which they could access the help they needed. For example one member of staff said support services such as human resources and IT were “incredible” and that staff from these departments would readily visit the ED to provide one-to-one support. Another member of staff said, “This is a forward-thinking trust and the opportunities we have to grow and develop are excellent.”

Staff said they felt there were good opportunities for professional development and multidisciplinary working. For example one nurse said, “The trust is very supportive. There are lots of secondment opportunities and always new positions advertised. We have great problem-solving teams that promote good sharing and learning. This is indicative of the culture here.”

Staff told us the senior executive team, including the chief executive officer, chief operational officer and operational lead, were more visible in the last year and they felt more involved with the trust as a result.

Clinical support workers we spoke with said they felt well respected by nurses and doctors and said they were empowered to raise concerns and ask questions.
Governance

A clinical governance lead was in post and led monthly cross-site governance meetings. Attendance at this meeting was compulsory, which the lead consultant had implemented to ensure all staff maintained an up to date understanding of complaints, near misses, serious incidents and mortalities. The trust clinical governance committee maintained oversight of departmental governance and outcomes.

We saw from looking at a sample of presentations and meeting minutes that the ED team used clinical governance meetings to discuss audit results, learning from incidents and other areas of work that impacted safety. However it was not always evident that outcomes were well defined. For example we saw consistently poor performance in record-keeping audits was discussed in a clinical governance meeting in May 2017. However there were no actions documented as part of this.

The consultant psychiatrist from the psychiatric liaison team met with an ED consultant on a monthly basis to review the care of patients who were known to both teams.

The quality and safety committee or the policy ratification committee were responsible for approving the policies and standard operating procedures formed by committees and clinical teams. We saw all of the policies in use by staff had been appropriately ratified before being implemented.

Management of risk, issues and performance

The senior team used a risk register to identify key risks to the service and to strategise plans to address them. As of November 2017 there were 19 risks on the risk register for the Tunbridge Wells site and 26 risks that applied to both urgent care sites. The key ED risks included the lack of bed availability in the hospital, particularly psychiatry beds, and overall low levels of middle grade doctor cover. The service had recruited emergency department practitioners who could provide cover for middle grade doctors. The operational and senior clinical teams used daily bed meetings to address the risks of low bed capacity and where possible identified alternatives such as community beds to help access and flow. All of the risks identified had an accountable owner and there was evidence in most cases of work to reduce the overall impact of the risks. For example, a business case had been submitted for a third resuscitation nurse per shift to reduce the risk of only two nurses being responsible for six patients if the unit was full. Two risks related to radiology and timely reporting of chest x-ray results. Staff identified both risks as high in September 2016 but there were no controls yet in place.

The safeguarding lead, paediatric staff, ENPs and consultants attended a monthly departmental meeting.

It was not evident that fire risk was consistently well managed by the trust’s fire safety team. For example a fire risk assessment in July 2017 found the department performed well in relation to safety and fire risk requirements. However the risk assessment contained contradictory data about the use and storage of flammable liquids and gases. In addition the risk assessment noted ‘N/A’ in response to adequate security measures in the ED despite the unit needing 24-hour security cover. This meant the process used for the risk assessment was not always quality checked.

The ED team demonstrated understanding of the security risks to staff and to patients that resulted from patients who were under the influence of alcohol or drugs or those who behaved violently. To manage this risk security staff were on site 24-hours, seven days a week and the
team worked closely with local police to provide a rapid response to incidents. The senior team used a clinical governance investigation system to identify how behaviour could be de-escalated in future and to ensure all staff involved were offered support if needed. We spoke with two members of the security team who demonstrated a detailed understanding of the needs of patients in the ED. For example they explained why some patients might present aggressively in the ED without intending to and that some mental health conditions manifested themselves in unpredictable communication styles. For example one member of the security team said, "If we calm someone down enough and get them to just talk to us then we can usually de-escalate a situation. People will usually tell us if they have a mental health condition so we know what sort of help they might need." The team also demonstrated awareness of the impact of their uniform and said they worked to try and reduce the risk of escalation if a patient reacted negatively to their presence.

A dedicated major incident team worked cross-site to deliver practical and simulated training exercises to all staff in the department. Two members of the team had an emergency care background and tailored the training to the needs of ED staff. A major incident link nurse was in post and worked with the team to ensure the department was prepared.

The senior team had prepared for the ‘winter pressure’ period by meeting with the clinical commissioning group, district nurses, the estates and facilities teams and the catering contractor to ensure services would continue during times of exceptional demand.

**Information management**

There was room for improvement in how information was shared between the ED team and psychiatric liaison team. For example ED staff could not access the notes of patients known to the liaison team, which presented the risk of delayed care and increased staff risk. This was because there was a delay in ED staff finding out if the patient had a history of violence or aggression. One nurse told us they had provided care to a patient who acted violently towards them but they did not know they had a significant history and track record of this because there was little information sharing between services.

The required documentation standards for each area of the ED were on display on a staff noticeboard. This meant staff could refer to a checklist for their area of work to ensure they adhered to trust standards.

**Engagement**

Staff used a secure social media communication group to stay up to date with changes or new projects in the department. In addition the trust provided periodic nursing engagement and learning forums to enable nurses and clinical support workers to have access to guest speakers and information on trust initiatives. The divisional team issued monthly newsletters to support staff in ensuring they understood changes to policies or new policies.

Matrons had carried out an assessment of the feedback from the NHS Friends and Family Test and used this to make improvements as part of the trust’s ‘You said we did’ initiative. For example they ensured healthy snacks were available in vending machines and provided more comfortable seating in the waiting area.

**Learning, continuous improvement and innovation**

New PDNs worked cross-site and had developed a significant improvement in staff training and networking opportunities. This included the opportunity to work with ED nurses at other trusts to share learning and experience the benefits of training together. In addition a paediatric PDN was
establishing team training and rotational posts for adult nurses to build their confidence and skills in paediatric care.

Opportunities for staff to spend time working with colleagues in other teams on a rotational basis had a positive impact on patient experience and staff practice. For example following a rotation with the psychiatric liaison team a foundation level doctor designed a new proforma for patients with a psychotic history who presented in the ECC. This would enable the team to more quickly assess patients with mental health needs and put enhanced care in place to manage risks.

The dementia strategy group had established terms of reference and a strategy that aimed to develop the trust into a dementia friendly organisation by 2020.
Maidstone and Tunbridge Wells NHS Trust was established in 2000 and provides a range of general hospital services and some areas of specialist complex care to around 560,000 people living in southwest Kent and east Sussex. The Trust’s core catchment areas are Maidstone and Tunbridge Wells and their surrounding boroughs, and it operates from two main clinical sites: Maidstone Hospital and Tunbridge Wells Hospital at Pembury.

The medical care service at Tunbridge Wells Hospital provides care and treatment for Gastroenterology, Respiratory, Cardiology, Care of the Elderly (including stroke and transient ischaemic attack) and Endocrinology (Diabetes), as well as offering some services within the community.

There is a Cardiac Catheter Laboratory at Tunbridge Wells Hospital focused on interventional procedures. There is a full cardio respiratory and respiratory physiology support service offering diagnostic procedures. There are 243 medical inpatient beds located across 12 wards at Tunbridge Wells.

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

The trust had 37,867 medical admissions between April 2016 and March 2017. Emergency admissions accounted for 18,948 (50%), 1,332 (3%) were elective, and the remaining 17,587 (46%) were day case. We were not given figures for the separate locations.

Across the trust, admissions for the top three medical specialties were:

- General Medicine 13,634
- Gastroenterology 9,053
- Geriatric Medicine 7,497

(Source: CQC Insight)

Is the service safe?

Mandatory training

Mandatory training was provided by the trust and staff completion monitored using computer software. Managers explained that a new web-based learning management system had been introduced to replace a spreadsheet record. We saw examples of both systems in use during our visit as some wards were still converting to the new learning management system.

Staff demonstrated the ease of which individual and team reports could be produced and described how the LMS generated email alerts sent to the individual concerned and their line manager whenever a topic became ‘due’.

Subjects covered by all staff included child and adult safeguarding, information governance, infection prevention and control, fire safety, health and safety and trust values. Clinical and scientific staff had additional role specific mandatory training which included higher level
safeguarding training, responding to deteriorating patients, record keeping and more detailed infection prevention and control training.

Some subjects were offered ‘on-line’ through the learning management system, which offered the flexibility of access from any computer connected to the internet. This meant staff could complete certain topics after hours or at home if desired. Other topics required attendance at a classroom session.

Staff we interviewed at the Tunbridge Wells Hospital at Pembury said they received a suitable amount of training to ensure they had the skills to do their jobs. This included training in sepsis management and the use of screening tools such as pre-printed stickers showing triggers for referring patients to outreach support. We also found that staff received training to help make them aware of the potential needs of people with mental health conditions, learning disability and dementia. Managers acknowledged training compliance rates for dementia awareness were lower than the target (see below) and gave examples of actions undertaken to remedy this. These included the appointment of a dementia lead nurse and recruitment of dementia ‘champions’ from each ward area.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training with the exception of information governance that had a 95% completion target. A breakdown of compliance for mandatory courses between April 2017 and June 2017 for medical or dental and nursing staff in Medicine is shown below:

Medical staff within the medicine core service were not meeting the trust target for five mandatory training modules, the lowest completion rate was for dementia awareness (including Privacy & Dignity standards) with 62% followed by medicine management training with 70%.
Nursing staff within Medicine did not meet the completion for three of 19 training modules; the lowest completion rate is for conflict resolution training with 50% followed by dementia awareness (including privacy & dignity standards) with 63%.

Tunbridge Wells Hospital had an 87% training completion rate.

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

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust had systems and processes in place to identify and report concerns to protect their patients. Staff spoke with had safeguarding training at the appropriate levels for their roles and were alert to any potential issues with adults or children. Female genital mutilation and sex exploitation awareness was incorporated into safeguarding training which was delivered as part of the annual mandatory training programme as well as induction courses for new staff.

In the wards we visited at The Tunbridge Wells Hospital at Pembury, we saw that training compliance rates met or exceeded the trust target. Staff described how they would identify a safeguarding concern and the processes used to report a concern or incident. We saw examples of safeguarding referrals and we noted the investigation documentation also included learning points following the investigation. Staff were able to identify the departmental safeguarding lead nurse to report concerns and obtain support. This indicated that staff identified the risks of abuse and were actively reporting it through appropriate channels.

The trust had recently formed a ‘safeguarding panel’ and we saw evidence that this been convened in October. Managers stated that this new arrangement enhanced the way the trust managed safeguarding enquiries and reduce any delays in learning being identified and shared.

Patients and relatives we spoke with on both sites said they felt safe on the ward and were always treated respectfully by staff.
Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses up to June 2017 for medical or dental and nursing staff in Medicine is shown below:

Medical staff within Medicine met the completion for four of the five safeguarding modules, it did not meet the 85% target for the safeguarding children level three module.

Nursing staff within Medicine met the completion for all five safeguarding modules. Tunbridge Wells Hospital had an 86% safeguarding training completion rate.

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
All areas we inspected were visibly clean, tidy and free from clutter. We were told that there was daily housekeeping support provided to each area and we saw operatives working throughout the day. Housekeepers had a routine cleaning schedule to follow and kept account of their progress by completing regular cleaning audits and quality monitoring. We saw records of these on cleaning trolleys and we noted staff changing the colour-coded mops and cloths to suit the cleaning task.

We visited five wards at the Tunbridge Wells Hospital at Pembury and saw that beds, trolleys and medical equipment were clean and stored correctly. Wide use was made of ‘I am clean stickers’ which detailed the date and time the article was cleaned along with the name of the person who cleaned it. We saw these details had been completed in all cases, which meant staff could quickly identify items and equipment that was clean and ready for use. On one ward we noted stickers in use but not on bedside chairs, which meant staff there has less assurance these items had been cleaned.

Medical services had infection prevention and control policies readily available for staff to access on the trust intranet. Staff were aware of the policies and knew how to access them. These included waste management policies, which were monitored through regular environmental audits. We saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal.

The trust had arrangements in place to support the management of infection prevention and control. This included an infection prevention team with qualified infection control nurses and a doctor with infection control responsibilities. The team worked across the hospitals coordinating with other health-care professionals, patients and visitors to prevent and control infections. The infection control teams’ responsibilities included giving advice, providing education and training, monitoring infection rates and audit infection prevention and control practice.

All staff were ‘bare below the elbows’ in line with trust policy and good practice. Staff explained that the trust had banned the use of name badge lanyards on infection prevention and control grounds and had opted for ‘wipe clean’ plastic badges or identification card holders.

We saw supplies of personal protective equipment such as aprons and gloves in dispensers on walls and we saw these items being used. Body fluid spillage kits were readily available. Antimicrobial hand-rub dispensers mounted on the walls outside each room or bay. These contained gel and we observed staff using the product as they moved around the premises.

We saw disposable curtains marked with the date changed. This complied with Hospital Building Note 00-09, infection control in the built environment and indicted that staff routinely changed curtains to help reduce the chances of germs passing from one person or object to another.

Sharps boxes were managed in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations). Clearly marked and secure containers were placed close to the areas where medical sharps were used. Instructions for staff on the safe disposal of sharps were displayed in clinical areas and the sluices. We saw clear guidance for staff on the action to take in the event of a needle stick injury. This was displayed in treatment rooms and other clinical areas.

There were adequate numbers of side rooms to allow any patient who presented a risk of cross infection to others to be isolated to reduce the risk. These rooms were clearly identified using a system of magnetic signs that helped inform visitors and staff about any special precautions needed. Similarly, posters about infection control were prominently displayed at ward entranceways to encourage visitors to help in reducing the risk of cross infection by maintaining good hand hygiene and not visiting if they are unwell.
Each of the medical wards and units we inspected displayed their infection prevention and control audit results, so patients, visitors and staff had current infection control information available.

The directorate of emergency and medical services had reported 1 case of meticillin-resistant staphylococcus aureus in the last year. The trust had a screening process for all inpatients and an isolation and treatment protocol for any identified cases. During the same period, medical services reported 18 cases of clostridium difficile.

The 2017 patient-led assessment of the care environment survey showed the trust scored 99.8%, for cleanliness, which was better than the England average (98%).

**Environment and equipment**

The service had suitable premises and equipment and looked after them well. There was access to emergency equipment, including portable oxygen, suction and automated defibrillators stored on purpose-built trolleys. These were stocked and checked daily in accordance with guide sheets attached to each trolley, which were collected by managers and audited monthly. All bays and rooms we visited had piped oxygen and suction and every device we checked functioned correctly. This was consistent with the emergency equipment checklists and indicated staff retained an active focus on ensuring these items were ready for immediate use should an emergency occurring.

Rooms were well-lit, air-conditioned and supplied with sufficient equipment and furnishings. Corridors, treatment rooms and toilets were spacious with doors wide enough to fit wheelchairs.

The wards and units were sited in relatively modern buildings and kept in good decorative order using dementia-friendly contrast colour schemes. We saw good examples of clear direction signs utilising colour codes and symbols.

The entryways to both hospitals had dropped kerbs to assist wheelchair users or those with limited mobility reach the entrance. Disabled parking spaces and ‘drop off’ areas were provided close to entrances and entrance doors were automated, again assisting people living with less mobility.

Paid car parking was provided to both staff and visitors.

Beds, furniture and equipment were labelled with asset numbers and labels showing service dates. Staff told us that the medical equipment was well maintained centrally by the electrical medical engineering department. And no one cited any problems in obtaining sufficient items for use. The ward stores we visited appeared clean with plentiful shelving and items clearly labelled.

Fire safety equipment was available throughout the hospital and we saw evidence that fire equipment safety checks had been completed by an external specialist contractor.

The 2017 patient-led assessment of the care environment survey showed the trust scored 96.8% for ‘condition, appearance and maintenance’, which was better than the England average of 94%.

**Assessing and responding to patient risk**

We saw that comprehensive risk assessments were carried out on patient admission and kept in the patient records. This included assessing the patient against the risk of falls, nutrition status, skin integrity and pain. In the six sets of patient records we examined, risk assessments had been regularly reviewed and updated.

Bed charts we saw were completed legibly and accurately and patient records showed that nursing staff escalated any concerns about deteriorating health and that decisions about changes to care or treatment plans were made by staff that were competent to do so. We saw ‘sepsis six’
management and screening tools in place such as pre-printed stickers showing staff the triggers for referring patients to the outreach support team

Senior clinical staff stated that there were two daily nursing handovers and six multidisciplinary meetings a week where each patient was risk assessed. We observed one multidisciplinary meeting and saw effective risk-based discussions and decisions that supported what we had been told.

The trust used a national early warning system track and trigger flowchart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). The scoring system enabled staff to identify patients who were becoming increasing unwell and provide them with increased support.

Nursing staff told us they had good support from the doctors and the clinical outreach teams when a patient’s deterioration was observed.

In the notes we reviewed we found that the national early warning system scores had been calculated consistently and accurately. Staff explained that a new computerised system was in the process of being implemented that prompted staff to complete observations and record them on portable devices. The ‘live’ system automatically triggered alerts to senior nursing and medical staff when observations were missed or readings detected patient deterioration. We saw a demonstration of the software capabilities but were told the system was offline as part of the implementation development.

**Patient moves per admission**

This information is routinely requested within the universal provider information request spreadsheet, to be completed within a standard template. The trust was unable to provide the appropriate data. The trust told us they were unable to provide accurate data regards ward transfers and appropriate clinical pathways within this data set.

Between August 2016 and July 2017, 590 patients moved during the night between (10pm and 8am) at Tunbridge Wells Hospital, 60 of which are attributed to Ward 12.  
*(Source: Trust Routine Provider Information Return P51)*

**Nursing staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

Based on our observations during the inspection, there were sufficient staff to meet the patients’ needs. We saw that actual staff on duty matched staffing templates and this information was clearly displayed on the ‘green cross’ posters at ward entrances.

Lack of registered nurse staffing was a concern raised by senior staff and managers and was included on the directorate risk register. The trust had taken action to address the shortfall in staffing such as recruiting overseas nurses. We were told another recruitment drive was in progress.

Managers stated that planned staffing was generally met, although bank and agency staff were often required. Bank use was encouraged by managers as staff were familiar with the ward processes and environment. Where agency staff were used, we were told that ‘lines’ were booked
in an attempt to provide staff who had been orientated to the ward. We saw examples of correctly completed agency orientation sheets which confirmed this.

We saw arrangements for nursing staff to hand over the care of patients between shifts and we noted the use of printed handover sheets. We looked at these sheets and found they contained relevant information on the specific needs and risks of patients that supported the delivery of safe care.

The trust has reported their staffing numbers below for the period June 2017 for Medicine. There are 103.98 less whole time equivalent nursing staff within medicine than the trust planned to provide safe care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing</td>
<td>498.38</td>
<td>394.40</td>
</tr>
<tr>
<td>Total</td>
<td>498.38</td>
<td>394.40</td>
</tr>
</tbody>
</table>

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

Vacancy rates

Between July 2016 and June 2017, the trust reported a vacancy rate of 19.0% in medical care. The rate at The Tunbridge Wells Hospital at Pembury was 20.2%

The trust has a target vacancy rate of 8.5% the overall vacancy rate for medicine and at both sites was worse than the trust target.

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

Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 1.1% in medical care. The Tunbridge Wells Hospital at Pembury accounted for 0.9%

The trust target for turnover was 10.5% which medicine and both sites were performing better than target.

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

Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 3.9% in medical care. The rate for Tunbridge Wells Hospital was 4.3%

The trust’s target sickness absence rate was 3.3% or lower, Tunbridge Wells Hospital was worse than the trust average which was 3.7%

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

Bank and agency staff usage

Between July 2016 and June 2017, the trust reported a bank and agency usage rate of 89% in medical care; total of 18,629 shifts of which 35% was covered by bank staff and 54% covered by agency, a total of 1,945 shifts were not covered.

- Tunbridge Wells Hospital: total of 10,806 shifts of which 33% covered by banks staff and 60% covered by agency, a total of 787 shifts were not covered.
The trust told us in their provider information request they had the highest bank or agency use on the following medical ward, ward 22, the reasons attributed to this was vacancies.

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

Medical staffing

Overall, we found that numbers of doctors at appropriate grades were adequate to meet the needs of patients.

Newly admitted patients received a timely review by a consultant trained in general internal medicine and we saw ward rounds taking place. A consultant on-call system operated and junior medical staff we spoke to told us they could access advice from a consultant and felt well-supported.

The trust has reported their staffing numbers below for the period June 2017 for Medicine.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>94.78</td>
<td>81.86</td>
</tr>
<tr>
<td>Total</td>
<td>94.78</td>
<td>81.86</td>
</tr>
</tbody>
</table>

There were 12.92 less WTE medical and dental staff within medicine rather than the trust planned to provide safe care.

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

Vacancy rates

Between July 2016 and June 2017, the trust reported a vacancy rate of 7.2% in medical care. The rate at The Tunbridge Wells Hospital at Pembury was 6.5%

The trust had a target vacancy rate of 8.5% the overall vacancy rate for medicine and at both sites was better compared to the trust target.

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

Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 1.1% in medical care. At Tunbridge Wells Hospital it was 0.4%

The trust target for turnover was 10.5%, medicine and both sites is performing better against this target.

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

Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 3.9% in medical care. At Tunbridge Wells Hospital it was 1.3%

The trust’s target sickness absence rate was 3.3% or lower, and both sites were better than 3.3%
Bank and locum staff usage

Between July 2016 and June 2017, the trust reported a locum and agency usage rate of 9% in medical care;

- The Tunbridge Wells Hospital at Pembury: Total of 646 shifts of which one percent was covered by locum staff and 99% covered by agency, a total of two shifts were not covered.

For medical care 12% of 1,836 shifts were covered by locum staff for the time period, 58% covered by agency and a total of two shifts was not covered.

The trust told us in their provider information request they had the highest bank or agency use on the following surgical wards, the short stay surgical unit and ward 31 which were at the Tunbridge Wells site, the reasons attributed to these were vacancies at both.

Staffing skill mix

Between June 2017 and 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 year 1-2) staff was the same.

Staffing skill mix for the 192 whole time equivalent staff working in Medicine at Maidstone and Tunbridge Wells NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>36%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>21%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. Medical care services used integrated records which were shared by doctors, nurses and other healthcare professionals. Staff explained that the paper records were being merged with electronic systems and were positive about the changes being implemented.
In the patient notes we reviewed we saw a good standard of record keeping. The records contained all required information such as admission details, signature list and consent to treatment. The care records included multidisciplinary input where required for example, entries made by physiotherapist, occupational and mental health practitioner. Progress notes were complete, clear, legible, dated and signed.

Patients’ records were readily accessible to those who needed them and we found on this visit that they were stored securely in locked notes trolleys.

We saw that patients were risk assessed in key safety areas using nationally recognised tools. For example, we noted the use of waterlow scores to assess the risk of pressure damage. We saw that risk assessments were reviewed and repeated within appropriate and recommended timescales.

On all wards saw staff updating and referring to purpose-built marker boards that were mounted on walls at the nurses’ station or bay. We observed patient names written on these boards and occasionally other details. When we asked, managers told us it was trust policy to record surnames only, but we saw this was inconsistently applied. The board did not have hinged covers which meant that the privacy of patients was not protected from casual observation by visitors or other patients.

**Medicines**

Overall, we found that medical services ensured the proper and safe use of medicines. The trust had current medicines management policies, together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Prescribers also had access to relevant resources on medicines management such as electronic and papers of the current British National Formulary.

We checked several resuscitation trolleys in medical services and noted that the trolley drawers were not secured by tamper evident tags. Although these had emergency use medicines in sealed boxes, these trolleys still contained intravenous fluids and infusions in drawers that could be opened by anyone. We felt this was a risk and brought it to the attention of the trust, who remedied this during the course of the inspection process.

The previous inspection report had highlighted concerns regarding competency checks for intravenous medicines for agency nurses. On this visit we saw that a local induction checklist was available and used to ensure agency nurses only undertook tasks when competent to do so.

We examined five prescription charts on wards in at The Tunbridge Wells Hospital at Pembury and found these were legally valid and contained information about people’s allergies. There was one missed dose on these charts. Most charts had been clinically screened by a member of the pharmacy team.

During our visits we saw that medicines were stored securely in locked, wall mounted cabinets and kept in key-coded rooms away from visitors. Controlled drugs were stored, recorded and handled in line with legislation. Spot checks on balances showed that contents of the cupboard matched the register. Medicines waste was handled in line with best practice and legislation and staff knew to check with the pharmacist before crushing medicines. They had access to resources to help with this.

We saw reminders for staff on critical medicines (medicines which should not be omitted) and lookalike or sound alike medicines to promote safe administration.
On two sites we checked, we noted temperature records for the medicines fridge were missing entries. On the day of the inspection, we saw that a new fridge record chart was being introduced by the trust to help improve temperature recording.

We found out of date medicines on one ward. This included medicines from the fridge and controlled drugs cabinet. Staff disposed of these immediately (apart from the controlled drug, which was segregated from in date stock). We also found some medicines stored at ambient temperature, which should be stored in the fridge. Staff disposed of them immediately.

Opening dates were not always on liquid medicines to ensure they were used within the correct expiry date. When we brought this the attention of the pharmacy and nursing staff, we saw they responded straight away to dispose of the stock and label the replacement medicines.

Staff knew how to report medicines incidents and demonstrated a good awareness of signs of sepsis.

Consultant microbiologist attends weekly ward rounds. We saw from prescription charts that antibiotics were reviewed regularly.

Staff told us that the trust dispensary was very busy and medicines did not always arrive on the ward in time; including medicines for people due to be discharged.

**Incidents**

The service managed patient safety incidents well. Staff were confident in recognising and recording incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported incidents using a commercial software package linked to the trust intranet and the people we spoke to confirmed they had received training and felt confident about using the system.

We saw evidence of learning from incidents that were shared across the trust through email alerts, announcements on the trust intranet and at local level during team and divisional meetings. For instance, we observed patients wearing anti-fall socks. Senior nurses stated this was the result of the directorate looking at ways to help reduce the number of patients slipping or falling, especially at night.

We noted that the software would not allow an incident to be ‘closed’ until the duty of candour section of the file was completed. This facility gave the trust extra assurance that duty of candour was being followed by managers dealing with the incident report.

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

(Source: NHS Improvement - STEIS (01/08/2016 - 31/07/2017)

**Breakdown of serious incidents reported to STEIS**
In accordance with the Serious Incident Framework 2015, the trust reported 48 serious incidents (SIs) in Medicine which met the reporting criteria set by NHS England between August 2016 and July 2017.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting serious incident criteria with 28 (58% of total incidents).
- All other categories with seven (15% of total incidents).
- Abuse/alleged abuse of adult patient by staff with five (10% of total incidents).
- Pressure ulcer meeting serious incident criteria with four (8% of total incidents).
- Venous thromboembolism meeting serious incident criteria with three (6% of total incidents).
- Surgical/invasive procedure incident meeting serious incident criteria with one (2% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

We observed ‘green cross’ charts displayed outside each ward we visited. These displayed current ‘safety thermometer’ information about key indicators such as falls and staffing levels. The charts helped relatives and visitors to the hospital understand what the trust was monitoring and how each ward was performing against the targets set by the trust. This indicted the organisation had developed a positive focus on safety and was transparent about the levels of harm-free care achieved.

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 21 new pressure ulcers, 24 falls with harm and 29 new catheter urinary tract infections between August 2016 and August 2017 for medical services.
The prevalence rate of pressure ulcers and catheter urinary tract infections has declined over the time period, with numbers falling to zero in August 2017.

Total falls reported were steady through the time period expect a peak in March 2017 however the most recent data reported no falls in August 2017.

(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. Managers checked to make sure staff followed guidance. New and updated guidance was evaluated and shared with staff.

We saw that staff were able to access national and local guidelines through the trust’s intranet. This was readily available to all staff and we noted there were appropriate links in place to access national guidelines if needed.

The standardised care pathways were based on current best practice and National Institute of Health and Care Excellence guidance. For example, the acute heart failure pathway and stroke pathways incorporated National Institute of Health and Care Excellence guidance. The trust routinely reviewed the effectiveness of care and treatment by using performance dashboards, local and national audits.
The minutes from various departmental and directorate-wide meetings showed that where audit results had been documented these were discussed and plans developed to address any issues.

**Pain relief**

The trust had a pain management policy that staff could read on the intranet, and the policy included information on how to contact the specialist pain team. Staff we spoke to know how to contact them.

Patient charts included space for recording patients’ perception of pain and we saw visual pain charts in use. These were designed to help patients who could not speak indicate their level of discomfort.

Nurses assessed pain at set intervals to check if they were comfortable and this was recorded on ‘rounding’ sheets.

Staff told us that pharmacist and pharmacy technician availability on the ward was “generally good”.

Patients confirmed to us that if needed, pain relief medication was promptly brought by staff.

**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 preferences.

The trust used nationally recognised tools to assess patients’ nutrition and hydration. We reviewed risk assessments while we examined patient notes and saw that overall, the nutritional assessments were up to date and additional support from the dietician service was available when needed. Some of the nutrition and fluid balance charts we sampled were incomplete. This meant it was not always possible to assess the patient’s hydration and nutritional status.

Staff explained that dieticians monitored patients who received nutrition through a nasogastric or parenteral feeding tube. Parenteral feeding is the process by which a patient receives nutrients intravenously bypassing the usual process of eating and digestion. We did not see any patients undergoing this therapy on the wards or units we visited.

Staff offered patients three main meals and snacks were available if needed. There was a choice of food available and the hospital was able to cater for specialist diets if required.

We saw staff using coloured plate mats to indicate people who needed assistance to eat their meals. In addition, the trust used a system of magnetised ‘pictograms’ to represent food or fluid restrictions as well as special dietary needs. These were mounted on display boards fixed to wall next to each bed in a bay or outside each separate room. These provided visiting staff and therapists with a visual reminder that the patient had a special requirement or need.

The 2017 patient-led assessment of the care environment survey showed the trust scored 92.84%, for food and hydration, which was better than the England average (89%).

**Patient outcomes - relative risk of readmission**

**Trust level**

Between May 2016 and April 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.

Elective admissions had a lower than expected risk of readmission overall, apart from general
Patients in general medicine had a higher than expected risk of readmission for elective admissions.

Patients in gastroenterology had a lower than expected risk of readmission for elective admissions.

Patients in cardiology had a lower than expected risk of readmission for elective admissions.

Non-Elective admissions general medicine and gastroenterology were similar to the expected value of 100.

Patients in general medicine had a higher 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 gastroenterology 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 (01/05/2016 - 30/04/2017))

The Tunbridge Wells Hospital at Pembury

Between May 2016 and April 2017, patients at The Tunbridge Wells Hospital at Pembury 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.

For Tunbridge Wells Hospital, all elective and non-elective admissions were in line with the England average apart from elective general medicine which was higher than the expected value.
Patients in general medicine had a higher than expected risk of readmission for elective admissions.

Patients in gastroenterology had a lower than expected risk of readmission for elective admissions.

Patients in Cardiology had a lower than expected risk of readmission for elective admissions.

Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions.

Patients in general medicine had a lower than expected risk of readmission for non-elective admissions.

Patients in gastroenterology had a similar to expected risk of readmission for non-elective admissions.

**Elective Admissions - The Tunbridge Wells Hospital**

**Non-Elective Admissions - The Tunbridge Wells Hospital**

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, Tunbridge Wells Hospital achieved a grade C in the latest audit, December 2016 to March 2017.

**The Tunbridge Wells Hospital at Pembury**

This site has been seen an improvement in its overall score from August to November 2016 audit where it scored a grade B from a previous score of D, however in the most recent audit it had moved down to a grade C.
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 one means that the result is in the lowest 25 per cent, whereas quartile four means that the result is in the highest 25 per cent for that audit year.
The 2016 National Diabetes Inpatient Audit identified 55 in patients with diabetes at Maidstone Hospital, 84.4% 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 two. This has dropped from the 2015 audit where Maidstone hospital scored 86.2%.

(Source: NHS Digital)

**Myocardial Ischaemia National Audit Project (MINAP)**

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

NSTEMI is a type of heart attack. NSTEMI stands for Non-ST-elevation myocardial infarction. Between April 2014 and March 2015, 31.7% of nSTEMI patients were admitted to a cardiac unit or ward at Maidstone and 99.2% were seen by a cardiologist or member of the team compared to an England average of 55% and 96.6%. Whereas for Tunbridge Wells Hospital 58.8% of nSTEMI patients were admitted to a cardiac unit or ward at Maidstone and 96.6% were seen by a cardiologist or member of the team compared to an England average of 95.1% and 55%.

The proportion of nSTEMI patients who were referred for or had angiography at Maidstone Hospital was 70% and at Tunbridge Wells Hospital was at 73% to an England average of 79%.

<table>
<thead>
<tr>
<th></th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maidstone Hospital</td>
<td>120</td>
<td>120</td>
<td>120 (120)</td>
</tr>
<tr>
<td></td>
<td>99.2%</td>
<td>31.7%</td>
<td>70% (No data)</td>
</tr>
<tr>
<td>Tunbridge Wells Hospital</td>
<td>119</td>
<td>119</td>
<td>111 (111)</td>
</tr>
<tr>
<td></td>
<td>96.6%</td>
<td>58.8%</td>
<td>73% (No data)</td>
</tr>
<tr>
<td>England: overall</td>
<td>45500</td>
<td>45500</td>
<td>38099 (38099)</td>
</tr>
<tr>
<td></td>
<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
</tr>
</tbody>
</table>

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

**Lung Cancer Audit**

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 61%, which was worse the audit minimum standard of 90%. The 2015 figure was 83.5%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 22.8%, this is worse than the national level. The 2015 figure was 20%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 68.4%, this is better than the national level. The 2015 figure was 56%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 71.4% this is better than the national level. The 2015 figure was 62%.

The one year relative survival rate for the trust in 2016 is 37.4% which is similar to the England average of 38%.

(Source: National Lung Cancer Audit)
National Audit of Inpatient Falls

The trust have 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 14.8% this worse than the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 8.3% this worse than the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 56% this similar to the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 75% this similar to the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

The trust had recruitment policies and procedures together with job descriptions for all grades of staff. Managers described how the trust completed recruitment checks to ensure new staff were experienced, qualified, competent and suitable for their post. All new employees undertook trust and local induction with additional support and training when required.

Agency staff had orientation packs delivered on their first shift and we saw completed examples matching staff names on rosters.

We saw electronic systems that assisted managers monitor the status of staff requiring validation and continuing registration with professional bodies. Registered nurses we spoke with told us the trust supported them in preparing for revalidation, which is a process all nurses and midwives must complete to renew their registration.

Management used the appraisal process to identify staff learning and development needs. Staff told us they had regular team meetings and were supported with their continuous professional development.

Nursing staff described having monthly 1:1 meetings with their ward managers. One nurse told us these happened “regularly and don’t get cancelled”. We saw examples of appraisal templates and completed forms.

We observed that staff were professional and competent in their interactions with colleagues, patients and their relatives/carers during our inspection.

A wide range of specialist nurses supported the nurses on the ward. For example, the dementia care team, palliative care team, safeguarding leads, diabetes care team and discharge coordinators.

Appraisal rates

Up to July 2017, 94% of staff within Medicine at the trust had received an appraisal compared to a trust target of 90%. Tunbridge Wells Hospital had an appraisal rate of 94%.

A split by staff group can be seen in the graph below:
Multidisciplinary working

We observed examples of good multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and general practitioners. Medical and nursing staff and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.

At meetings, we observed positive and proactive engagement between all members of the multidisciplinary team. We found the ward rounds were well organised and well attended by all members of the multidisciplinary team.

Medical, nursing and therapy staff of all grades described the good working relationships between staff and directorates.

The wards used integrated patient records, which were shared by clinical staff and therapists. This improved communication and meant that care was better co-ordinated between healthcare professionals.

Seven-day services

Seven-day cover was not available for all support services such as psychiatric support, radiology and some therapy services. There was no access to dieticians or speech and language therapists at weekends. This had an impact on the care of patients particularly on the stroke ward, where dietary advice and support with eating affected recovery and discharge times.

Medical out of hours cover were provided by on-call, agency or locum staff supplementing the permanent members of staff. Consultant cover was available every day including weekends, with on-call arrangements for bank holidays.

Diagnostic services were available throughout the week and staff did not report any issues with obtaining diagnostic results out of normal hours.

Discharge lounges were open during the day, from Monday to Friday.

Access to information

The trust had introduced a number of new electronic systems since our last visit. These included clinical packages such as electronic prescribing as well as general software such as the learning
management system. Electronic patient records were in the process of implementation during our inspection. Staff described the enhancements in positive terms.

At the time of our visit we saw mainly paper-based patient files. This meant there were sometimes delays when sharing information between hospitals and other providers who used electronic records and means of communication.

We saw that policies and clinical guidance was available on the intranet. Staff also had access to information and guidance from specialist nurses, such as the diabetic, stoma, and tissue viability nurses and the link nurses for dementia care, infection control and safeguarding.

There were systems in place to ensure the safe transfer of information when a patient moved between wards or hospitals.

All the staff we spoke with told us there was good communication and access to information between staff and between medical specialities.

Doctors told us they had prompt access to diagnostic results such as blood results and imaging. Staff said there was little or no delay in retrieving patient notes from the archives.

Site managers and senior staff routinely collected site data to inform the management of the hospital and the trust as a whole.

Management held ward and departmental meetings on a regular basis. The minutes from these meetings confirmed that information was shared including clinical updates and lessons learnt from incidents and complaints.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Across the medical directorate, staff demonstrated a good understanding of the legislation and best practice regarding consent, the mental capacity act and Deprivation of Liberty Safeguards. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment.

The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, the Mental Capacity Act, 2005 guidance and checklists for use when dealing with cases.

Mental Capacity Act and Deprivation of Liberty Safeguards training completion

The trust reported that between April 2017 and July 2017 mental capacity act (MCA) training had been completed by 98% of staff within Medicine.

The trust did not provide deprivation of liberty training as a separate module as this was part of the safeguarding level two module this was completed by 95% of divisional medical staff and 91% of nursing staff.

(Source: Trust Routine Provider Information Return P39)

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 of all grades treating patients and visitors with kindness, compassion, courtesy and respect.
All staff wore dementia friendly badges that clearly stated their names and we saw displays showing key staff working in each ward or unit area as well as posters describing how to identify staff grades and specialities from their uniform colours. This meant patients and visitors could more easily identify who was attending them. We also saw nurses wearing ‘nurse in charge’ armbands, which assisted staff and visitors who wanted to ask questions or seek help.

Staff introduced themselves to patients and relatives and we saw that patient privacy and dignity was maintained at all times. For example, curtains were used consistently in the bays and we saw staff knocking before entering bathrooms, side rooms and treatment rooms.

Our observations were supported by feedback from the patients we spoke to. They said they felt safe and were always treated kindly and respectfully. They told us there was no difference in the quality of care received during the day or at night. Patients said that staff asked them if they had everything they needed, were comfortable, pain free and had adequate hydration.

We saw examples of survey leaflets distributed in the medical unit. Called ‘Did you get great care today?’ the trust used the services of an independent organisation that allowed patients or carers to provide feedback on their healthcare. The 2017 patient-led assessment of the care environment survey showed the trust scored 86.9% for ‘privacy, dignity and wellbeing’, which was better than the England average (83%).

The units we visited comprised of side rooms with ensuite facilities. The acute medical unit provided a combination of rooms and bays as well as a day unit with couches. Rooms were prioritised for patients presenting with infection risks, but were also used to avoid mixed sex breaches in the bays.

We noted toilet door signs could be designated for use by men or women by a sliding plate, which helped to preserve the dignity of patients when bed bays were reallocated to different genders. Managers explained that while people of different genders were “occasionally” admitted into the same bay, but this was “always resolved before the night shift”.

**Friends and Family test performance**

The Friends and Family Test response rate for Medicine at the trust was 30% which was better than the England average of 25% between August 2016 and July 2017.

**Friends and family Test – Response rate between August 2016 and July 2017 by site.**
The average response rate for the trust varied between nine percent and 100%. There were some wards that had a low recommendation trend between July 2016 and July 2017 for example Charles Dickens Day Unit. It is also worth noting that data is only included for wards with total responses above 100 and the top 12 wards per site are shown.

(Source: NHS England Friends and Family Test)

**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 spoke to confirmed that staff explained care and treatment plans and they were provided with clear information. We saw staff providing people with information about their medicines during their stay. Staff described examples of times they involved other specialists such as the end of life care team to ensure people had correct medicines prescribed and ready for discharge. For example, the trust provided a chemotherapy triage phone line for people to call if they were experiencing problematic side effect from their medicines.
We observed staff wearing dementia-friendly name badges and we saw the widespread use of pictograms on magnetic boards outside rooms and bays. This indicated the trust actively considered ways to inform and involve patients and relatives about who was providing care and how this was being provided.

**Emotional support**

Staff provided emotional support to patients to minimise their distress. The hospital had arrangements in place to provide support when needed, which included help from specialists such as end of life, diabetes and dementia nurses.

Patients also had access to physiotherapists and occupational therapists who provided practical support and encouragement for patients with both acute and long-term conditions. Patients spoke highly of the therapy staff and told us of the help and support they received from them.

We saw examples of thank you notes and cards written to staff expressing their gratitude and some of these had been placed on display in ward offices.

There was a non-denominational hospital chaplaincy service, which provided pastoral support for patients and their relatives, carers and staff. Three chaplains were employed by the trust and the team was augmented by several church or mosque volunteers. The chaplaincy were available 24 hours a day throughout the week and could be contacted by staff, relatives or carers through the hospital switchboard. Staff we spoke to knew this and we also saw service leaflets on display in wards and units on both hospital sites.

The chaplain explained that all patients that wished to were encouraged and supported to attend the non-denominational Christian church service on Sunday and Islamic prayer services were also offered on Fridays. The chaplaincy team visited the ward at other time and provided spiritual and emotional support to patients, staff and relatives.

**Is the service responsive?**

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

**Average length of stay**

**Trust Level**

Between June 2016 and May 2017 the average length of stay for medical elective patients at the trust was 4.7 days, which was higher than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 8.5 days, which was higher than the England average of 6.6 days.

**Average length of stay for elective specialties:**

- Average length of stay for elective patients in gynaecological oncology was higher than the England average.

- Average length of stay for elective patients in cardiology was lower than the England average.

- Average length of stay for elective patients in gastroenterology was lower than the England average.

**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 similar to the England average.
- Average length of stay for non-elective patients in gastroenterology was higher than the England average.

**Elective Average Length of Stay – Trust Level**

![Bar chart showing elective average length of stay by specialty and trust level.

**Non-Elective Average Length of Stay – Trust Level**

![Bar chart showing non-elective average length of stay by specialty and trust level.

**The Tunbridge Wells Hospital at Pembury**

Between June 2016 and May 2017 the average length of stay for medical elective patients at The Tunbridge Wells Hospital was 3.7 days, which was lower than England average of 4.2 days. For medical non-elective patients, the average length of stay was 8.4 days, which was higher than England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology was lower than the England average.

- Average length of stay for elective patients in gastroenterology was lower than the England average.

- Average length of stay for elective patients in general medicine was higher than the England average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in geriatric medicine was lower than the England average.

- 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 gastroenterology was lower than the England average.

**Elective Average Length of Stay - The Tunbridge Wells Hospital**

<table>
<thead>
<tr>
<th></th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.7</td>
<td>4.2</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1.7</td>
<td>2.1</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>2.3</td>
<td>3.4</td>
</tr>
<tr>
<td>General Medicine</td>
<td>3.7</td>
<td>3.4</td>
</tr>
</tbody>
</table>

**Non-Elective Average Length of Stay - The Tunbridge Wells Hospital**

<table>
<thead>
<tr>
<th></th>
<th>This site</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>8.4</td>
<td>6.6</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>9.2</td>
<td>9.6</td>
</tr>
<tr>
<td>General Medicine</td>
<td>6.7</td>
<td>6.2</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>7.5</td>
<td>7.6</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

**Meeting people's individual needs**

The service took account of patients’ individual needs. The trust employed specialist nurses to support the ward staff. This included dementia nurses and learning difficulty link nurses who provided support, training and had developed resource files for staff to reference. Wards also had ‘champions’ who acted as additional resources to promote best practice.

For instance, the 2017 patient-led assessment of the care environment survey showed the trust scored 92.79% for dementia care, which was significantly better than the England average of 76% and 94.53% for care of people with disabilities against an average of 82%.

Red trays were used on the wards to identify those patients who needed assistance with feeding. We saw that eating and drinking requirements were clearly displayed near each bed or room using magnetised signs.

Nurses used ‘intentional rounding’ to help ensure that patients’ needs were met. Nursing staff usually carried out the rounds at set times through the days and we saw completed records confirming this.

We saw pictorial aids available for use with people with communication difficulties. Each bed had a call bell in place and within reach of the patient. We saw these being answered promptly by staff. Throughout the hospital we saw leaflets and useful information on display to help patients and their relatives understand their conditions and the treatment options available. The printed information was only available in English. Staff told us that an interpreter service was available for those patients who needed assistance.
The general environment had been designed to provide assistance for those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and manual handling equipment.

Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request. This meant that the hospital was able to care for patients with mobility difficulties.

**Access and flow**

People could access the service when they needed it. Overall, arrangements to admit, treat and discharge patients were in line with good practice.

Staff told us that patients were sometimes admitted to other parts of the hospital because of pressure on bed capacity. Outliers are patients admitted to wards outside of their speciality. This was a risk as the general environment was not always appropriate and staff did not always have the experience and expertise to manage the ‘outlying’ patients’ conditions.

Tunbridge Wells short stay surgical unit staff told us that it was challenging to get medicines doctors to come to the unit and that patients could wait hours to see a medicines doctor. We observed two medical patients’ notes in the short stay surgical unit both verified long patient’s waits to see medical department doctors. In one case a patient waited 21 hours, in another they had waited 17 hours and not yet seen a doctor. On the day of our inspection there were four outlier patients receiving care in areas of Tunbridge Wells hospital outside of their speciality.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

The trust’s referral to treatment time for admitted pathways for Medicine has been consistently above the England average for the whole time period, in August 2016, it was at 97% for this group of patients being treated within 18 weeks versus the England average of 91%.

The most recent data for July 2017 showed 99% 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**

Five specialties were better than the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>100%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>
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. We saw advice leaflets readily available on the wards and departments we inspected. Patients had access to the Patient Liaison and Advice service (PALs), who supported patients with concerns and complaints and provided information about NHS services.

Staff confirmed that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings and briefings. We reviewed a sample of team meeting minutes and saw that complaints were discussed and monitored.

Staff could access the complaints policy on the trust’s intranet and knew how to direct patients to make a complaint. Medical and nursing staff told us that they received feedback from any complaint they had been involved in.

Patients we spoke with said they would raise any issues or concerns with the ward staff in the first instance and were aware that a complaints process existed.

Between July 2016 and June 2017 there were 76 complaints about medical care. The trust took an average of 46 days to investigate and close complaints, this is not with their complaints policy, which states complaints should be completed within 25 days or within 60 days for complex complaints. The top three subjects the complaints related to were all aspects of clinical treatment (44) admissions, discharge and transfer arrangements with 12 and communication / information to patients (written and oral) with seven.

- Tunbridge Wells Hospital: There were 33 complaints.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

We saw examples of strong local ward and department leadership. The trust had managers with the right skills and abilities to run a service providing high-quality sustainable care.

Staff told us they felt well supported, valued and that their opinions counted. At a local level, we saw that nurses in charge were clearly identified by the use of armbands, which helped ensure local leaders were visible to staff and visitors.

All ward managers we spoke with knew what their wards were doing well and could clearly articulate the challenges and risks their team faced in delivering good care.

Staff generally spoke in positive terms about the visibility of the senior management team. They told us that the chief executive and chief nurse visited front line services on a weekly basis. They said they felt free to raise any issues with them direct or through their line manager.

Vision and Strategy
The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

We saw poster displays and other publications about the vision and values as we visited the wards. These were readily available for staff, patients and the public to view. In addition to information published for staff on the trust intranet, the trust published information about its mission, values and vision on its public website.

The trust’s started purpose was to provide safe, compassionate and sustainable health services and its vision to provide the highest, consistent, quality care to patients, whether in or outside hospital setting.

We saw values statements based on the word “PRIDE”, which meant “Patient First, Respect, Innovation, Delivery and Excellence”. Staff we spoke to were able to describe these statements and give examples that described an improving safety culture, better clinical leadership and governance.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke to confirmed this and described in positive terms how they felt appreciated, supported and enjoyed their work.

Staff spoke in positive terms about the team working with medical and specialist support to provide care.

Staff said they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure. This suggested that the trust had an ‘open culture’ in which staff could raise concerns without fear.

Governance

The trust operated a divisional governance model and ‘Triumvirate working’. This was a structure, which ensured that both clinicians and managers were involved in the management and planning of hospital activities at every level. The Triumvirate model usually consisted of a lead clinician, a senior nurse and a manager. Each of the triumvirate leadership teams had responsibility for designated wards and departments.

We reviewed the minutes of meetings, which demonstrated that regular team and management meetings took place. The minutes documented how information on incidents and complaints were investigated and any learning shared and good practice promoted.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

We found there were divisional risk registers in place. Managers we spoke with were aware of the risk registers and knew the main risks and the actions needed to reduce the risks.

Information Management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. The trust’s website provided safety and quality performance reports and links to other websites such as NHS Choices. This gave patients and the public a wide range of information about the safety and governance of the hospital.
Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. Senior clinicians described how the trust was a member of the Kent & Medway NHS Emergency Planning Group and the South East London, Kent & Medway Trauma Network Emergency Planning Reference Group.

Managers told us that the Trust was also a member of the Kent Resilience Forum, which brings together emergency services and other responders such as the NHS, utilities and the voluntary sector.

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups including the Stakeholder Forum, League of Friends and Healthwatch, feedback from the Friends and Family Test, inpatient surveys, complaints and the ‘How Are We Doing?’ initiative.

Stroke services organised ward based patient groups run in conjunction with charitable organisations. Patients and their families were given access to support groups and information resources to help them understand and adjust to stroke and traumatic brain injuries.

The “hello my name is …” initiative was widely practiced by staff and during our visit and we heard examples of staff using this when talking with patients. The initiative is aimed at raising awareness for staff to always introduce themselves to patients. Patients confirmed that staff always introduced themselves before any treatment or therapy.

The management team told us that any good ideas put forward by staff were discussed at weekly ward meetings and monthly team meetings. Useful suggestions and good ideas were then passed on to the clinical and quality boards. All the staff we spoke with felt informed and involved with the day-to-day running of the service and its strategic direction.

Learning, continuous improvement and innovation

The department was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.
The trust provides a range of general and specialised surgery including planned and emergency procedures. These covered a range of specialities including breast, gynaecological, oncology, ophthalmology, urology, gastro-intestinal, orthopaedics, pain management, vascular (day case only) and ear, nose and throat. The Tunbridge Wells site has a unit for emergency trauma surgery.

The trust has 20 main operating theatres across the two sites and each site has a day surgery unit. The trust has 12 surgical wards, which have 253 inpatient beds.

(Source: Routine Provider Information Return– “Sites-Acute” tab)

The trust had 34,951 surgical admissions between April 2016 and March 2017. Emergency admissions accounted for 8,651 (24.8%), 21,494 (61.5%) were day case, and the remaining 4,806 (13.8%) were elective.

(Source: CQC Insight)

Is the service safe?

Safeguarding

Safeguarding training completion rates

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

A breakdown of compliance for safeguarding courses between 01/04/2017 and 30/06/2017 for medical/dental and nursing/midwifery staff in Surgery is shown below:

![Safeguarding Training Completion By Module](chart.png)

![Safeguarding Training Completion By Module](chart.png)
Medical and Dental staff achieved the target of 85% for all safeguarding courses, except safeguarding children level 3, where compliance was 71%.

Nursing and Midwifery staff achieved the target of 85% for all safeguarding courses.
(Source: Trust Provider Information Request P18)

Both permanent and agency staff we spoke to were able to describe when they should refer a matter for safeguarding and who they would report to. Staff described safeguarding referrals they had made in the past.

During the inspection we saw that a staff member had made a safeguarding referral the day we were present. We saw the referral had been made through the correct channels and a safeguarding lead was coming to the unit to see the patient involved.

Mandatory training

The trust set a target of 85% for completion of mandatory training across 18 mandatory training courses. Its target for information governance training was 95%.

The service provided mandatory training in key skills to staff and met its overall training target. However it did not meet target levels for all individual training modules.

A breakdown of compliance for mandatory courses between April 2017 and June 2017 for medical/dental and nursing/midwifery staff in surgical care is shown below:
Medical and Dental staff did not achieve the target of 85% for four mandatory training courses, the lowest completion modules were Dementia Awareness (including Privacy & Dignity standards) with 50% followed by Medicine management training with 60% completion.

Nursing and Midwifery staff did not achieve the target of 85% for all training courses, the lowest courses were Dementia Awareness (including Privacy & Dignity standards), where compliance was 53% and Conflict resolution with 60% compliance.

Tunbridge Wells Hospital had an 85.8% mandatory training completion rate, there were five
modules where this location did not achieve the target; the lowest was Conflict resolution with a 50% completion rate followed by Dementia Awareness (including Privacy & Dignity standards) with 53% completion rate.

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

There was a policy for sepsis management last updated in 2016. At the time of inspection, 95.5% of the general surgeries directorate and 95.5% of theatres staff had completed their sepsis training. This meant the directorate exceeded the trust target of 85% for completion of mandatory training. Staff we spoke to reflected and understanding of sepsis screening tools and care bundles and showed us the plastic sepsis information cards they carried with them.

We saw that mandatory training included training modules about dementia awareness. However, only 53% of staff in the directorate had completed the training. This could mean staff did not have the knowledge and understanding to treat patients living with dementia in line with agreed guidance. However, senior staff explained the Dementia Awareness training rate was low because they were currently rolling out a new training program this training rate did not reflect the number of staff who had received dementia basic awareness training as part of mandatory training.

All staff in the directorate, 100% had completed Mental Capacity Act training. The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, the Mental Capacity Act 2005 guidance and checklists for use when dealing with cases.

This meant the staff would have an understanding of mental health conditions and their responsibilities for patients living with these conditions in line with agreed guidance.

We saw that staff were not required to have mandatory training specific to patients living with learning disabilities or autism.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

We saw there were policies and processes in place to keep the hospital environment clean. We saw there were standard operating procedures for cleaning clinical, non-clinical and specialist areas.

We saw monthly, weekly and quarterly cleaning audit results reflected all surgical departments and wards met the trust target of 90% or higher.

All of the surgical theatres and wards we observed appeared clean.

We saw the hospital had a Hand Hygiene Policy and Procedure that was in date. The hospital audited hand hygiene monthly. We saw results of monthly hand hygiene audits from April through September 2017 across four wards. The departments scored between 97% and 100% in all audits. This meant hand hygiene audits across the theatre departments and wards we saw that there were gloves and aprons available to staff throughout the surgical departments, wards and theatres at both hospitals. We saw staff members put on gloves before entering patient rooms on the wards. This meant supplies were available which could reduce the spread of infection and staff were using those supplies.

We saw that surgical trays were kept in the theatres preparations rooms. We reviewed 14 packaged equipment trays; all were labelled, in date and sealed. Staff told us that the equipment was decontaminated off site they said there had been problems with the service previously but
they had been resolved and they now received decontaminated equipment in a timely fashion. This ensured equipment would be clean and current.

We noted that there were pictures of each kind of tray in the room for staff awareness. This meant staff would know what equipment should be available on each tray and could raise the matter during preparation if equipment was missing or there was a problem with it.

The hospital has a system for managing the risk of Legionella (Legionnaires disease), a lung infection caused by Legionella bacteria. Legionella bacteria is spread when water supplies become contaminated with the bacteria which is more likely in larger, more complex water systems such as those found in hospitals. We spoke with one staff member who explained that hospital managed Legionella risk by flushing taps daily, submitting temperature readings weekly and testing the water for Legionella bacteria quarterly.

We reviewed the most recent Legionella quarterly tests. The August 2017 results demonstrated that no legionella was detected.

The trust provided data reflecting there had been no Meticillin-Resistant Staphylococcus aureus cases across the trust in the 12 months between April 2016 and March 2017. Meticillin-Resistant Staphylococcus aureus is a type of bacterial infection, which is resistant to many antibiotics and is capable of causing harm to patients.

The trust provided data reflecting there had been no Meticillin-sensitive Staphylococcus aureus cases in surgery departments across the trust in the 12 months between April 2016 and March 2017. Meticillin-sensitive Staphylococcus aureus is a type of bacteria in the same family as Meticillin-Resistant Staphylococcus aureus, but is more easily treated.

The trust provided data reflecting there had been three Escherichia coli cases at Tunbridge Wells in the 12 months between April 2016 and March 2017. Escherichia coli is a type of bacteria that can cause diarrhoea, urinary tract infections, respiratory illness, and other illnesses.

The trust provided data reflecting there had been no carbapenemase-resistant Enterobacteriaceae cases across the trust in the 12 months between April 2016 and March 2017. Carbapenemase-resistant Enterobacteriaceae is an antibiotic resistant bacterium capable of causing harm to patients. Notably, patients thought to be at risk of carbapenemase-resistant Enterobacteriaceae were managed as if they were infected unless tests proved otherwise.

We spoke to staff who worked in the pre-operative departments of both hospitals (while there was staff dedicated to each hospital, the manager oversaw the pre-operative departments at both hospitals and staff could occasionally provide cover at either hospital). They explained that surgical patients were tested for meticillin-resistant Staphylococcus aureus. If there was a positive result indicating the presence of Meticillin-Resistant Staphylococcus aureus, elective and non-emergency patients were treated and were required to have a further three clear tests before surgery.

Staff explained that any patients who had possible exposure to carbapenemase-resistant Enterobacteriaceae in the past 12 months would be screened. We saw this was in line with the hospitals Control and Management of carbapenemase-resistant Enterobacteriaceae and carbapenemase-resistant Enterobacteriaceae Policy, which was in date.

If an urgent or emergency patient had a positive or unknown Meticillin-Resistant Staphylococcus aureus result or had been exposed to carbapenemase-resistant Enterobacteriaceae in the past 12 months, they would be treated as a patient with an infectious disease. This meant liaising with the
consultant and infection control team; urgent testing, arranging for surgery in the last timeslot of the day and treatment in a private room.

The trust provided data reflecting there had been eight Clostridium difficile case at Tunbridge Wells in the 12 months between April 2016 and March 2017. Clostridium difficile is a type of bacteria that can infect the bowel and cause diarrhoea.

We saw that the hospital has an endoscope reprocessing unit, where flexible endoscopes were reprocessed (decontaminated), separate from the unit where endoscopies were performed. The reprocessing unit was secured by a locked door. We saw that equipment followed a dirty to clean pathway, including separate rooms for clean and dirty scopes with separate entrances. This was in line with the Department of Health, Health Technical Memorandum 01-06: Decontamination of flexible endoscopes.

**Environment and equipment**

The service had some suitable premises and equipment and some premises were not suitable as outlined below.

We looked at 19 supplies and pieces of equipment on the ward trolley, such as needles, syringes and equipment to manage blocked airways, and saw they were sealed and in date.

However, we saw that one drawer was an open shelf; this meant any person on the ward could easily tamper with or remove supplies or equipment from the trolley. Two of the drawers had been switched so that all of the supplies listed in drawer four, were actually in drawer five. In an emergency this could delay staff in finding the equipment they needed.

We observed staff using sharps in a safe way. We saw staff using safe practice to put blades onto handles and saw staff in theatres department used a magnetic blade box. This meant staff minimised risks in their use and disposal of sharps.

We saw emergency equipment in the theatres including emergency eye wash equipment. There were adult and paediatric resuscitation and difficult airway trolleys available for theatres.

We saw that resuscitation trolleys on the wards and in theatres were unlocked and were not sealed with tamper evident seals. Trolleys need to be kept where they are accessible in the case of emergencies. In theatres they were kept in the department where only staff could access them but the trolleys on the wards were in a public space. This meant that staff or members of the public could remove or tamper with supplies from the trolleys and staff would not know the trolleys had been accessed.

Since the inspection the trust reported it has taken remedial action to ensure a tagging system is in place to provide tamper-evidence and secure the intravenous fluids contained within these trolleys at the trust. The hospital reported for those trolleys that were not compatible with tamper tags, the additional tamper evident containers had been placed. The daily checklist has been amended to include the tamper tag check. This means that it will be evident if anyone has tampered with trolleys or their contents and staff can take action.

Staff told us a theatre practitioner performed anaesthetic machine checks. As part of the checks they calibrated the oxygen sensor, checked valves, flushed the system, checked gases, etc. Log books were kept to record anaesthetic machine checks. Staff told us they were confident checks were performed by ODPs on anaesthetic equipment.

In theatre five we saw the logbook was completed and signed in accordance with best practice. However, we saw anaesthetic machine checks were not always recorded. We observed the log
book in theatre one was signed inconsistently, had no checklist and one week was missing. In theatre four, staff could not find the log book when it was requested.

**Design, maintenance and use of facilities**

**Surgical Short Stay Unit**

The Surgical Short Stay Unit was built to provide day surgery patients with a ward to recover for approximately four hours, and not more than 23 hours. Therefore, when it was being used as a Surgical Short Stay Unit the unit was fitted with trollies separated by curtains; there were no private rooms, attached bathrooms or TVs. There were two toilets and two shower room/toilets on the Surgical Short Stay Unit. Staff reported there were not always enough showers and toilets to serve patients, particularly when patients were showering as this limited the number of available toilets to two.

We saw the entire Surgical Short Stay Unit had been escalated for longer term recovery due to increased demand for beds; staff told us they were not aware of a plan for de-escalation in the foreseeable future due to capacity demands.

The process for ward escalation was defined in the Escalation and Patient Flow Management and Procedure, which was in date. However, the long term Surgical Short Stay Unit escalation did not appear to be on the trusts escalation protocol. This meant there was not planned flow for the escalation of the Surgical Short Stay Unit.

When the ward was escalated, the hospital replaced trollies (which are generally used for transport and short term care) with hospital beds in line with the general escalation protocol.

The Escalation policy stated, ‘An individual risk assessment will be taken of each patient placed in the escalation areas to minimise the risk of an adverse incident.’ However, we did not see individual risk assessments and when we asked staff about patient assessments they told us patients with certain diagnoses or care requirements were excluded, however we did not see documentation of individual risk assessments.

There were surgical, medical and orthopaedic patients treated on the Surgical Short Stay Unit. Staff told us that although there were criteria for admission they were not always followed. Staff told us they sometimes had to ‘push back’ when there were requests to put these patients on the Surgical Short Stay Unit.

Staff told us the ward received lower acuity patients with the exception of tracheotomy patients, patients with diarrhoea and vomiting and patients who wandered due to short term confusion or a longer term diagnosis. Staff on the ward were not able to provide a document defining the patient criteria for the escalated Surgical Short Stay Unit. Although CQC requested the information, the hospital did not provide information patient criteria for the escalated Surgical Short Stay Unit.

There are no further criteria in either the escalation policy or the Surgical Short Stay Unit general admission criteria for patients admitted to the Surgical Short Stay Unit during escalation.

Each bay was separated by a paper curtain. We noted that some patients kept the curtains open and some closed them but the conversation could be heard behind the curtains. This meant that patients were treated on large open wards which could create an infection risk.

As the day surgery ward had been escalated, the department no longer had a fixed recovery ward for day patients. Staff told us that they ‘borrowed’ space from other departments. We saw on the day we were present that day surgery had ‘borrowed’ space for six trollies from the theatres
recovery area. We saw that the trollies were not separated by curtains and two patients were awaiting their surgeries.

We observed there were two showers and four toilets to serve patients and visitors in the Surgical Short Stay Unit. Two of the toilets were in bathrooms with the showers. As a result, in some cases only two toilets were available to all patients in the ward. Staff told us this meant patients might have to wait for showers or toilets.

Staff told us that lack of places to have private confidential conversations was an issue elsewhere in the hospital. For instance, they told us pre-operative patients could be seen in a curtained space or an enclosed space called a pods, but these were not adequately sound proof. This meant patients in pre-operative sessions might have confidential conversations where they could be overheard or, might not provide confidential information for fear of being overheard.

We saw that in the theatre departments, doors to secure areas were locked and required passes or codes to enter. This meant unauthorised people could not enter the areas which could pose a risk to patients, staff, equipment and supplies.

Some theatres, for instance where orthopaedic surgery was performed, had lamina flow ventilation. This is a ventilation system which blows clean air constantly over the area where the surgery is performed to ensure a sterile environment.

We saw there was a preparation room, shared by two theatres, where equipment was prepared before surgery. This area did not have a lamina flow system but used a filtrated air system to ensure equipment remained uncontaminated.

However, we did note that the office in the surgery reception area was left unlocked when no staff members were present and we were able to access the reception area. This could pose a threat to patients and records or supplies held in this area.

**Maintenance and use of equipment**

We reviewed 11 pieces of equipment in theatres and noted all equipment was labelled with stickers reflecting that they had been serviced in the past year.

We saw that sinks in the wards were compliant with regulations to ensure that they minimised the spread of infection.

**Managing waste and clinical specimens**

We saw that in theatres, waste was segregated and classified to keep people safe. We saw domestic waste was disposed of in bins with black bags and infectious waste in bins with orange bags. All bins we reviewed in theatres were empty. This meant the department was compliant with regulations requiring them to segregate waste and manage waste to minimise risk to staff and service users.

**Assessing and responding to patient risk**

We spoke to pre-operative nurses who explained how they worked with patients, anaesthetists, consultants and specialists to identify and address risks prior to surgery. These risks could include comorbidities such as diabetes, sleep apnoea, other diagnoses, weight, previous problems with anaesthesia and other issues.
If a patient was identified as high risk by the nurses based on responses to health questions or other information, the patient could be referred to the high risk clinic. At this clinic they would meet with the anaesthetist to address the risks.

We saw there was sepsis information available to staff which was posted in the breakroom and department. The hospital had a sepsis lead nurse and staff told us they were available as necessary. Staff we spoke to were able to demonstrate an understanding of sepsis signs and treatment. They showed us the sepsis information cards they carried as reminder about sepsis. Staff told us audits had reflected that staff needed to work on their sepsis awareness. They told us they were working to improve knowledge with training, monitoring and Sepsis Champions.

The World Health Organisation Safer Surgery Checklist is a checklist to ensure all members of the theatres team take necessary steps to avoid incidents and injury associated with surgery. There had been never events at Tunbridge Wells Hospital that could have been avoided by accurate use of the World Health Organisation Checklist. Staff told us after these events learning was shared and they had taken the World Health Organisation Checklist more seriously; although it was repetitive, they saw the World Health Organisation Checklist’s value.

We observed staff performing the World Health Organisation Checklist in theatres during our inspection. We saw they applied the checklist correctly. This meant, on the day of inspection, there were processes and systems in place to protect surgery patients from accidents or injury.

We saw the trust audited compliance with application of the World Health Organisation Safer Surgery Checklist in 5% -16% of cases at Tunbridge Wells Hospital, depending on the theatre. Audits across all theatres, excluding endoscopy, at both sites from April through October 2017 showed staff complied with the World Health Organisation Safer Surgery Checklist in 98% to 100% of audits. This showed theatres staff were completing the World Health Organisation Safer Surgery Checklist and the trust exceeded its target of 90% compliance for all audits.

We saw the trust audited the endoscopy theatres World Health Organisation safer surgery checklist compliance separately. Audits across both hospitals in the trust from April through October 2017 reflected compliance of more than 90% for all audits. This showed endoscopy staff were completing the World Health Organisation safer surgery checklist and the trust exceeded its target of 90% compliance for all audits.

Staff told us the World Health Organisation checklist used in the endoscopy theatres was developed collaboratively and approved by a lead consultant to be signed by the lead endoscopist.

Staff told us they had access to mental health staff. They told us they worked well together, knew how to contact them and mental health staff were accessible and responsive.

The trust used the National Early Warning System track and trigger flowchart. The flowchart is a scoring system in which a score is allocated to physiological measurements (temperature, oxygen, blood pressure, pulse, etc) to assess risk. The National Early Warning System flowchart allowed staff to identify patients who were becoming unwell, before they became critical and provide them with increased support.

There was a twenty-four hour in house service for emergency surgery and there was an agreement with another trust for emergency interventional radiology services.

**Nursing staffing**

The trust has reported their staffing numbers below for the period April and June 2017. There is a total of 158.09 WTE less staff in surgery across all staffing groups.
Qualified nursing & health visiting staff (Qualified nurses) had less than 74.59 WTE staff then the trust planned for to provide safe care within surgery.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>400.07</td>
<td>325.48</td>
</tr>
<tr>
<td>Total</td>
<td>400.07</td>
<td>325.48</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 26.6% in Surgical care at Tunbridge Wells Hospital.

The trust has a target vacancy rate of 8.5% the overall vacancy rate for surgery was worse than this trust target.

(Source: Routine Provider Information Request P17 Vacancies)

This issue was rated as a moderate risk on the trust’s risk register, which could affect the ability of the theatres to safely and efficiently run several theatres lists.

Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 1.2% in Surgical care at Tunbridge Wells Hospital.

The trust target for turnover was 10.5% the turnover rate for surgery was better than the target.

(Source: Routine Provider Information Request P18 Turnover)

Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 3.2% in Surgical care at Tunbridge Wells Hospital.

The trust's target sickness absence rate is 3.3% or lower, the hospital was better than the trust average which was 3.7%.

(Source: Routine Provider Information Request P19 Sickness)

Bank and agency staff usage

Between July 2016 and June 2017, the trust reported a bank and agency usage rate of 91% in Surgical care:

- Tunbridge Wells Hospital: Total of 10,360 shifts of which 68% covered by banks staff and 26% covered by agency, a total of 941 shifts were not covered.

For surgical care 51% of 12,349 shifts were covered by bank staff for the time period, 40% covered by agency and a total of 1,053 shifts was not covered, accounting for an average 87 shifts a month.

The trust told us in their provider information request they had the highest bank or agency use on the following surgical wards, the short stay surgical unit and ward 31, the reasons attributed to these were vacancies at both.
Staff we spoke to in different departments reported differing levels of agency and bank staff usage. Staff in the pre-operative department told us they used no agency staff and one regular member of bank staff.

Staff we spoke to in the theatres departments told us vacant shifts were often filled by staff performing overtime hours. The number of overtime hours were highlighted by an electronic rostering system. The system would not stop overtime shifts but would flag excessive shifts. This was managed by band 7 staff. Band 7 staff provided examples of when they had told staff to limit their overtime due to tiredness on shifts. This meant the system allowed staff to work unlimited overtime but senior staff were monitoring individuals.

However, the risk register identified rostering in theatres as a moderate risk to the trust because the current paper system left the department open to the risk of mis-reporting staff on duty or creating an inaccurate audit trail.

Staff told us they did not always have enough staff to fill the roster. For instance, staff on the Surgical Short Stay Unit told us they often did not have as many staff members as the register required. They told us they managed short staffing by raising incident reports when they believed this might put patients at risk.

The hospital reported that 941 shifts were not filled by any staff. We saw the hospital managed uncovered shifts by keeping record of: average fill rate of shifts; associated nurse sensitive indicators such as FFT scores, falls and pressure ulcers; comments about whether the risk level was expectable or rational for under filling; and fiscal indicators. The spreadsheets we provided were from summer 2017. However, their commentary indicated that some shifts were unfilled due to vacancies or staff absence rather than a risk analysis.

Staff members told us the Surgical Short Stay Unit had trouble recruiting and retaining staff because staff had to be ‘day case nurses’ but also had to be willing to work nights and weekends. They told us this meant it would not fit many nurses’ experience or requirements.

Staff on the Surgical Short Stay Unit told us they had a high level of agency staff usage. They reported they tried to use the same agency staff members repeatedly although this was not always possible. The told us not all agency staff received inductions, although some did.

**Medical staffing**

The trust reported their staffing numbers for medical and dental staff with less than 18.95 WTE staff then the trust planned for to provide safe care within surgery.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>268.00</td>
<td>249.05</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>268.00</strong></td>
<td><strong>249.05</strong></td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

258
Between July 2016 and June 2017, the trust reported a vacancy rate of -42.9% in Surgical care at Tunbridge Wells Hospital.

The trust has a target vacancy rate of 8.5%, Medical and dental staff at Tunbridge Wells Hospital is overstaffed by 42.9% and does not have a vacancy rate.
(Source: Routine Provider Information Request P17 Vacancies)

The trust risk register reflected there was a lack of consultant anaesthetists at the hospital following changes to the rota to meet relevant guidelines. This was rated as a moderate risk level. Risks could include; increased complexity in covering all aspects of the rota, reduced ability to cover additional activity, sickness and leave, increased locum use and increased costs.

The risk register also identified a shortage of endoscopy clinicians that could impact the trust’s ability to endoscopy targets including for cancer and diagnostic pathways.

**Turnover rates**

Between July 2016 and June 2017, the trust reported a turnover rate of 1% in Surgical care at Tunbridge Wells Hospital.

The trust target for turnover was 10.5% which surgery is better against.
(Source: Routine Provider Information Request P18 Turnover)

**Sickness rates**

Between July 2016 and June 2017, the trust reported a sickness rate of 1% in Surgical care at Tunbridge Wells Hospital.

The trust’s target sickness absence rate is 3.3% or lower, the hospital was better than target and the trust average which was 3.7%.
(Source: Routine Provider Information Request P19 Sickness)

**Bank and locum staff usage**

Between July 2016 and June 2017, the trust reported a locum and agency usage rate of 99% in Surgical care;

- Tunbridge Wells Hospital: Total of 3,489 shifts of which 29% covered by locum staff and 70% covered by agency, a total of 44 shifts were not covered.

For surgical care at the trust, 30% of 6,976 shifts were covered by locum staff for the time period, 69% were covered by agency and a total of 70 shifts were not covered, accounting for an average six shifts a month.

The trust told us in their provider information request they had the highest bank or agency use on the following surgical wards, the short stay surgical unit and ward 31 which are at the Tunbridge Wells site.
(Source: Routine Provider Information Request P2P Medical Locums)

**Staffing skill mix**

Between 01 June 2017 and 30 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 year 1-2) staff was higher.
Staffing skill mix for the whole time equivalent staff working at Maidstone and Tunbridge Wells NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>38%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>16%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Surgery was consultant led and there was a consultant for general surgery on call at all times. There were consultant led ward rounds twice a day. There was a consultant of the week who was on call for acute patients seven days a week and was to see all high risk patients within an hour.

Records

Staff kept clear and up-to-date records which documented care and were available to all staff providing care. The trust used integrated records which were shared by doctors, nurses and other healthcare professionals. Paper records were being merged with electronic systems and we were told the hospital planned to become ‘paperless’ in the future.

Records were clear, up-to-date and available to all staff providing care, however they did not always record pain observations.

We reviewed four sets of patient records on the Surgical Short Stay Unit including two medical patients and two surgical patients who were all managed by the nurses on the short stay surgical ward. We saw that all notes were signed and dated.

Surgical patients’ notes included pre-operative notes, post-operative checklists, World Health Organisation checklists and consent forms. This meant staff had the necessary information in available to them before surgery.

However, we saw that none of the four sets of records reflected regular pain scoring or management. One set of notes did not include a falls assessment and two did not include nutritional scores.

We saw the hospital audited 50 anaesthetic charts in January 2017. The audit showed that staff were not meeting the standards for record keeping set by the trust for any element of the audits. To meet the standards, at least 100% of records needed to be compliant; to partially meet the standards, 80% compliance was necessary. Compliance was partially met or not met in the following audited sections: Patient Information (83%), Pre-op Assessment (71%), Airway (89%), Intra Op (78%), Post Op (82%) and certain diagnostic tests for high risk patients (59%). This showed the records did not meet the trusts standards in any area.
Medicines

The service prescribed, gave, recorded and stored medicines well. Patients generally received the right medication at the right dose at the right time although there are some issues with pain management as discussed below.

The trust had current medicines management policies, together with protocols for high-risk procedures involving medicines such as the intravenous administration of antibiotics. These were readily available for staff to access. Prescribers also had access to relevant resources on medicines management such as electronic and papers of the current British National Formulary.

Throughout the wards and theatres we observed medicines were stored securely and kept within their expiry dates. We saw that during rounds medicines were kept with charts on a lockable trolley so that the nurse could move around the ward with the medications.

We saw throughout the wards and theatres controlled drugs were stored, recorded and handled in line with policy. Spot checks on balances showed that contents of the cupboard matched the register.

We saw reminders for staff on critical medicines (medicines which should not be omitted) and lookalike/sound alike medicines to promote safe administration.

We saw throughout the wards and theatres medicines waste was handled in line with policy.

However, the resuscitation trolleys throughout the wards and theatres were not tamper evident. As described above, since the inspection the trust reported it has taken remedial action to ensure a tagging system is in place to provide tamper-evidence and secure the IV fluids contained within these trolleys at the trust.

Opening dates were not always on liquid medicines to ensure they were used within the correct expiry date.

On the recovery ward, the temperature of the medicines fridge was not always monitored. For example, 20 days were missed in August 2017, 9 days were missed in September 2017 and 7 out of 18 days were missed in October 2017.

We found an out of date cytotoxic spill kit on the ward (expired 2015); staff disposed of this immediately.

Incidents

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 01 August 2016 and 31 July 2017, the hospital reported two incidents classified as never events for Surgery. Incident 2016/23057/RWF occurred in July 2016, a wrong sided femoral knee component was inserted rather than a left. The second incident 2016/29789/RWF occurred in November 2016, an incorrect procedure, Novasure ablation, was carried out to a patient who attended for gynaecology day case.
A third never event occurred in the week leading up to the inspection (in addition to those listed above) where the wrong body part received a pain block during a surgery, although surgery was performed on the correct body part.

The service managed patient safety incidents well in some instances. Staff recognised incidents and reported them in line with policy, although serious incidents were not always classified in a timely way. Managers investigated incidents but lessons were not always shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and support.

Staff told us there was an incident reporting culture; they were encouraged to report incidents and there was a no ‘blame culture’ associated with reporting incidents. Staff were able to tell us the kinds of incidents that should be reported and give examples of when they had reported incidents.

Staff told us when they reported an incident on the reporting system; they could tick a box to request feedback. They told us when they ticked the box, they usually received the feedback.

The provider had a responsibility under Duty of Candour, which required them to tell patients or their family members when certain incidents occur. We saw the provider met this duty with regard to the never events. For instance, after the most recent never event, the anaesthetist involved spoke to the patient directly to explain and apologise.

We saw that learning was taken and shared from some incidents. For instance, staff told us that after the most recent never event, the matter had been reviewed and that staff was being reminded to ‘stop before you block’. We saw that there were ‘Stop Before You Block’ signs in the staff rooms which we were told had been put up since the never event. A full analysis had not yet been completed.

Staff told us sometimes lessons were shared by e-mail. We saw boards in the staff room for sharing learning from incidents. We saw information from the never events was posted there.

We saw when root cause analysis were completed; the lessons were shared with those involved. In one case we saw a supervision and support plan for a staff member. In another case a policy was changed.

However, we saw that sharing was not always identified or shared and learning was not systematically identified, disseminated or audited.

Further, we saw that learning might be shared at a meeting, on a notice board or in notes. However, there was no set way to share all learning from incidents and there was no system to ensure that staff had seen the information or identify which staff might still need to be informed. This meant senior staff might no know who had been informed of learning or changes and staff might not know if they had missed information.
Lessons from incidents were not always complete or imbedded. For instance, we saw signs in the theatre department about not using certain equipment; however the sign did not provide information about what equipment to use instead or further resources. When we asked staff they told us they thought they knew what changes to make, but that the precise information had not been provided. Staff told us they would receive e-mails about changes to practice but no further information or training. This meant staff might receive information about learning from incidents but not know how to apply or imbed it.

Staff told us they were not regularly informed about investigation process or outcomes. We saw that incidents were on the agenda of the hospital’s Theatre Monthly Team Meeting Minutes, but were not always discussed. This meant staff were not receiving regular information to keep them up to date.

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

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents in Surgery which met the reporting criteria set by NHS England between 01 August 2016 and 31 July 2017.

The incident types broke down as follows:

- Surgical/invasive procedure incident meeting serious incident criteria with three (30% of total incidents).
- Slips/trips/falls meeting serious incident criteria with three (30% of total incidents).
- Treatment delay meeting serious incident criteria with one (10% of total incidents).
- All other categories with one (10% of total incidents).
- Sub-optimal care of the deteriorating patient meeting serious incident criteria with one (10% of total incidents).
- HCAI/Infection control incident meeting serious incident criteria with one (10% of total incidents).

(Source: Strategic Executive Information System)

**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 seven new pressure ulcers, 16 falls with harm and 12 new catheter urinary tract infections between 01 August 2016 and 31 August 2017 for Surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Maidstone and Tunbridge Wells NHS Trust

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

We saw policies, guidelines and Standard Operating Procedures were evidence based, comprehensive and in date.

The hospital stored all policies and guidelines on an electronic system. Staff were able to demonstrate how they could access the policies and guidelines on the electronic system.

We observed staff applying guidelines when discussing the order of an emergency surgery list.
**Nutrition and hydration**

Staff generally 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 preferences. However, some patients were starved for longer than clinically necessary before surgery when surgeries were delayed.

Patients and staff told us patients were able to choose their food from various options and the kitchens catered for any special dietary requirements.

Staff on the Surgical Short Stay Unit told us that it was not set up for hot meals as it was a day surgery unit, but when the unit was escalated, they arranged for hot meals to be served. Patients on the Surgical Short Stay Unit told us that they received hot meals, drinks and sandwiches. They said staff gave good food options however patients on the ward provided mixed reviews about the food telling us it was anywhere from bad to excellent.

Patients on Ward 31 reported they had received clear information about fasting times and understood why fasting was important. One patient told us they were given food immediately after going to recovery and that the food was excellent.

However, two patients we spoke to in the waiting area told us they had been starved for more than twelve hours while waiting for surgery due to delays. One of four sets of notes we reviewed reflected excessive fasting times prior to surgery. The patient fasted for 22 hours without food and went 15 hours without water. Clinically unnecessary fasting times could put patients at risk discomfort and injury.

**Pain relief**

We saw that pain during surgeries was managed by the anaesthetist who met with patients before surgery to understand their surgery, history and individual needs as part of the pre-operative process. Anaesthetists use their knowledge and expertise to manage patients’ pain during the surgical process. The anaesthetists and consultants were available to discuss pain management after patients were on the ward and staff told us they were accessible.

Staff told us in some cases the doctor would provide a verbal order for the medication over the phone so that the patient would not need to wait. In this case the doctor would sign the order later in the day.

Patients on all wards were asked to use a scale of one to ten to rate their level of pain. However pain was managed differently on different wards.

Patients we spoke to on Ward 31 reported they had adequate pain medicines and were not in pain.

On the Surgical Short Stay Unit we saw that patients’ pain was not always managed quickly and proactively. We observed staff on the ward asking patients for their pain score and offering patients medication. Some patients told us their pain was well managed however, some told us they were in pain.

We reviewed four sets of patient notes on the Surgical Short Stay Unit. On one set of notes, no pain assessment was completed. The other three sets of notes all reflected delays to pain management. One set of notes reflected a patient rated their pain as five out of ten but had to wait
90 minutes for pain medication to be given. Another set of notes reflected a patient with a pain score of five out of ten waited 70 minutes for pain relief and their pain was not assessed again for nine hours.

We reviewed one set of notes from the Surgical Short Stay Unit where a patient rated their pain eight to ten out of ten for more than 48 hours. The patient gave a pain score of nine out of ten at 6:14, received pain medication at 9:53 rated their pain score as nine out of ten at 9:55, 14:00 and 18:20 before receiving pain medication at 18:20. The patient was treated with the same pain medications throughout the 48 hour period. The patient’s pain level was not escalated for consultant or anaesthesiologist review for 48 hours. When we asked treating nurses on the ward about this, they told us they could not explain why the pain levels had not been escalated sooner but they should have been.

When we asked other nurses on the ward about time scales for escalating pain, they told us they would expect to contact a consultant or anaesthetist in a matter of one or two hours, if pain medication was not effective. A senior nurse told us they would expect to see pain escalated within half an hour if pain medication was not working. Staff told us they would take a second pain score 20 minutes after pain medicines were given but this was not always documented.

However, the trust’s guideline for the assessment of pain in adults and pain assessment tool did not provide clear guidance about when or how often pain should be reviewed and recorded after the initial assessment. This meant if a nurse was unsure about when to take pain observations, there was no clear guideline to which they could refer.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

Between 01 May 2016 and 30 April 2017:

All patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.

Ear nose and throat patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

Urology patients at the trust had a similar expected risk of readmission for elective admissions when compared to the England average.

All patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

General Surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & Orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Ear nose and throat patients at the trust had a higher 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 (01/05/2016 - 30/04/2017))

The Tunbridge Wells Hospital

Between 01 May 2016 and 30 April 2017:

All patients at The Tunbridge Wells Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients at The Tunbridge Wells Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Ear nose and throat patients at The Tunbridge Wells Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

Trauma & Orthopaedics patients at The Tunbridge Wells Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.

All patients at The Tunbridge Wells Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

General Surgery patients at The Tunbridge Wells Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & Orthopaedics patients at The Tunbridge Wells Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Ear nose and throat patients at The Tunbridge Wells Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - The Tunbridge Wells Hospital
Non-Elective Admissions - The Tunbridge Wells Hospital

Hip Fracture Audit
In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6.3% which was within the expected range. The 2015 figure was 8.3%.

The proportion of patients having surgery on the day of or day after admission was 76.3%, which was worse than the national standard of 85%. The 2015 figure was 80.5%.

The perioperative medical assessment rate was 98%, which failed to meet the national standard of 100%. The 2015 figure was 94.6%

The proportion of patients not developing pressure ulcers was 98.8% which falls in the top 25% of trusts. The 2015 figure was 95.7%.

The length of stay was 23.1 days, which falls in the middle 50% of trusts. The 2015 figure was 23.2 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit
In the 2015 Bowel Cancer Audit, 80.3% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2014 figure was 75.9%.

The risk-adjusted 90-day post-operative mortality rate was 4.3% which was within the expected range. The 2014 figure was 1.6%

The risk-adjusted 2-year post-operative mortality rate was 11.4% which was a positive outlier. The 2014 figure was 23.6%

The risk-adjusted 30-day unplanned readmission rate was 9.6% which was within the expected range. The 2014 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 41.8% which was within the expected range. The 2014 figure was 39.6%

(Source: National Bowel Cancer Audit)

National Vascular Registry
Data is not available for this metric.
### Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 2.6%. This placed the trust within top 25% of all trusts for this measure.

The trust was not eligible for the 90-day post-operative mortality metric.

The proportion of patients treated with curative intent in the **Strategic Clinical Network** was 37.6% this 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.

### National Emergency Laparotomy Audit

In the 2016 National Emergency Laparotomy Audit, The Tunbridge Wells Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 136 cases.

The Tunbridge Wells Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 93 cases.

The Tunbridge Wells Hospital achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 84 cases.

The Tunbridge Wells Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 67 cases.

The risk-adjusted 30-day mortality for The Tunbridge Wells Hospital was within the expected range, based on 233 cases.

### Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures 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 performance on groin hernias was worse than the England average. Groin Hernia – EQ-5D index showed slightly better performance than the England average.

No trust data was available for Varicose Veins.

For hip replacements, performance was slightly better than the England average.

For Knee replacements performance was about the same as the England average.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff in the theatres departments described orientation and training programs for new and existing staff.

Staff told us they were working to increase the competency of staff by training four Band 4 theatres staff members to become assistant practitioners. Assistant practitioners were trained in one to two particular areas of clinical practice to provide certain types of care under the direction of a nurse. This upskilling could provide the theatres team with more skill and flexibility through internal training.

However, on the Surgical Short Stay Unit, staff told us there was very little time for training.

We saw training was different in different departments. Pre-operative staff told us they had a yearly pre-operative study day where they had speakers updating them on topics such as National Institute for Health and Care Excellence guidelines, anti-coagulation, sleep apnoea and hypertension.

Staff described using a simulation machine to support learning for theatres staff. They said the simulation machine was available for staff from the Maidstone site as well. This meant staff had the opportunity to practice scenarios in a realistic setting with no risk to patients and staff could review the scenario on video afterward to gain further learning from the practice.

Revalidation is a Nursing and Midwifery Council process for nurses to revalidate their licenses every three years. Nurses require support from managers or senior colleagues to complete the revalidation process. Staff we asked about revalidation told us either they received support from
managers and mentors or they had not gone through the process yet, but saw their colleagues had received support.

We saw information about revalidation posted for staff in staff break rooms. This meant staff had access to the information they needed to take steps toward their revalidation.

**Appraisal rates**

Between April 2017 and June 2017, 78% of staff within Surgery at the trust had received an appraisal compared to a trust target of 90%.

A split by staff group can be seen in the graph below:

Tunbridge Wells Hospital had a 76% appraisal completion rate; this was below the trust target of 90% as well as the trust wide average of 88%.

*Source: Routine Provider Information Request P43 Appraisals*

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff reported they knew how to contact members of other teams. Agency staff told us their induction included information about how to contact doctors, pharmacy and other departments.

Patients on Ward 31 reported receiving multidisciplinary care. For instance one ward patient reported they had seen the physiotherapist on three of the last four days. They noted physiotherapy was important because they would not be able to go home until they reached certain physiotherapy milestones.
Patients noted the good communication between staff, wards, consultants and the different departments.

Staff on the Surgical Short Stay Unit told us consultants and anaesthetists from the surgical department, which was attached to the Surgical Short Stay Unit, were available and came to the unit when requested. They told us physiotherapist and diagnostic imaging services were available throughout the day.

We saw a physiotherapist treating patients on the Surgical Short Stay Unit at the time of our inspection. Staff on the Surgical Short Stay Unit told us the physiotherapists were responsive, although there were not enough for the unit and physiotherapists could not see everyone. They told us patients waiting to be discharged were prioritised for physiotherapy. If patients waiting for discharge could not be seen that day, patients could go home and return the following day for the appointment. This meant patients might be inconvenienced, but could go home when they were medically fit for discharge rather than waiting on the ward.

However, Surgical Short Stay Unit staff told us that it was challenging to get doctors from the Medical department (as opposed to surgical or other department) to come to the unit and that patients could wait hours to see a Medical Department doctor. We observed two medical patients’ notes in the Surgical Short Stay Unit both verified long patient waits to see medical department doctors. In one case a patient waited 21 hours, in another they had waited 17 hours and not yet seen a doctor. The provider has reported since the inspection that a dedicated medical team is now assigned to medical outliers throughout the hospital. The team is located on the Surgical Short Stay Unit thus medical patients on the unit should have access to medical staff.

Staff at both hospitals told us when they take a patient hand over they would get a brief overview of the handover information by telephone before the patient arrived and they would receive a full nurse to nurse handover in person when a nurse brought a patient to the ward.

Staff in the pre-operative department told us about how they worked with senior nurses, anaesthetists and consultants to ensure any concerns about patients were resolved before surgery.

However, staff told us that the pharmacy were very busy and medicines did not always arrive on time. The Trust Clinical Governance Committee minutes from July 2017 identified low pharmacy staffing as a risk. Staff told us patient discharges had been delayed when medicines delivery from the pharmacy was late.

Staff told us that some multidisciplinary work was not as smooth as they would like. For instance the scheduling team did not always schedule preoperative appointments in a timely fashion. This could result in rushed tests, delays and surgery cancellations.

**Seven-day services**

Although patients could be inpatients at the hospital seven days a week, multidisciplinary services were not always available. The pharmacy team were available Monday to Friday during working hours, Saturdays 9:00 am until 4:00 pm and Sundays and bank holidays 10:00 am until 4:00 pm. Physiotherapists, occupational therapists, and dietary consultants were available Monday to Friday during working hours.

Respiratory physiotherapists and emergency diagnostic services were on call for emergency services at all times. This meant emergency respiratory and diagnostic support was available to inpatients at all times and this patient care would not be delayed by department opening times.
Health Promotion

The service monitored the effectiveness of care and treatment and used the findings to improve them.

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had access to an electronic records system that they could all update.

Staff told us they usually had access to information necessary to treat patients.

Pre-operative staff explained their process for using a tool to collect and evaluate incoming surgical patients’ information. Patients met with a pre-assessment nurse prior to surgery to discuss the surgery, health and risks. Patients received a copy of the questions they would discuss with the nurse prior to the appointment so that they could be prepared.

We saw that staff discussed lists prior to beginning surgery. Theatres staff told us they avoided handovers during surgery by ensuring that all staff present would be on the rota for the entire list. If a staff member could not be present for the entire list, they would be present in addition to the required number of staff members.

However, staff told us surgical lists were often inaccurate. Surgical lists are important because they put information about all the patients who are having surgery on a given day and theatre together so that staff can plan for the theatre session and ensure they have the right supplies and people for the procedures going forward.

We observed a theatre list and saw that one of the five procedures listed was incorrect. In this case, the surgery was still able to go forward.

We saw multiple incident reports showing theatres lists had errors. These showed the wrong procedure was listed or not all procedures were listed for each patient. This meant at the time of surgery the wrong procedure could be performed, the right equipment might not be available and not enough time might be planned for the surgery. As a result, patients could be injured and surgeries had been delayed or cancelled.

Senior staff told us that although this was a known issue, no solutions had been implemented and no one person was held accountable for each list. This meant the underlying issues had not been addressed and incidents were likely to continue.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that between April 2017 and June 2017 Mental Capacity Act training has been completed by 92% of staff within Surgery.

The trust did not provide deprivation of liberty training as a separate module, this was part of the safeguarding level two module, this was completed by 92% of staff within Surgery.

(Source: Routine Provider Information Request P40 – Statutory and Mandatory Training)
Pre-operative nurses told us they considered capacity in every case. If they had questions or concerns about capacity they escalated the issue to the pre-operative sister. When best interest meetings were needed, staff told us both the sister and the matron for safeguarding were involved in the process and decision.

Staff across departments described working with a family and staff at a best interests meetings to get the best outcomes for patients.

Staff we spoke to demonstrated an understanding of the Mental Capacity Act, their roles under the Mental Capacity Act and the roles of doctors and social services with regard to the Mental Capacity Act and patient capacity assessments. We saw information about Mental Capacity Act, best interest decision and consent in staff break rooms.

We reviewed records for two surgical patients. We saw they included necessary consent documentation.

One patient reported staff asked for consent before doing anything.

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### Is the service caring?

**Compassionate care**

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

**Friends and Family test performance**

The Friends and Family Test response rate for Surgery at Maidstone and Tunbridge Wells NHS Trust was 26% which was worse than the England average of 29% between 01 August 2016 and 31 July 2017. The Tunbridge Wells Hospital response rate was 19% which is also worse than the England average.

A breakdown of response rate by site can be viewed below.

**Friends and family test response rate at Maidstone and Tunbridge Wells NHS Trust, by site.**
Patients at both hospitals told us that they were treated with dignity and respect. For instance one patient told us staff always treated them with dignity and respect when managing their incontinency issues. Another patient said they were embarrassed by staff providing personal care at first, but the staff’s direct manner about care calmed them down.

Some patients told us that when they were having a private discussion with nurses or doctors or receiving care, nurses always took care to close curtains and that they knocked on the doors of private rooms before entering.

Staff told us they weighed bariatric patients in private spaces to maintain privacy and dignity.

Patients told us they had been visited by the consultant or anaesthetist and that these professionals made them feel safe.

Staff told us they had opened a hall for day patients to access theatres directly so they did not have to walk through the Surgical Short Stay Unit on their way to theatre to ensure their privacy and dignity.

However, we saw that dignity and privacy were not always respected. For instance, on the Surgical Short Stay Unit, we saw that male and female patients were sometimes required to stay in the same ward. In October 2017, eight mixed sex breaches were reported.

To mitigate the effect of mixing the wards, staff would put men at one end of the ward and women at the other. However, the beds were only separated by curtains and patients could have to walk by patients of the opposite sex to use the showers or toilets. Further, there were only four toilets and two showers on the ward. This meant patients might have to pass patients of the opposite sex in their bedclothes, the numbers of available facilities would be limited by sex and patient's privacy and dignity was not protected.

Due to the Surgical Short Stay Unit escalation, there were no individual rooms or fixed changing areas where day patients could change. Staff told us patients would change in a small meeting room down the hall and then return to await their surgery. This did not ensure patients privacy and dignity.
**Emotional support**

Patients noted that staff were caring, genuine, friendly and kind. Patients also told us that staff made them feel safe and well looked after.

Staff in the pre-operative department told us they ensured that the same nurse saw repeat patients so the nurse had a relationship with the patient. The same nurse would meet and escort patients to theatre when the patient needed extra support.

Staff understood the importance of patients’ maintaining contact with their family and friends and enabled this.

Staff told us about arranging for a patient to receive an international call on the ward phone and we saw staff loan patients their own mobile telephone chargers so patients could use their mobiles.

**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.

Some patients told us they received clear information including directions and explanations before surgery and about the processes and self care after surgery.

One patient said they were able to choose an epidural for pain management rather than a full anaesthesia. Unfortunately, the epidural had not worked so in the end they had to anaesthetise them. Another patient told us a meeting had been set up for the patient, their adult child and relevant consultant to discuss their going into a care home. This meant that patients were involved in making decisions that effected their care and wellness.

However, one patient told us they did not know ‘what was happening’ with their care. They felt that the nurses changed often so no one knew what was happening with their case and they were not a priority.

Pre-operative staff described finding the best way to communicate with each individual patient. For instance, depending on the patient’s needs they might draw pictures or use a monitor to communicate information to patients.

**Is the service responsive?**

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

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

People could usually access the service when they needed it. Lengths of stay were generally shorter than the national average.
Average length of stay

Trust Level
Between 01 June 2016 and 31 May 2017:
The average length of stay for all medical elective patients at the trust was 2.7 days, which is lower compared to the England average of 3.2 days.
The average length of stay for Trauma & Orthopaedics medical elective patients at the trust was 2.7 days, which is lower compared to the England average of 3.4 days.
The average length of stay for General Surgery medical elective patients at the trust was 3.5 days, which is higher compared to the England average of 3.3 days.
The average length of stay for Urology medical elective patients at the trust was 1.7 days, which is lower compared to the England average of 2.0 days.
The average length of stay for all medical non-elective patients at the trust was 6.4 days, which is higher compared to the England average of 5.1 days.
The average length of stay for General Surgery medical non-elective patients at the trust was 5.5 days, which is higher compared to the England average of 4.0 days.
The average length of stay for Trauma & Orthopaedics medical non-elective patients at the trust was 9.9 days, which is higher compared to the England average of 8.9 days.
The average length of stay for ear nose and throat medical non-elective patients at the trust was 2.2 days, which is the same as the England average of 2.2 days.

Elective Average Length of Stay – Trust Level

Non-Elective Average Length of Stay – Trust Level

The Tunbridge Wells Hospital
Between 01 June 2016 and 31 May 2017:
The average length of stay for all medical elective patients at The Tunbridge Wells Hospital was 2.7 days, which is lower compared to the England average of 3.2 days.
The average length of stay for Trauma & Orthopaedics medical elective patients at The
Tunbridge Wells Hospital was 3.0 days, which is lower compared to the England average of 3.4 days.

The average length of stay for ear nose and throat medical elective patients at The Tunbridge Wells Hospital was 1.4 days, which is lower compared to the England average of 1.6 days.

The average length of stay for General Surgery medical elective patients at The Tunbridge Wells Hospital was 2.9 days, which is lower compared to the England average of 3.3 days.

The average length of stay for all medical non-elective patients at The Tunbridge Wells Hospital was 6.4 days, which is higher compared to the England average of 5.1 days.

The average length of stay for General Surgery medical non-elective patients at The Tunbridge Wells Hospital was 5.4 days, which is higher compared to the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics medical non-elective patients at The Tunbridge Wells Hospital was 9.7 days, which is higher compared to the England average of 8.9 days.

The average length of stay for ear nose and throat medical non-elective patients at The Tunbridge Wells Hospital was 2.2 days, which is the same as the England average of 2.2 days.

### Elective Average Length of Stay - The Tunbridge Wells Hospital

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<thead>
<tr>
<th></th>
<th>This Site</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>3.0</td>
<td>3.4</td>
</tr>
<tr>
<td>ENT</td>
<td>1.4</td>
<td>1.6</td>
</tr>
<tr>
<td>General Surgery</td>
<td>2.9</td>
<td>3.3</td>
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### Non-Elective Average Length of Stay - The Tunbridge Wells Hospital

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<tr>
<th></th>
<th>This Site</th>
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</thead>
<tbody>
<tr>
<td>All</td>
<td>6.4</td>
<td>5.1</td>
</tr>
<tr>
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<td>4.0</td>
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<tr>
<td>Trauma &amp; Orthopaedics</td>
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<td>8.9</td>
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<tr>
<td>ENT</td>
<td>2.2</td>
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### Meeting people’s individual needs

The service usually took account of patients’ individual needs.

We saw that the hospital delivered services to take account for the needs of different people. Staff on the Surgical Short Stay Unit told us they did not care for patients with high dependency needs, for instance those living with advanced dementia as they would have been cared for on a ward with facilities to care for those patients’ needs.

We spoke to a patient living with dementia and their adult child on Ward 31. They reported the patient received the level of care they needed. They were assisted with all transferring, walking and bathing. They said the patient was never hungry and they were satisfied with the meals.
offered and fortification drinks and the patient was offered drinks throughout the day. Both felt that the patient was safe on the ward.

Staff told us they use the ‘This is me’ personal dementia folder to share information about patients living with dementia and facilitate patient’s sharing information about themselves.

One staff member described their colleague, a dementia nurse, supporting a patient living with advanced dementia. They told us the dementia nurse met the patient before the surgery and stayed with the patient for the entire process to alleviate the patient’s concerns and confusion.

Staff told us they did not use patient family members as translators. They told us they arranged for patients who did not speak English had access to translators. Staff gave examples of arranging for medical translators, and rebooking pre-assessment meetings so that a patient could have a translator.

We saw that when the patient rang to help to go to the toilet, staff responded quickly.

Patients and staff told us that patients with special diets were catered for. They described special diets for a range of patients including diabetics, people with religious dietary requirements, vegetarians and vegans.

Staff told us when they worked with patients with learning disabilities; they welcomed the patients support network including family and carers.

However, staff told us they were not able to provide written material in other languages or they did not know how to obtain them.

We saw patients in the Surgical Assessment Unit did not have a safe place to put their belongings. This meant personal belonging could be taken or patients could be caused stress about whether their belongings were safe when they were not present.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Between 01 August 2016 and March 2017 the trust’s referral to treatment time for admitted pathways for surgery was higher than the England average. From April 2017 the rate fell and was similar to the England average until July 2017.

(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. Of these, three of specialties were above the England average.
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>87%</td>
<td>75%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>88%</td>
<td>73%</td>
</tr>
<tr>
<td>Urology</td>
<td>81%</td>
<td>77%</td>
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**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.

Over the two years, the percentage of cancelled operations at the trust has been below the England average except in two periods Q4 2015/16 and Q1 2017/18, when it was notably higher than the England average.

Theatre cancellation reports reflect that non-clinical reasons for cancellations in August through October 2017 included, surgeons with illnesses, surgeon on leave without cover, no patient notes, no ward beds, patient refusal and patient did not appear.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Maidstone and Tunbridge Wells NHS Trust**

![Graph showing cancelled operations over time]

**Cancelled Operations as a percentage of elective admissions - Maidstone and Tunbridge Wells NHS Trust**

Between Q3 2015/16 the trusts performance was lower than the England average, from Q2 2016/17 to Q4 2016/17 the rate increased and was worse than the average. In Q1 2017/18 the
We saw delays throughout the system kept patients in the hospital, or in the wrong department, longer than required for clinical reasons.

Staff told us pre-operative appointments were sometimes delayed. This could cause delays or cancellation of surgery. Incident reports verified that pre-operative appointment delays had caused surgery cancellations.

We spoke to two patients who told us their pre-operative appointments or surgeries had been cancelled. Both told us their appointments had been quickly rescheduled and the pre-operative appointment was rescheduled in time for the operation to take place.

One patient also noted that while care in the hospital was good, the computer system was ‘dreadful’ resulting in incomplete appointment letters.

Several patients complained of delays. We met two patients in a waiting room at noon who said they had been waiting for their surgery since early morning and fasting since midnight. They said no one had provided any information about the reason for or length of the delay. We saw a senior member of staff tell one patient at noon they would enquire about the delay, but at 12:30 the staff member had not returned and both patients were still waiting.

We saw several patients who had been told they were ready for discharge; however, their discharge was delayed because discharge paperwork had not arrived. We saw one patient explaining to staff they had been waiting for the paperwork all morning. They said they had explained the spouse had a doctor’s appointment so they needed to leave, but they continued to wait.

We spoke to staff who said patients at the end of the surgery list were usually discharged from the hospital around 9:00 pm to 10:00 pm. While this was acceptable for many patients, it meant that patients returning to care homes or who required transportation to be discharged would require an unplanned bed overnight.

Tunbridge Wells Theatre Team Meeting minutes and staff reflected post surgical patients could be held in recovery when ward beds were used for emergency flow patients. Patients could end up with prolonged recovery time and in some cases spent the night in recovery. This meant patients might not have the right facilities and staff for their care, pressure was added to recovery staff and other surgeries could be delayed.

Due to the escalation of the Surgical Short Stay Unit to a ward, there was no fixed recovery area for day case patients. The lack of space meant that some day surgeries had to be cancelled or put ‘on hold’ until it was clear whether there would be space for the patients.

Learning from complaints and concerns

The service treated concerns and complaints seriously and investigated them. However, lessons were not always learned from the results and there were long delays for responses.

Summary of complaints

Between July 2016 and June 2017 there were 88 complaints about Surgical Care. The trust took an average of 50 days to investigate and close complaints; this did not comply with the
complaints policy, which stated complaints should be closed within 25 days unless it’s a complex complaint in which the trust had a target of 60 days.

Tunbridge Wells Hospital: There were 58 complaints, the majority was similar with all aspects of clinical treatment, followed by admissions, discharge and transfer arrangements, this site took, on average, 54 days to investigate and close complaints.

(Source: Routine Provider Information Request P61 – Complaints)

Staff we spoke to told us they tried to resolve patients’ complaints on the ward as soon as a patient raised concerns. This meant concerns could be addressed and resolved or escalated during the patient’s care to minimise impact.

We reviewed five complaint files. We saw the trust took 55 to 183 days to respond to the complaints, none of which were marked as complex. No apologies were made for delay in responding and we did not see any holding letters explaining the delay. This meant patients were waiting long periods of time for responses without any acknowledgement from the trust.

We saw that in four of five files the trust apologised, provided a clear response to the complainants’ concerns and provided contact details so complainant could revert to the trust with any further questions or concerns. In one response the trust did not apologise or provide a meaningful response to the patients concerns. This meant patients usually received meaningful responses to their concerns.

Staff told us learning from some complaints was shared at the meetings.

Is the service well-led?

Vision and Strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action. It was not clear that it was developed with involvement from staff, patients, and key groups representing the local community.

We saw that the strategy for theatres was part of the larger strategy for the critical care department. The trust aimed to provide safe and effective critical care to the local communities.

For the surgical department the strategy focussed on maximising the use of theatres, and ensuring that pre assessment processes were as efficient as possible for the service and patients. We saw that staffing (recruiting and retention) was a focus for 2016-2017 but the following years had other focuses based on theatres capacity.

The vision and strategy was not in line with the understanding of staff and managers we spoke to at both hospitals. Staff told us repeatedly the primary and immediate focus continued to be on staffing.

Governance

The trust had a Trust Clinical Governance Committee which met monthly. The committee’s aim was to review complaints, incidents, legal issues, Patient advice and liaison service and audit in one forum to bridge the information from all of these sources. The committee was informed by and fed information to Directorate Clinical Governance Committees to address governance at the directorate level.
Staff in the theatres department told us that they had monthly directorate governance meetings where governance issues were discussed with staff.

The Surgery Directorate is a stand alone directorate, although anaesthetics, intensive care unit and theatres were part of the Critical care Directorate. Both Critical care and Surgery form part of the planned care division. Both hold directorate level clinical governance meetings and both are represented at Trust Clinical Governance committee. Two of the three sets of Clinical governance committee meeting minutes recorded that the surgery department was represented at the meeting. The third set of minutes reflected there was a representative, but they had not attended. This meant the department could feed directly into the top of the clinical governance system, even if they did not always attend meetings.

The Clinical Governance Committee was chaired by the Medical Director or (interim) Chief Nurse in their absence. The committee included managers or leads from clinical departments across the trust, legal, risk, complaints and Patient advice and liaison service departments. This meant the right people were present to discuss clinical governance and risk.

We saw that at the meetings the committee identified themes and trends. Trust wide learning was shared for dissemination through the Directorate Clinical Governance Committees. However, we did not see an action plan or responsibilities assigned for future actions. This meant it was not always clear from the notes, what future actions were required or who was responsible for them.

**Management of risk, issues and performance**

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, it was not clear that all staff understood these systems. The department was making positive change toward risk management, but change was not yet fully employed.

We saw that there was a critical care risk register. This register included several departments including theatres and surgical wards. We saw that there were individual risk registers for departments, although staff we asked in most departments we visited were not able to locate the register.

We spoke to senior staff about perceived risks we saw that in some cases staffs understanding of risks aligned with the risk register, and that in some cases they did not. This meant that where staff were aware of risks they could mitigate the risks but in areas where staff were not aware of risks, they might not be directly addressing them.

Senior staff showed us how they could use the incident management system to review open incidents and get alerts. They told us these were discussed at risk meetings.

Staff in the theatre department told us one of their biggest risks was staffing, which was in alignment with the risk register. Staff described how senior management supported the division with daily communications about staffing, logistical support and backing for new ideas.

However senior staff in the Surgical Short Stay Unit told us the biggest risk to their department was management of patient expectations.

The escalation of the Surgical Short Stay Unit was included on the trust risk register with an amber risk rating. This reflected the risks of escalation were regularly formally reviewed and responded to. The risk register showed controls had been put in place including a de-escalation plan for the unit discussed and implemented daily.
Senior hospital management worked directly with senior departmental staff to manage some risks. For instance, the trust had twice daily bed meetings, involving both hospitals’ management, to discuss the hospitals’ capacity and demand using a telephone link so that both hospitals were involved. Risks including patients with infectious diseases were also discussed at this meeting.

We observed senior hospital management and a senior representative for each department from each hospital attended the meetings. We heard representatives from each department outline their needs and capacity and discussed how they could help meet hospital-wide demand. This meant that managers from across the hospital understood individual department’s capacity and worked together to manage the demand.

Maidstone Hospital Theatre Monthly staff meeting minutes reflected that department managers were preparing staff to take an influx of patients from Tunbridge Wells when it became necessary due to winter (or other) pressures. This meant staff across the trust were working together to address foreseeable problems.

We reviewed two Never Events and two serious incidents.

We saw that the Serious Incident Policy guiding the incident investigations was robust and comprehensive.

We saw that an investigation had been completed with regard to each incident. We saw that a root cause analysis was completed for each investigation, staff and family were involved in the investigations, all found a root cause and Duty of candour letters were sent.

However, we saw that in half of the investigations, the root cause analysis tool was not used in line with best practice. In one investigation there was a six day delay to declare the Never Event and in another there was a two week delay to identify the incident.

We also saw that dates were not always included, the final report was not always shared with patient or family, in one case there was no evidence of an interview with a key consultant and only one report planned to audit the effectiveness of the recommendation. This meant the reports might not always be investigated, shared or outcome audited to determine or share the most valuable information.

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. However, it did not appear staff had relationships with more senior management beyond their own direct line managers.

Senior staff explained that there is always an executive staff member on site or on call. The on call executive staff members were able to make high level decisions including decisions about unexpected incidents, staffing, emergencies, etc.

Staff on the wards and in theatre told us they felt their immediate supervisors were visible, accessible and supportive. They reported that ward and theatre managers were very hands on and involved with the day to day working of the departments. Likewise, department managers reported they had close and supportive relationships with upper management, who they were involved with on a day to day basis.

We saw in department Monthly Theatres Staff Meeting notes that theatres department had a monthly meeting were information was shared and discussed. This included sharing learning and
support and also highlighting good work by handing out thankyou cards and compliments at the meetings.

However, staff on the wards told us they did not have any relationship with or see executive management.

**Culture**

Staff we spoke to had mixed reviews about the culture and moral of the trust. Some staff told us they felt appreciated and supported and enjoyed their work.

However, some staff told us that moral was affected by staffing. Several people raised the issues of staffing on the Surgical Short Stay Unit and the challenges faced by the ward because staff were required to play two different roles; one as day surgery recovery staff and one as overnight ward staff.

Patients on the surgical wards reported that staff worked well as a team to provide care.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage required services, and collaborated with partner organisations effectively.

Trust was also a member of the Kent Resilience Forum, which brings together emergency services and other responders such as the NHS, utilities and the voluntary sector.

The trust had various opportunities for the public to engage including the Stakeholder Forum, League of Friends, Patient Experience Committee, Patient and Representative Working Group, feedback from the Friends and Family Test, inpatient surveys, complaints and the ‘How Are We Doing?’ initiative.

The trust engaged in the “hello my name is …” initiative which is aimed at ensuring staff always introduce themselves to patients. Patients confirmed that staff always introduced themselves before any treatment or therapy and we observed this in interactions.

We saw that the trust engaged with a wide variety of staff members through groups like the LGBT+ (Lesbian Gay Bisexual Transgender+) Network and cultural diversity network.

We saw there were engagement meetings with surgery staff and ward managers and Listening in Action Forums which engaged frontline staff in finding improvements for patient care.

**Learning, continuous improvement and innovation**

The department had a simulation machine which provided staff the opportunity to practice scenarios in a realistic setting with no risk to patients. Staff could review the scenario on video afterward to gain further learning from the practice and the hospital was able to use it to help train staff from other hospitals.
We carried out an unannounced inspection of the critical care unit at Tunbridge Well Hospital as part of the new phase of our inspection methodology.

We last inspected the unit in 2015 and rated it as inadequate.

**Facts and data**
The trust has 18 Critical Care beds. A breakdown of these beds by type is below.

### Breakdown of critical care beds by type, Maidstone and Tunbridge Wells NHS Trust and England

#### This trust

- Adult, 100.0%

#### England

- Adult, 68.2%
- Neonatal, 24.0%
- Paediatric, 7.7%

(Source: NHS England)

The Tunbridge Wells Hospital has one Critical Care ward; the Acute Intensive Care Unit, with nine critical care beds (used flexibly for level 2 and 3 patients) which totalled an Intensive Care Society (ICS) nursing dependency of 7.

(Source: Trust Provider Information Request)

**Is the service safe?**

### Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them in line with policy.

Tunbridge Wells reported 215 patient incidents between 1 September 2016 and 26 October 2017, of these, 187 (87%) were found to cause ‘no harm’ to the patient. This demonstrated a positive reporting culture within the unit.

We reviewed an incident report document compiled by one of the lead nurses for the intensive care unit. This detailed an overview of the incidents that occurred between May and July 2017, and included a short description of the incident and the learning points following this. This was
available for staff to review in the staff room. Incidents were also discussed at a variety of meetings that staff of differing levels attended, from the intensive care unit team meetings to the Clinical Governance meeting which we saw minutes from.

**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 August 2016 and July 2017, the trust reported no incidents classified as never events for Critical Care.

*(Source: Strategic Executive Information System)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in Critical Care which met the reporting criteria set by NHS England between August 2016 and July 2017.

*(Source: Strategic Executive Information System)*

**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, no falls with harm and no new catheter urinary tract infections between August 2016 and August 2017.

*(Source: NHS Digital)*

Safety thermometer data was displayed on the ward.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.

Tunbridge Wells Hospital’s unit and equipment was visibly clean, tidy and well organised. The intensive care unit was considered a ‘very high’ risk area for cleanliness due to the vulnerability of its patients. Weekly audits were carried out checking the cleanliness of the facilities, estates and nursing equipment used on the unit. Each section reviewed had to score a minimum of 90% to be compliant.

We were provided with the audit reports from 31 July to 30 October 2017. We noted that weekly audits had not been completed on four of these weeks which meant they could not provide assurances that the ward was consistently kept clean. However, on the 10 weeks where they were checked, we saw that they were compliant with scores between 98% and 100%, which was better than the target.
Between November 2016 and October 2017, there was one case of unit acquired Methicillin Sensitive Staphylococcus infection, (equivalent to 0.39 per 1000 beds) and no cases of Clostridium Difficile infection.

Intensive Care National Audit Research Centre data indicated that high-risk sepsis admissions to the unit were 0% during April to June 2017. This was lower than similar units.

The unit participated in a Commissioning for Quality & Innovation measure for sepsis screening. The target for sepsis screening was 80%, and the unit’s most recent result was 81%.

We saw that all staff in the intensive care unit were bare below the elbows and observed them cleaning their hands before and in between patient contact, in line with infection control policies. All staff uniforms appeared clean and we observed staff wearing personal protective equipment such as gloves and aprons when needed to.

There was hand sanitising gel at the entrance to the units, which we saw staff and visitors using on arrival to the unit. This helped to reduce the spread of infection to and from the ward.

We spoke to a member of the domestic staff who had been working on the intensive care unit for a number of years, was very happy working there and proud of the work that they did to keep the unit clean.

The intensive care unit staff took part in hand hygiene audits to ensure staff were complying with a number of key aspects of hand hygiene. This included washing hands between patient contact and ensuring that all staff were bare below the elbow. We reviewed the hand hygiene audits for Tunbridge Wells Hospital from April 2017 to September 2017 and saw these results ranged from 98% in April, 99% in May, July and August, and 100% in June and September. These results were better than the trust target of 90%.

The unit acquired blood infection rates for the Tunbridge Wells intensive care unit, as reported through Intensive Care National Audit Research Centre, was slightly worse than in similar critical care units, and slightly better than in all critical care units.

Staff received training in infection prevention and control as part of their mandatory training. The rate of training completion for infection prevention and control was 98% across the nursing staff, which was better than the trust target. For medical doctors across the critical care directorate, this was 92%, also better than the hospital target.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The intensive care unit at Tunbridge Wells Hospital was located on Level minus-one, Purple Zone, of the hospital and was accessible by stairs or lifts. There was a waiting area outside the entrance to the intensive care unit where visitors could wait until a member of staff was available to escort them onto the unit. The intensive care unit itself was locked, and visitors were required to use an intercom to identify themselves and who they were visiting. The ward clerk would then ask them to wait in the waiting area until a member of staff could accompany them to their relative.

The unit had nine glass fronted single rooms, arranged around a central island containing a large workstation at each end and a large office. This allowed the rooms to be closed to prevent infection and disturbances, but staff from the workstations could easily observe the patients and staff and respond if necessary.

The majority of the equipment we inspected at the Tunbridge Wells unit was clean and displayed labels detailing their cleaning and servicing status. We reviewed five pieces of breathing equipment, and five consumables, all of which had in date servicing stickers displayed. The equipment cupboard was well organised and all the equipment within it appeared clean, however there were no labels to confirm this.

We observed the sluice area to be clean and tidy. Stored commodes were clean and labelled.
We saw completed checklists at the Tunbridge Wells site that demonstrated daily flushes of the water system were completed. However, there was one entry for the previous day which had not been ticked. We spoke to a member of staff who advised us it had been done but it had not been ticked. This did not provide assurance that documentation of the procedure was being consistently completed.

We reviewed a folder at the Tunbridge Wells site containing daily monitoring sheets and checklists of medical equipment and medical devices. This folder was disorganised with loose sheets of paper and there were four days in October that were missing checklists. This did not provide assurance that these checks were being completed or documented regularly.

**Medicines**

The service prescribed, gave, recorded and stored medicines well.

We did not find any evidence that resuscitation trolleys were tamper evident. Although some contained medicines in sealed boxes, these trolleys still contained intra-venous fluids and infusions which were not tamper evident. Tamper evident trolleys and containers have replaceable tags that are broken when opened, so staff are aware if the trolley may have been accessed prior to them using the trolley. This is particularly important when the trolleys are in areas accessible to the public. However, following the inspection, the trust told us that a new tagging system was in place to provide evidence of tampering. Trolleys that were not compatible with the tags had additional tamper evident containers added. The daily checklist was amended to include the ‘tamper tag’ check. This provided adequate assurance that any tampering with the trolley could be easily identified and action could be taken.

We checked four prescription charts. These were legally valid and contained information about people’s allergies. Where medicines were intentionally omitted, the correct codes were used to note this. All charts had been clinically screened by a member of the pharmacy team.

The temperature of the medicines fridge was monitored regularly and within range.

Medicines were stored securely.

Controlled drugs at both sites were stored, recorded and handled in line with best practice and legislation. Spot checks on balances showed that contents of the cupboard matched the register.

We found one out of date medicine in the unit; staff disposed of these immediately. Medicines waste was handled in line with best practice on both sites.

Staff knew how to report medicines incidents.

**Records**

Staff kept records of patients’ care and treatment. The notes were completed on paper records that were stored in a mobile cabinet on the unit which could only be accessed by critical care staff with a key code.

We reviewed three sets of patient notes. In all of these notes, risk assessments and associated care plans for the patients were completed.

Four prescription charts were checked; these were legally valid and contained information about people’s allergies. Where medicines were intentionally omitted, the correct codes were used to note this. A cross site records audit was undertaken in July 2017. This audit focussed on the daily record sheet completed by medical staff on both intensive care unit s. There were five criteria that the record were checked against, of which, only one of these met the expected standard of
completion which was the patient management plans were clearly documented – this had 100% compliance.

Demographics and supportive treatments partially met the expected standard with 80% compliance, and cause of admission and patients physiology did not meet the expected standard at 68% and 45% respectively. The action plan stated this was to be discussed at a future governance meeting, with a planned re-audit date of 2018.

A nursing documentation audit was undertaken in February 2017, this assessed five sections of the nursing notes. Of the four sets of notes audited, one achieved an ‘A’ or green result and would be re-audited within 12 months, two received a ‘B’ or amber result and therefore require re-auditing in 9 months, and one achieved a ‘C’ or red result requiring re-audit in four months. The ‘A’ results did not require an action plan, however the ‘B’ and ‘C’ results did and we did not see action plans for these results.

**Safeguarding**

Staff understood how to protect patients from abuse. Staff had training in how to recognise and report abuse.

The intensive care unit was set up and designed for adult admissions only. However, children were able to visit patients on the unit which meant that staff could encounter vulnerable children. This meant that safeguarding adults, and safeguarding children levels one and two, were essential for staff to be able to identify and escalate safeguarding concerns.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. The intensive care unit only accepted adults aged 18 and over, and therefore nursing staff only completed level one safeguarding children training. However some medical staff had completed level two safeguarding children training in addition to this.

A breakdown of compliance for safeguarding courses between April 2017 and June 2017 for support and nursing/midwifery staff is shown below:
We spoke to a member of staff on the Tunbridge Wells intensive care unit who gave an example of when they had raised a safeguarding issue. A relative had brought their child with them to visit a patient, and then left the unit. The staff member became concerned and escalated this through the correct channels. They told us that the training they had been given had helped them to identify this as a safeguarding issue.

We asked the provider for medical staff data for the intensive care unit doctors. The trust was unable to break this down to intensive care unit level, however across the critical care directorate, the compliance rate for safeguarding training for safeguarding children levels one was 97%, level two was 94%; safeguarding adults level one was 85% and safeguarding adults level two was 80%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
This meant the hospital was meeting its own target of 85% in safeguarding adults training, was worse than its own target in safeguarding adults level two training, but was exceeding (better than) its target in safeguarding children levels one and two.

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust set a target of between 85% and 90% for completion of mandatory training.

A breakdown of compliance for mandatory courses between April 2017 and June 2017 for nursing staff is shown below:

![Mandatory training completion by module](image)

Critical care was not meeting their own target for four modules and the lowest completion rate was for dementia awareness (including Privacy & Dignity standards) at 50%.

Tunbridge Wells Hospital had a 90% mandatory training completion rate, there were five modules the site was not meeting.

We asked the provider for medical staff data for the intensive care unit doctors. Following the inspection, the trust provided us with trust-wide overview of the medical staff safeguarding training compliance. The medical staff were performing better than the trust target in both adult and children safeguarding levels one and two. However, no medical staff had received level three safeguarding training. Although the ICU only routinely took adult patients, there had been once occasion where a child under the age of 18 had been cared for on one of the units. This meant that a minimum of level three safeguarding needed to be attained to ensure the safety of vulnerable children in line with national guidance.
Assessing and responding to patient risk

We spoke with two consultants who told us that all deaths were discussed at the joint cross site meeting – each site had their own consultant lead for this. Following the inspection, the trust sent us documents detailing ICU deaths discussed between February and May 2017, indicating that all deaths were discussed as part of the ICU mortality review process. However, when we reviewed the trust-wide mortality and morbidity review meetings, we saw that only one ICU death had been discussed out of three sets of meetings.

The hospital used Patient at Risk scores which was an early warning score tool used to help staff identify if patients were deteriorating.

There was an outreach team which provided support for the management of deteriorating patients on the wards 24 hours a day, 365 days a year. The outreach team could be contacted via a bleep system or by mobile. This was in line with national guidance. This had changed since the previous inspection where they were only available during the day on weekdays. We spoke to members of the outreach team who felt they were an effective team and worked together well. Patients discharged from the intensive care unit to other wards were followed up for three consecutive days or as deemed necessary.

However, staff from the outreach team told us that sometimes when the intensive care unit or wards were busy, the outreach service was suspended. We requested data on this and saw that (trust wide) the outreach service from April to October 2017 had no uncovered hours. However, we also saw data that showed that From April to October 2017, the outreach team spent 66 hours covering in the intensive care unit due to escalation.

When there were no beds available in the intensive care unit, patients could be nursed in the neighbouring recovery room by members of intensive care unit staff. This would either be covered by the intensive care unit team or by the outreach team depending on capacity. Whilst on our inspection at the Tunbridge Wells site, we observed that a patient was being transferred to the recovery area for a critical care bed, and a member of the intensive care unit from the Maidstone site came across to nurse them.

There was a Standard Operational Policy for the Management and Delivery of Critical Care in the Emergency Recovery Unit, however this was overdue for review with a review date of January 2017. This policy set out the roles and responsibilities of critical care staff in the event of a patient requiring admission to a critical care bed and none being available on the unit. In those circumstances, patients could be admitted to the theatre recovery area (adjacent to the intensive care unit), and nursed by intensive care staff until a bed in the unit became available.

Nursing staffing

The service had enough staff with the right qualifications, skills, training and experience to provide the right care and treatment.

The trust reported their staffing numbers below for the period April 2017 and June 2017.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE Staff</th>
<th>Number in post at June 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>108.23</td>
<td>108.43</td>
</tr>
<tr>
<td>Total</td>
<td>108.23</td>
<td>108.43</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)
At the time of our inspection of the Tunbridge Wells intensive care unit, there were nine beds, currently suitably staffed for seven level three patients. On each shift, in addition to nursing staff, one Clinical Support Worker worked. Clinical Support Workers would watch high dependence, level one patients, assist nursing staff and re-stock equipment.

The outreach team was staffed with one outreach nurse per site, day and night, with one extra shift at night. Sickness was covered by staff taking a bleep (an emergency pager) onto the ward.

Staff told us that there were permanent members of intensive care unit staff signed up to the bank system. When bank staff were not available to cover unfilled shifts, the matron or nurse in charge would go to agreed framework agencies for qualified intensive care unit staff. In rare cases where staff were still not available, the matron would conduct a risk assessment for going to non-framework agencies to obtain staff.

Vacancy rates

Between July 2016 and June 2017, the trust reported a vacancy rate of 5.3% in Critical Care which is better when compared to a trust average of 11.4% and the trust target 8.5%;

- Maidstone Hospital: 6.4%
- Tunbridge Wells Hospital: 3.8%

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

Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 0.5% in Critical Care compared to the trust average of 1% and the trust's target turnover rate is 10.5%;

Critical care had a lower turnover compared to the trust target as well as the trust average for the 12 month period.

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

Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 2.7% in Critical Care;

- Tunbridge Wells Hospital: 2.8%
- Critical care had a lower sickness rate compared to the trust target of 3.3% as well as the trust average for the 12 month period.

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

Bank and agency staff usage

Between July 2016 and June 2017, the trust reported bank and agency usage in Critical Care was as follows;
• Tunbridge Wells Hospital: had a total of 724 shifts, of which 59% were covered by bank staff, a further 21% covered by agency staff and a total of 85 shifts were not filled.

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

We spoke with staff who advised that the majority of the time that shifts need to be filled, they used either staff from Maidstone, or bank staff, and that they rarely used agency staff.

Medical staffing

The Intensive Care Society and the British Association of Critical Care Nurses (guidance states that the consultant work patterns should deliver continuity of care. At our previous inspection, we saw that consultants only worked one day at a time, covering the intensive care unit Monday to Friday between 8am and 5pm, which was not in line with guidance. At this inspection, we saw that consultants worked three days at a time. This was an improvement from the previous inspection but was still not in line with best practice which stated consultants should work five days in a row to provide continuity of care. We spoke with a senior member of the medical team who told us that some staff found working five days in a row too tiring and intense. Whils they encouraged staff to work more than three days in a row, if staff did not feel they could commit to this they would allow them to work a minimum of three days consecutively.

The consultant rota was fully recruited to with one vacancy being filled by a locum consultant. All of the new recruits were dual trained which meant they were trained in anaesthetics and intensive care medicine. We spoke to non-medical staff on the ward who told us that since the new rota and recruitment, consultants had been more available and responsive to non-medical staff needs.

At weekends, there was one intensive care consultant providing cover. This had improved since our last inspection where one consultant would cover both sites. This also meant that the consultant on call could be on site within 30 minutes, as recommended in the Core Standards of the Intensive Care Society and the British Association of Critical Care Nurses.

The Intensive Care Society and the British Association of Critical Care Nurses recommends that a ratio of one consultant to 14 patients should not be exceeded, and following the implementation of one consultant per site at the weekend and out of hours, this was not exceeded.

Major incident awareness and training

The service for planned for emergencies.

There was a trust wide major incident plan that provided a framework for staff to follow when a major incident was declared. Each department had an associated major incident action card which we saw displayed in the ward office. This demonstrated the cascade that occurred in the event of a major incident. We spoke to a Clinical Support Worker who told us about their role in a major incident and how they have had attended practices and scenario training.

In addition to this, there were guidelines for escalation of critical care capacity during major incidents. This included flowcharts for an increase demand on beds and the steps to take in this instance, and also referred back to the major incident action cards.

Is the service effective?

Patient outcomes

The service provided care and treatment based on national guidance and evidence of its effectiveness.
The trust had two units which contributed to the Intensive Care National Audit Research Centre which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 annual report. More recent quarterly data may be available via the evidence grids. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre)

**Hospital mortality (all patients)**

For the acute intensive care unit at Tunbridge Wells Hospital the risk adjusted hospital mortality ratio was 0.7 in 2015/16. This was better than the national aggregate. The figure in the 2014/15 annual report was 0.7.

(Source: Intensive Care National Audit Research Centre)

**Hospital mortality (for low risk patients)**

For the acute intensive care unit at Tunbridge Wells Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.3. This was better than the England average. The figure in the 2014/15 annual report was 0.2.

(Source: Intensive Care National Audit Research Centre)

Rates for patients re-admitted to the intensive care unit: The rate of readmission within 48 hours of patients being discharged at Tunbridge Wells Hospital was 0%, which was better than other similar units. This indicated that patients were being discharged when it was clinically effective to do so.

**Competent staff**

The service made sure staff were competent for their roles. However managers did not always ensure appraisals were completed.

Between April 2017 and June 2017, 55% of staff within Critical Care at the trust had received an appraisal compared to a trust target of 90%.

A split by staff group can be seen in the graph below:
Both sites and Critical Care overall are below the trust target of 90% as well as the trust average of 88%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

We spoke to a member of staff who told us that their appraisal was very useful, and as a result of this is now booked onto additional computer training as part of their objective.

A member of staff described their induction to the unit, and was given a four week supernumerary period to settle in and also given a preceptor.

The core standards for intensive care recommends that 50% of nursing staff should have a post registration critical care qualification. 51% of staff at the Tunbridge Wells site had this qualification, meaning the units met this standard. In addition to this, all new members of staff undertake the ‘foundations of intensive care’ course which was accredited with a local university.

We saw a set of specific competencies for clinical support workers working within the intensive care environment. These included being assessed for competency in describing the psychological needs of patients during critical illness and understanding the policy on using patient diaries and the benefit of using these for the patient post discharge.

Medical staff appraisals were completed on a yearly basis between September and January. The provider told us that all seven intensive care unit doctors based at Tunbridge Wells had an appraisal by October 2017.

Evidence based care and treatment

The service monitored effectiveness of care and treatment.

The National Institute for Health and Care Excellence provides national guidance and advice to improve health and social care.

National Institute for Health and Care Excellence guideline CG83, 2009 – rehabilitation after critical illness. This guideline states that patients with rehabilitation needs should be reviewed after their discharge from critical care. At our last inspection, there was no post discharge follow up for patients. At this inspection, we saw that follow up clinics had been instigated at both sites and there were dedicated nurses who took this on as part of their role in the unit.

National Institute for Health and Care Excellence guideline CG50 – Acutely unwell patients in hospital: recognition of, and response to, acute illness in adults in hospital (2007) – part of this guideline states that patients should not be transferred from intensive care unit at night (between 10pm and 6am.). At the Tunbridge Wells hospital, we saw that for 481 patients discharged from intensive care unit, 51 (10%) were discharged at night. This had improved from the last inspection result (14%), but was still high. Staff told us that whilst they always avoid night time discharges, pressure on the beds was such that sometimes there was no other option.

National Institute for Health and Care Excellence guideline CG135 - Organ donation for transplantation: improving donor identification and consent rates for organ donation (2011). This guideline states that organ donation should be considered as a usual part of ‘end-of-life care’ planning.

The intensive care unit at both sites participated in organ donation work and had specialist nurses in post. At the Tunbridge Wells site, between 1 September 2016 and 30 September 2017, there were 68 deaths, of which, 5 were able to donate organs. This gave an organ donation rate of 8%.
The Guidance for the Provision of Intensive Care Services 2015 states that all patients should be screened for delirium. The hospital completed a delirium screening audit between May and August 2017 based on 42 patients. Of the seven criteria tested, two partially met the standard, two met the standard and three did not meet the standard. We saw an action plan detailing actions to tackle two of the criteria not met (pain scores and bowel preparation), however the third failed criteria which was the use of anti-psychotics, did not have an action plan in place but instead was to be tested at the re-audit stage.

**Access to Information**

Staff had access to up to date, accurate and comprehensive information on patient’s care and treatment.

There was an electronic monitoring system where staff could look at a screen displaying each patient’s observations from the desk in the centre of the unit. If a patient at risk score scored between three and five, it would bleep. This electronic system helped staff monitor all patients, at one time from a central location.

Patient bedside notes were paper based, but staff could access electronic referral systems such as the picture archiving communication system which allowed staff to look at radiological imaging and reports.

Staff showed us the intensive care unit e-link web page which was available on the intranet. This was a page that all staff could access and locate policies and procedures in one place.

**Seven-day services**

At the weekend, an anaesthetist based in theatres was always on site, and one intensivist was on the critical care unit. The intensivist would carry out two ward rounds per day. We reviewed sets of patient records that demonstrated there was consultant presence on both days of the weekend and that these were consecutive.

**Nutrition and Hydration**

There was a dietician attached to the unit. We reviewed three sets of notes and saw evidence in all three that there was regular dietetic input.

The intensive care unit used the malnutrition universal screening tool to assess the nutritional needs of patients. Nutrition and hydration was managed effectively. We spoke to a dietician who had daily input with the patients and intensive care unit team.

**Multidisciplinary working**

Staff of different kinds worked together as a team, however there were limited formal processes for this.

A variety of staff worked within the intensive care unit, such as dieticians and the pain team. However, there was no daily multidisciplinary meeting at the Tunbridge Wells site. National best practice considers it usual for representatives of all members of the multidisciplinary team to attend a daily meeting.

The intensive care unit had an outreach team which was a recommendation jointly of the Faculty of Intensive Care Medicine and Intensive Care Society core standards. This comprised of a team of senior nurses used within the hospital to provide advice and guidance for staff caring for patients on other wards who may be showing signs of deterioration or for patients who have
recently been discharged from the intensive care unit. This service was available 24 hours a day, seven days a week, in line with the recommendations.

We attended the Joint Sepsis Strategy Group meeting. Members of the outreach team attended this meeting as well as microbiologists, pharmacists, vascular access nurse, intensive care unit consultant, patient safety team and the critical care matron, demonstrating a multidisciplinary approach.

Staff told us that the pain team attended the unit regularly although we did not see them during the course of our inspection.

We spoke to the Emergency Department Psychiatric Liaison Officer who was visiting a patient in the intensive care unit. Their role was to respond to referrals from the intensive care unit team and review patients either as a routine referral (within 48 hours) or urgent referral (within 2 hours). They covered 8am to 8pm seven days a week. Outside of these hours, there was a crisis team based in Maidstone.

There was a dedicated unit dietician, and in all of the sets of notes we reviewed, we observed there was daily dietician input.

Staff told us that pharmacist and pharmacy technician availability on the ward was good. Staff told us that the consultant microbiologist worked closely with staff on the ward to ensure people were prescribed the correct antibiotics.

**Pain relief**

The critical care pain observation tool, which rates critically ill patients pain based on clinical observation had been introduced for use on patients who have a certain level of sedation. For patients who are awake or not sedated, a regular pain scale from zero to ten was used.

The majority of the intensivists had an anaesthetics background and could assist if patients were in pain. Staff also had access to a chronic pain team and other specialist nurses such as a tissue viability nurse. We were told that all of these staff were readily accessible.

The trust sent us examples of pain assessment tools such as the Abbey pain scale which assesses pain in patients with dementia or cognitive impairment.

**Nutrition and hydration**

We spoke to a senior member of the dietetics team on the unit. They described how the dietetic input was in line with the Core Standards for Intensive Care Support guidelines which stated there must be a dietician as part of the critical care multidisciplinary team and that the dietician should be at least a band 7.

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

The trust reported that between April 2017 and June 2017, Mental Capacity Act Level 1 training had been completed by 99% of staff within Critical Care.

A staff member told us that they had received scenario training around mental capacity. The safeguarding lead visited from the other site and was able to give support and answer questions on the subject.

Deprivation of liberty training is not one of the training modules we have been provided data for.
**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion.

On the Tunbridge Wells intensive care unit, we spoke with a patient and their two relatives. The patient was registered blind and their assistance dog was allowed to visit them in the unit which they were delighted about. The patient and relatives were very happy with the care they were receiving.

Staff interactions were positive and respectful. We observed a consultant enter a patient room and introduce themselves to the patient and tell them what their role was. We spoke to a nurse on the unit who told us that they would be happy to bring their own relatives onto the unit and felt that they provided very high standards of care.

We observed that patient’s privacy and dignity was respected at the Tunbridge Wells intensive care unit, and the availability of individual patient rooms helped to facilitate this. However, there was only one shower room which contained a toilet, and one other toilet. These were located next to each other. Staff showed us that they had made the ‘male’ or female’ signs interchangeable, but there was still a risk that patients who were ready for discharge from the ward, might have to pass patients of the opposite sex in their bed clothes which may impact a patients dignity. The risk of this however was limited by the single patient room environment.

Friends and Family Test were not available for either intensive care unit site. This was because the Friends and Family Test was only applicable if a patient was discharged directly home from the intensive care unit. Due to the nature of the patients on intensive care unit, it was likely that they would be transferred to another ward before being discharged home.

**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.

Relatives could visit their loved ones between 11am and 8pm. However, the ward information board outside of the unit stated that “we try to be flexible so please ask (if relatives wanted to visit outside these hours)”. We saw relatives visiting outside of these hours whilst we were on the unit.

We spoke to two relatives who told us the care was ‘superb’. They were kept informed about the plan for their relative’s discharge.

The information board outside the unit also had information such as what a patient may need when coming into intensive care unit – for example, there were photographs of everyday items such as toothpaste, hearing aids, photographs etc. to help relatives and patients see at a glance a useful reminder of what they may need to bring with them.

There was a relatives information board outside the unit. This detailed various pieces of information such as what ventilation meant and how patients were monitored. The information was written in simple terms and avoided the use of medical terminology. It also detailed the units layout and routine, including visiting hours and discharge information.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.
Both of the units used patient diaries. These were used for patients, relatives and staff to record key moments in their recovery or when they had visited. We spoke to a relative who told us about the diary and how they thought it was a positive idea. These could be reviewed, if the patient wished, in the follow up clinics run by the unit.

As part of the follow up clinic, patients were given the opportunity to complete a hospital anxiety and depression score to give an indication of the risk of this. Depending on the outcome of the score, patients could either be referred back to the GP, or could be signposted to counselling advice.

Is the service responsive?

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

The unit did not have a separate high dependency unit on which to care for high dependency patients. When the unit had sufficient capacity, high dependency (level one) patients could be cared for on the unit, and clinical support workers could be utilised to support these patients. Occasionally, patients would be cared for at Tunbridge Wells Hospital in the adjacent recovery unit and there was a policy and procedure in place for this.

There was an en-suite visitors bedroom for family members to stay on the ward. Staff gave us examples of where relatives had stayed on the unit, for example where a patient with learning difficulties had a relative stay with them to make them feel more comfortable.

Relatives could visit their loved ones between 11am and 8pm. However, the ward information board outside of the unit stated that “we try to be flexible so please ask (if relatives wanted to visit outside these hours)”. We saw relatives visiting outside of these hours whilst we were on the unit.

The website informed patients of current roadworks nearby to one of the hospital sites which may cause them delay getting to, or leaving, the hospital.

Meeting people’s individual needs
The service took account of patients’ individual needs.

An interpreting service had been introduced to the trust since our last inspection and it was hospital policy to only used translators accessed through this service.

The website contained information on the ‘accessible information standard’. This advised patients of how they could access support if they had sensory or physical impairment, and receive information in a way which they could understand. However, we did not see any leaflets available in an alternative language or information about how to access information in another language on the units.

There was detailed information available on the website for patients called: Intensive care: a guide for patients and relatives. This contained both practical information about getting to the unit, what patients may need, and other information regarding a typical day on the intensive care unit and use of patient diaries.

The waiting room for relatives and visitors had a hot and cold drinks dispenser which was complimentary. There was a vast array of patient information leaflets available in the waiting room and posters signposting patients to different support groups and organisations.
There was a multi-faith centre accessible to patients, visitors and relatives. There was a multi-faith chaplain and they were supported by volunteers who could visit patients on request and provide support.

Staff told us that the units used ‘this is me’ documentation which is a support tool for patients with short or long term memory loss or communication issues. The ‘this is me’ form included details on the person’s cultural and family background; events, people and places from their lives; preferences, routines and details about their personality.

There was a relatives room, separate to the waiting room, available in the unit. This was designed as a comfortable room for relatives to reflect away from the clinical environment. There were tissues, complaints process leaflets and information about creating your own memory boxes in this room.

**Access and flow**

**Bed occupancy**

Between September 2016 and August 2017, Maidstone and Tunbridge Wells NHS Trust had seen adult bed occupancy fluctuate, remaining worse than the England average for the entire reporting period except December 2016 and May 2017. Overall the trust has performed worse than the England average.

**Adult Critical Care Bed occupancy rates, Maidstone and Tunbridge Wells NHS Trust.**

![Graph showing bed occupancy rates](image)

Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

**Delayed discharges**

For the intensive care unit at Tunbridge Wells Hospital, there were 3,294 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 7.8%. This compares to the national aggregate of 5.3%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2014/15 annual report was 11.2%.

(Source: Intensive Care National Audit Research Centre)

Patients that had a discharge delayed up to four hours, ranged between 48% and 75% at Tunbridge Wells Hospital. This meant that the majority of patients fit for discharge were waiting up to four hours to be discharged to a suitable ward.

**Non-clinical transfers**

For the intensive care unit at Tunbridge Wells hospital, there were 613 admissions, of which
0.2% had a non-clinical transfer out of the unit. Compared with other units this unit was slightly better than the England average. The figure in the 2014/15 annual report was 0.4%.

(Source: Intensive Care National Audit Research Centre)

No patients were transferred to the intensive care unit for non-clinical reasons at either site during the past 12 months.

**Non-delayed out of hours discharges to the ward**

For the intensive care unit at Tunbridge Wells Hospital, 2.6% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. Compared with other units, this unit was around the same as the England average. The figure in the 2014/15 annual report was 5.4%.

(Source: Intensive Care National Audit Research Centre (Intensive Care National Audit Research Centre))

There was a follow up clinic to help patients come to terms with their intensive care unit journey. Ward clerks sent letters out to patients who had been discharged for up to two months, inviting them in for an appointment with one of the intensive care unit nurses. A senior nurse had produced a report on the efficacy of the clinic between July 2016 and July 2017. Of 214 letters sent out to patients offering the service, 25 patients attended (12%).

We spoke with the outreach team. They told us they thought the flow through intensive care unit could be improved due to the capacity issues and difficulty in discharging patients back out on to wards. They told us that the outreach team was sometimes used to look after patients who couldn’t access the unit because of capacity issues and this then affected the capacity of the outreach service.

**Learning from complaints and concerns**

**Summary of complaints**

Between July 2016 and June 2017 there were no complaints relating to the intensive care unit.

The trust website had a section dedicated to how to complain and examples of anonymised complaint outcomes. However, none of the examples related to intensive care unit patients.

We saw leaflets explaining how patients could complain in the waiting areas.

We saw multiple plaudits and letters thanking the nurse for both the care whilst on the ITU and for the follow up clinic.

**Is the service well-led?**

**Leadership**

The lead matron for the critical care directorate covered both intensive care unit sites. The directorate encompassed intensive care unit, theatres, endoscopy, pain and pre assessment.

On each site, there was a site matron who held critical care qualifications. The site matron for Tunbridge Wells was on leave at the time of our inspection. Staff told us that both the lead matron and site matrons were visible on the units. Site matrons had a percentage of their workload which
was designated for clinical work, which meant staff saw them on the ground and they had the opportunity to work with the team.

The intensive care unit outreach team worked cross site but were managed by the matron for the Maidstone site.

Site Matrons managed the band 7 nurses who in turn managed the band 6 and band 5 nurses.

Staff told us that the directorate lead and site matrons were visible, but above that, staff rarely saw senior or executive members.

**Vision and Strategy**

The trust had a vision for what it wanted to achieve.

The intensive care units sat under the critical care directorate. The directorate also encompassed theatres, pre-assessment and the chronic pain team. The critical care directorate vision was ‘delivering safe and effective critical care and pain services, to the population of West Kent and East Sussex’.

Displayed outside both of the intensive care units was the vision for critical care staff. This was to: support and foster the highest quality of care to all patients and their families; train individuals who are passionate about adult critical care and who will become leaders in the field; foster an academic, diverse, educational environment that encourages ongoing professional development, evaluation and constructive feedback; lead the field of critical care nursing and medicine; advocate on behalf of patients and their families, emphasising prevention, treatment and research relating to adult critical illness.

The critical care directorate strategy encompassed clinical strategies across all three departments, and these were colour coded to demonstrate where they fitted in with the trust’s overarching strategy strands: caring organisation, sustainable services and improvement driven. For the ITU, the clinical strategies for 2016/17 had been achieved with the objectives of setting up ITU follow-up clinics and to meet recommended intensivist numbers. There were no objectives set for 2017/18 and the 2018 – 2021 objectives were to increase information technology to reduce paper in ITU and to review ITU staffing and provision. The clinical strategy was listed as improving patients care in ITU and increasing the productivity of both ITUs through technology. Also being alert to the pressures experienced hospital and how to address these in light of current capacity and future demands on the service.

We spoke to staff who told us that one thing they would like to change about the unit was to get patients who were suitable for discharge, discharged from the unit quicker.

Since our last inspection, the outreach service had been increased to 24 hours from the previous 5 day week 9-5, which now complied with the National Confidential Enquiry into Patient Outcome and Death guidelines.

**Culture**

There was a positive culture that supported and valued staff.

We spoke to a member of domestic staff who was very happy here and had been in role for a number of years.

We spoke to a CSW who told us that working on the unit was ‘superb’. They are given support to attend their studies, and to complete their competencies.
A dietician told us that the staff on the intensive care unit were really experienced and the quality of care was fantastic. They felt it was a good team environment to work in.

A ward clerk said the unit was a very supportive environment. “All in it together” and would recommend it as a place to work and was proud to work here.

Staff told us they felt able to raise concerns and that the team was very supportive

**Governance**

There was a trust-wide Clinical Governance Committee which met monthly. The committee was informed by the directorate level meetings such as the critical care board meeting and the clinical operations and delivery committee.

The Clinical Governance Committee was chaired by the Medical Director or (interim) Chief Nurse in their absence. The committee included representatives from clinical departments across the trust, including the legal, risk, complaints and PALS departments. We saw that there was regular attendance from an intensive care unit representative.

We saw minutes of the Clinical Operations and Delivery Committee and saw that both the Critical Care Lead matron and one of the lead nurses for intensive care unit was in attendance. Learning from incidents and SIs were a standing agenda, along with a ‘safety moment’ of the month such as sepsis and associated National Institute for Health and Care Excellence guidance.

We saw minutes of the Critical Care Directorate board meeting. This was a cross site meeting where representatives of each of the critical care department attended. This fed into the trust wide clinical governance meetings.

**Management of risk, issues and performance**

There was a risk register seen for the critical care directorate. Within this, there were four risks listed for the intensive care unit departments. The highest rated risks were out of hours, delayed discharges and outreach suspension.

Each site also had a hazard profile which listed local risks and issues. These detailed local issues per intensive care unit site, including staff working in isolation in side rooms and risk of staff dealing with distressed relatives on a regular basis. These all had controls listed on the document, with electronic links or signposting to the relevant guiding policy.

Senior staff showed us how they could use the electronic risk and incident management system to review open incidents and risks. They could also easily access mandatory training and other key data about their staff and service.

We saw evidence from meeting minutes that incidents and audit data such as Intensive Care National Audit Research Centre outcomes were discussed at a range of team meetings. White boards situated within the department displayed safety data such as safety thermometer data and audit outcomes such as the latest Intensive Care National Audit Research Centre outcomes.

**Engagement**

There were team meetings that staff attended. Staff told us that if they were unable to attend the team meetings, they would be sent the minutes. This included sharing learning and support and chances to raise issues.

There was a matrons' workshop that was held for matrons across the departments to attend. We spoke with a site matron regarding this who told us it was a good opportunity to share best practice.

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A Nursing Engagement and Leadership Forum was held monthly. This was open to all bands of nursing staff, students and clinical support workers. It occurred at the same time on both sites, with topics circulated the day before the meeting.

We spoke with members of staff who were attending training to be ‘champions’ in their chosen field such as dementia, end of life care, medical devices or health and safety. They told us they were supported in this training.

Because of the nature of the critical care environment, there was no public involvement in how the department was run but patients and relatives were asked to comment on their care. However, other than the displaying of thank you cards and feedback from patients at the follow up clinic, we did not see any evidence of analysis of feedback or any trend analysis to drive improvement.

The website contained information for patients and relatives visiting the critical care unit.
The trust has 46 paediatric beds across two sites – Maidstone Hospital and Tunbridge Wells Hospital. In addition to the across two sites, the trust also provides paediatric outpatient services at both sites.

Maidstone and Tunbridge Wells NHS Trust (MTW) also offers tertiary service paediatric orthopaedic surgery for the whole of Kent and parts of Sussex.

(Source: Routine Trust Provider Information Return (RPIR) – Beds tab)

The trust had 4,222 spells between July 2016 and June 2017.

Emergency spells accounted for 77% (3,240 spells), 12% (510 spells) were day case spells, and the remaining 11% (472 spells) were elective.

Tunbridge Wells hospital has two wards Hedgehog ward that has 23 inpatient single rooms and Woodland that has an ambulatory care unit and day case beds. There is also a neonatal unit, which has 18 beds and provides level 2 unit care.

Percentage of spells in children’s services by type of appointment and site, July 2016 and June 2017, Maidstone and Tunbridge Wells NHS Trust.

Total number of children’s spells by site, Maidstone and Tunbridge Wells NHS Trust

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Tunbridge Wells Hospital</td>
<td>3,699</td>
</tr>
<tr>
<td>The Maidstone Hospital</td>
<td>289</td>
</tr>
<tr>
<td>Neville Childhood Epilepsy Centre</td>
<td>234</td>
</tr>
<tr>
<td>This trust</td>
<td>4,222</td>
</tr>
<tr>
<td>England average</td>
<td>1,100,097</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode statistics)

Is the service safe?
Mandatory training

We found staff had the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment. Staff told us it was their responsibility to ensure they were up to date with training and managers oversaw the training rates.

Mandatory training was a mixture of on-line training and face to face training. Modules included; safeguarding, information governance, infection control and prevention and fire safety. Additional modules were undertaken dependant on the staff member’s role. We saw training was appropriate for staff to deliver care in a safe way.

We saw evidence, which indicated staff were compliant with mandatory training. Staff told us they attended mandatory training days and completed online training packages in addition to this.

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

Breakdown of compliance for mandatory courses as of August 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division are shown below:

The below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services such as maternity, as well as those working in children’s services.

Medical and dental staff in the Women’s and Children’s division met the 85% target for mandatory training compliance for nine modules. Medicine management training had the lowest completion rate with only 61% which equated to 211 of the 288 eligible staff members completing the training.
Nursing and Midwifery staff in the Women’s and Children’s division met the 85% target for mandatory training compliance for nine modules. Conflict resolution training had the lowest completion rate with only 46% which equated to 28 of the 61 eligible staff members completing the training.

Staff completed a comprehensive induction package on starting employment in children’s services. They were an additional staff member for the first three weeks of working in any area of the service and could shadow staff in the service during that time. Staff told us this was invaluable in understanding how each part of the service worked.

**Safeguarding**

Staff understood their safeguarding responsibilities and could describe the safeguarding policies and procedures.

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

A breakdown of compliance for safeguarding courses as of August 2017 for medical/dental and nursing/midwifery staff in the Women’s & Children’s Division is shown below:

The below compliance applies to staff who fall under the trust’s Women’s & Children’s Division, this therefore includes staff that work in other services such as maternity, as well as those working in children’s services.
The 85% target was met for all of the safeguarding modules by medical and dental staff in the Women’s & Children’s division at the trust. Safeguarding children level 1 had the highest completion rate with 98%, this equated to 165 of the 168 eligible staff members completing the training.

Staff had access to a named nurse for safeguarding and a paediatrician with child protection experience and skills to provide immediate advice, assessment and a report if necessary.

Safeguarding training included training on female genital mutilation, childhood sexual exploitation and understood their duties to report this in line with guidance.

Staff spoke to had a good understanding of their responsibilities when reporting safeguarding concerns and how to keep children and their families safe from abuse and harm. Staff reported 28 incidents on the trust’s electronic reporting system from January to December 2017.

The named safeguarding nurse managed all paediatric services across both sites including children’s accident and emergency, neonatal services, specialist nurses and the community
nursing team. She managed escalation to other agencies and was contactable by phone at all times. Staff could contact the lead for advice or to discuss difficult cases.

There was a named safeguarding doctor who discussed initiatives and audit report findings with the community paediatrician.

Child protection medical forms were discussed at peer review and audited and these were reported on to the governance committee.

The trust was not yet live on the Child Protection - Information Sharing project. However, this was too occur in soon after the inspection. Systems used this linking information technology across health and social care to help organisations to change business processes so that basic information could be shared securely between them.

Staff could flag, on the trust's electronic booking system, if a child or young person was on a protection plan.

Staff completed proformas when children and young people were admitted to the ward. This would identify if a child was on a protection plan. If the child or young person had a named social worker, staff contacted the social worker to let them know they were an inpatient, keep them updated during their stay and inform them on discharge. Staff told us they had good working relationships with the social work team.

If a child did not attend their appointment in outpatients, this would be highlighted on the end of day report. The doctor completing the outcome sheets would review patients who did not attend and if necessary escalate this to the safeguarding team.

The service had safeguarding link nurses to liaise between the safeguarding lead and operational staff.

The safeguarding team would deal with children up to the age of 18. Patients up to the age of 16 years could be admitted to the paediatric ward. However there was no outreach service available for 16 and 17 year olds admitted to adult wards. The safeguarding lead was not routinely informed if a child was on an adult ward and relied on the wards informing them.

The trust acknowledged that it was not referring any domestic abuse to the Multi Agency Risk Assessment Conference. This is a victim focused information sharing and risk management meeting attended by all key agencies. The trust had no specific training on domestic abuse though it was an element of the safeguarding level 3 training that staff had.

The children’s directorate was unaware of the PREVENT training initiative and the National Health Service England directive of 85% of staff trained by March 2018.

**Cleanliness, infection control and hygiene**

The children’s and young people’s services controlled infection risk well. Staff followed effective systems and processes to prevent and protect people from a healthcare associated infection.

The Lead Infection prevention nurse led infection prevention and control at the trust.

Staff attended infection, prevention and control training and we saw training rates were above the target score of 95%. In addition to this staff completed aseptic non-touch technique training, this involves applying the strictest rules to minimize the risk of infection.
We visited woodland, hedgehog, the neonatal unit, waiting areas, plays rooms and parents rooms. All areas we visited were visibly clean and free from clutter. Staff completed daily cleaning checklists for rooms and equipment, we saw checklists were complete.

We saw audits of cleaning checklists which indicated the service was compliant in completing checklists. The outpatient area scored on average 100% from August 2017 to January 2018, Hedgehog scored 97.8 and Woodland scored on average 99.5% over the same period. Areas are audited depending on the level of infection risk they have, in the outpatient department this was significant and audits were carried out quarterly and in the Hedgehog and Woodland, the risk was high so this was monthly. This was in line with the national specifications for cleanliness. We saw cleaning staff using colour coded mops, cloths and buckets in line with policy and national specifications of cleanliness guidance.

We saw disposable curtains in treatment areas which had been changed within the last six months in accordance with hospital policy.

We saw sharps bins were available in treatment areas where sharps may be used. This demonstrated compliance with health and safety regulation 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 completed cleaning checklists for cleaning toys in playrooms and waiting areas and there was a designated member of staff for cleaning equipment on the neonatal unit. We saw them cleaning equipment and placing ‘I am clean’ notices on equipment to indicate it was clean and ready for use.

CQC Children’s Survey 2014 – Q26
In the CQC children’s survey 2014 the trust scored 9.19 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts other trusts.
(Source: CQC Children’s Survey, RCPCH)

Infection prevention and control standard operating procedures and policies we reviewed were up to date and accessible by staff on the hospital intranet. This assured us the units were following evidence-based procedures whilst preventing the spread of infections.

We observed staff adhered to the infection control policies, including ‘bare below the elbows’, hand hygiene, long hair tied up and correct use of personal protective equipment such as gloves and disposable aprons.

We saw hand hygiene results which indicated in August, September, October, November and December, the Hedgehog, woodland and the neonatal intensive care unit scored 100% when they were audited cleaning their hands before patient contact.

There were sufficient numbers of hand washing sinks available, in line with Health Building Note (HBN) 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 handwashing sinks. Sanitising hand gel was readily available throughout the hospital.
Alcohol hand cleaning gel dispensers was available at all entrances to areas and we saw staff and visitors use them.

**Environment and equipment**

The design and maintenance of the paediatric services assisted in keeping children safe. The entrances to the services were swipe card only and visitors had to ring a bell to be admitted. Only paediatric staff or staff assigned with specific access to the paediatric unit could access with a swipe card. A general trust swipe card did not give admittance. This gave the department a very secure control on who was entering the department.

Hedgehog ward had two high visibility rooms that were equipped and staffed to high dependency unit level and had the equipment for enhanced monitoring of unwell children. There was no central monitoring available.

We saw clinical rooms; clean and dirty utility rooms and the kitchen were keypad entry only. Keypads were of a height adults could reach, but a small child would be unable to.

We saw a range of specialist equipment for children, to carry out examinations, consumables and a wide variety of toys to provide distraction techniques.

Equipment was serviced regularly and we looked at many pieces of equipment, all had stickers to indicate they had been service in the last 12 months.

Electrical equipment had electrical safety tests completed regularly and we saw stickers on equipment which indicated this was the case.

A variety of disposable items of clinical equipment was available in treatment rooms. All items we checked were in date.

Resuscitation trolleys were available and easily accessible to all staff. Trolleys were tamper evident. All trolleys had daily checklists. The checklists were completed daily for the last two months. We saw equipment was available for children of all sizes and all disposable equipment on the trolley was in date.

**CQC Children’s Survey 2014 – Q2, Q7, Q25**

In the CQC children’s survey 2014 the trust scored 9.11 out of ten for the question ‘Did you feel safe on the hospital ward?’ This was about the same as other trusts other trusts.

The trust scored 9.24 out of ten for the question ‘Did you feel that your child was safe on the hospital ward?’ This was about the same as other trusts other trusts.

The trust scored 8.98 out of ten for the question ‘Did the ward where your child stayed have appropriate equipment or adaptions for your child?’ This was about the same as other trusts other trusts.

A list of all scores from the survey which fall under the safe domain are listed below.

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
</table>

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25. Did the ward where your child stayed have appropriate equipment or adaptions for your child?  
   S3: 0-15 8.98 Adults: 9.19 About the same as other trusts

26. How clean do you think the hospital room or ward was that your child was in?  
   S3: 0-15 9.19 Adults: 9.19 About the same as other trusts

53. For most of their stay in hospital what type of ward did your child stay on?  
   S3: 0-15 10.00 Adults: 10.00 About the same as other trusts

57. Did you feel that your child was safe on the hospital ward?  
   S3: 0-7 9.24 Adults: 9.24 About the same as other trusts

2. Did you feel safe on the hospital ward?  
   S3: 8-15 9.11 CYP: 9.11 About the same as other trusts

In the theatre recovery area there were dedicated bays for children which were screened off from the adult recovery area. This was in line with the royal college of surgeons, standards for children’s surgery recommends: to minimise any distress that children and young people should not be cared for alongside adults in recovery areas and parents should be allowed to visit their child in recovery.

The neonatal unit had cots available for babies of all sizes and we saw additional cots were available. There was a variety of specialist equipment available, such as ultrasound scanners to assess baby’s hearts and brains and equipment to maintain the temperature of babies.

The store room was well stocked with a wide variety of equipment to support staff caring for babies and all stock was clearly labelled and colour coded for ease of access.

**Assessing and responding to patient risk**

We found a wide range of risk assessments, screening tools and record charts were used to minimize risk to patients. Effective policies and procedures were in place to manage a patient in an emergency.

Every child had a Paediatric Early Warning Score which is a tool to identify if a child was becoming more unwell. This form had a system which guided staff to the appropriate action. We reviewed a selection of the forms and saw that staff escalated any concerns in the correct manner from these recordings.

Staff used an electronic hand held devices to record the results of an early warning system to identify if a child was becoming more unwell. This could be accessed by any member of staff involved in the child’s care, so they could be alerted to any change in the child’s condition.

Managers audited the completion of paediatric early warning scores and in the most recent audits in August 2017 and January 2018, scored 100%.

There was an escalation policy. Any child requiring transfer to another hospital for any reason including critical care was transferred to a nearby trust with these facilities through a contracted retrieval service. Staff had a good understanding of the process, which was in line with the policy.
The service had a sepsis policy and clinical guidance for sepsis in infants and children which referred to relevant national and professional guidelines.

The trust used a paediatric sepsis screening tool and antibiotic protocol. All staff received training on induction and attended a two yearly update. Staff we spoke with were aware of how to assess and manage sepsis.

Staff had developed a proforma for the assessment and management of febrile neutropenia, to assist staff in responding quickly to unwell children.

All children attending as day cases were pre-assessed. This was done either by attendance to the pre-assessment clinic or by a telephone assessment depending on the nature of the child’s treatment.

A registered nurse always escorted children to and from theatre and carried a grab bag with them in case of emergency.

Staff had training to respond to patients in an emergency. We saw 86.2% of medical staff had attended basic life support. Eighty four percent of nursing staff were trained in paediatric basic life support. In addition to this, 69% of nursing staff were trained in emergency paediatric life support.

In addition to this, staff taught parents of babies under 34 weeks basic neonatal life support and choking rescue training.

Staff followed the National Patient Safety Agency five steps to safer surgery as part of the World Health Organisation surgical safety checklist. The purpose of the checklist was to check all safety elements of a patient’s operation before proceeding. We saw completed checklists in patients records.

Any patients seen in the ambulatory unit who required inpatient care were transferred to the Tunbridge Wells Hospital at Pembury. A multi-disciplinary team, which included a paediatrician, carried out a risk assessment to decide if transport was possible with parents in a car or whether an ambulance transfer was required. If a patient’s care needs could not be provided for at the Tunbridge Wells hospital at Pembury could be transported to another hospital by the retrieval team. This was in line with the paediatric transfer policy.

The trust had a child abduction plan, approved in January 2015. The plan formed apart of major incident training. We received information which indicated 72.6% of staff had attended major incident training. Staff we spoke with were aware of the process.

**Nursing staffing**

The service had sufficient numbers of staff to provide safe care and treatment to children and young people.

We saw that on Hedgehog ward there were six registered children nurses plus a nursery nurse on duty in the morning and five trained nurses and a nursery nurse on duty in the afternoon and overnight.

Where an assessment had been made for the need of a greater nurse to patient ratio, such as one to one nursing, these were provided in accordance with the 2013 Royal College of Nursing guidance.

A senior children’s nurse led the unit at all times.

The neonatal unit had seven trained nurse and one nursery nurse in the day and five trained nurses and two nursery nurses overnight. The staff ratio in the neonatal was two to one, one to one in the intensive care unit and four to one in the special care baby unit. This was in line with
the British Association of Perinatal medicine guidelines.

The trust has reported the following planned and actual staffing figures for nursing and midwifery registered staff working in children’s services for the period January 2017 to June 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Services for Children &amp; Young People</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
</tr>
<tr>
<td>January 17</td>
<td></td>
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<tr>
<td>February 17</td>
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<tr>
<td>March 17</td>
<td></td>
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<tr>
<td>April 17</td>
<td></td>
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<tr>
<td>May 17</td>
<td></td>
</tr>
<tr>
<td>June 17</td>
<td></td>
</tr>
</tbody>
</table>

As at June 2017, there are 6.66 WTE less staff in post than the trust had planned to provide safe care.  
(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

However, during surgical lists, we saw two members of staff were regularly off the ward taking patients to and from theatre. This left one qualified nurse on the day care and ambulatory ward which meant there was risk to patient safety in event of an emergency.

**Vacancy rates**

Between July 2016 and June 2017 the trust reported an average vacancy rate of 7.1% for nursing and midwifery staff in children’s services;

- Maidstone Hospital: 0%
- Tunbridge Wells Hospital: 7.2%
- Other: 10.7%

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

All staff vacancies in the Tunbridge Wells paediatric service had been filled.

**Turnover rates**

Between July 2016 and June 2017, the trust reported an average turnover rate of 0.9% for nursing and midwifery staff in children’s services.

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

**Sickness rates**

Between July 2016 and June 2017 the trust reported an average sickness rate of 4.0% for nursing and midwifery staff in children’s services, which is above the overall trust target of 3.3% for sickness rates.

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

**Medical staffing**

There was a paediatric registrar and a paediatric house officer on site at all times who had access to all consultants and pediatric consultants.
All medical cases were under the care of a consultant paediatrician. All surgical patients were admitted under their specialist surgeon but are also seen by a paediatrician consultant on ward rounds and are under the care of a paediatric registrar and senior house officer. There was Consultant cover was until 10pm each day then a paediatric registrar and senior house officer overnight. The unit always had a paediatric doctor on site.

When a paediatric anaesthetist was not available, such as in an emergency, an anaesthetist with paediatric skills and competency was used. A paediatric consultant was available at all times. This was consistent with Standards for Children’s surgery, The Royal College of Surgeons, 2013 Standards for Children.

The trust has reported the following planned and actual staffing figures for medical & dental registered staff working in children’s services for the period January 2017 to June 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE in post</th>
<th>WTE planned</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 17</td>
<td>42.35</td>
<td>43.80</td>
</tr>
<tr>
<td>February 17</td>
<td>42.35</td>
<td>43.80</td>
</tr>
<tr>
<td>March 17</td>
<td>43.85</td>
<td>43.80</td>
</tr>
<tr>
<td>April 17</td>
<td>43.65</td>
<td>44.25</td>
</tr>
<tr>
<td>May 17</td>
<td>43.45</td>
<td>43.65</td>
</tr>
<tr>
<td>June 17</td>
<td>43.65</td>
<td>42.45</td>
</tr>
</tbody>
</table>

As at June 2017, there were 1.2 WTE more staff in post than the trust had planned to provide safe care.

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

**Vacancy rates**
Between July 2016 and June 2017 the trust reported an over establishment by 0.4% for medical and dental staff in children’s services;
- Tunbridge Wells Hospital: -0.4%

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

**Turnover rates**
Between July 2016 and June 2017, the trust reported an average turnover rate of 1.1% for medical & dental staff in children’s services.

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

**Sickness rates**
Between July 2016 and June 2017 the trust reported an average sickness rate of 3.9% for medical & dental staff in children’s services, which is above the overall trust target of 3.3% for sickness rates.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
**Staffing skill mix**

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

**Staffing skill mix for the 40 whole time equivalent staff working in Children’s services at Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>41%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>42%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior</td>
<td>10%</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

**Records**

All the records we reviewed in all the paediatric departments had multidisciplinary medical records, completed by everyone associated with their care. We reviewed five sets of medical records. All of these had the relevant information recorded such as patient details, diagnosis and management plan, observation charts and assessment of nutritional status where applicable. Staff were therefore able to obtain the correct information and provide the plan of care to the patients. All records were comprehensive and easy to read, there were signed and dated.

All test results were accessible on the computer system and recorded in the medical records along with risk assessments and specific condition care plans.

Both hospital sites used the same system and records were easily transferred between sites when this was required.

There were flags on the electronic system which alerted staff to whether children attending the hospital were under child protection known to social services or the hospital safeguarding team.

Children with complex or long term medical conditions carried health passports, which contained information about medication they may be on.

An electronic discharge notification was sent to a child or young person’s GP on their discharge. This was a summary of care received. Staff also sent a more detailed discharge letter.

Staff encouraged parents to bring in personal child health records (red books), to ease information sharing from hospital to health visitors.
Children with mental health needs were assessed by the mental health community team and this was also recorded in the multidisciplinary record.

We saw that the staff worked closely with the mental health team who also provided advice about the environment and mental health training to staff.

The neonatal unit situated between the maternity unit and paediatric unit used an electronic care record. This is a care record made available at the point of care, wherever care is delivered. If a baby entered neonatal care, this linked with the maternity record, allowing data to move seamlessly between neonatal and maternity services. This system also links with other neonatal units nationally.

**Medicines**

Staff prescribed and administered medicines to children in line with the relevant legislation and current national guidance.

Medications were stored securely including medication fridges that were locked. Fridge maximum and minimum fridge temperatures were checked daily and this was recorded to ensure that medicines were stored in accordance with manufacturers’ recommendations.

Controlled drugs were stored in accordance with legislation and there were regular stock checks of controlled drugs.

Medication charts reviewed showed that medicines were prescribed by medical practitioners.

Local topical anaesthetic creams cause numbness to the area where they are applied. They were applied to children and young people who required a cannula to be inserted into their vein for the administration of an anaesthetic or blood sampling. Topical creams and oral pain killers such as paracetamol and ibuprofen were covered under a patient group direction. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor.

Since the last inspection in 2015, training and sign off, of competencies for staff to administer these drugs had improved and was only administered by staff with authorisation to use the direction in line with the trust’s policies.

Staff had access to national formularies such as the British National Formulary for Children and a local electronic formulary detailing the preferred antibiotics for specific infections.

The service followed neutropenia guidelines that were on the computer and were up to date. Children were administered antibiotics within an hour of diagnosis and this was overseen by specialist oncology nurses, one of which was always on duty.

There was also a paediatric sepsis guideline and antibiotics were administered within an hour. This process was a Performance of Commissioning for Quality and Innovation target that is a national framework for locally agreed quality improvement schemes. Commissioners monitored the achievement of local quality improvement goals and targets, this goal had been met for the last quarter.

All babies admitted to the neonatal unit meeting the criteria for risk of sepsis were administered preventative antibiotics until they had two clear C-reactive protein blood culture test results. C-reactive protein is a nonspecific, acute-phase protein that rises in response to infectious and non-infectious inflammatory processes and assists in establishing or exclude the diagnosis of sepsis in full-term or near-term infants.
Paediatricians reviewed medication on ward rounds and clinical areas were supported by daily visits from a paediatric pharmacist. The pharmacist showed us how they reviewed drug sheets and how they denoted any questions or instruction on the record for the attention of the attending paediatrician. There was good communication between the pharmacist and clinicians and this demonstrated that dosages, length of time of treatment, contraindications and drug interactions was monitored by the pharmacist and acted upon.

Medication records recorded children’s weight and allergies.

All out of date or unused medication was returned to pharmacy for disposal.

Advice was provided to carers about any medication on discharge. This included the patient passport which documented what medication had been administered and when it was next due. There was space for carers to continue to record medication at home so that regularly required medication and analgesia could be monitored by carer to provide the most effective recovery. The pharmacist monitored antimicrobial prescription and visited the ward daily.

**Incidents**

The staff we spoke with understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses.

Staff told us they were encouraged to report incidents and there was a no ‘blame culture’ associated with reporting incidents.

Incidents were recorded on the trust’s electronic system and there were systems in place to investigate and take action. Staff could request feedback. In addition to this, staff received feedback at staff meetings and we saw minutes of meetings to indicate this was occurring.

National patient safety alerts were shared via email and action would be taken dependent on the subject of the alert. For example, the pharmacist would deal with any relating to medicines and informed staff of the outcome of any action.

From January to December 2017, 303 incidents were reported in the children’s and young people services.

**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 children’s services.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England between September 2016 and August 2017.

The breakdown of incident type was:

- Pending review (a category must be selected before incident is closed) with one (50% of total incidents). We saw a root cause analysis of this incident, which clearly identified change made because of this incident and the subsequent investigation findings.
• Medication incident meeting SI criteria with one (50% of total incidents).

(Source: Strategic Executive Information System (STEIS))

We saw completed root cause analysis documents and the lessons were shared with those involved.

Although it was evident that lesson learned in the children’s services was shared within the directorate and practice changed as a result, it was less clear how learning was systematically identified, disseminated or audited across the trust.

All children deaths expected and unexpected were discussed at the child death overview panel with paediatric consultant lead and other relevant parties including a GP, health visitor, and school nursing; they were discussed at the clinical governance meetings, directorate meetings and perinatal mortality meetings.

We saw an example of the directorate report to the mortality surveillance group that looked at the number of deaths, themes and trends, local learning and trust wide learning to share. It also highlighted issues to be escalated to the mortality surveillance group. Staff told us lessons were shared by e-mail.

The duty of candour is a regulatory duty relating to openness and transparency. It 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. Staff we spoke with had a good knowledge of the duty of candour and, senior staff were clear about their responsibilities in relation to the duty of candour.

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 was intended to focus attention on patient harms and their elimination.

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or catheter urinary tract infections between August 2016 and August 2017 for children’s services.

(Source: NHS Digital)

There was a paediatric safety thermometer in use in all paediatric departments.

which indicated 72.6% of staff had attended major incident training as at 31st October 2017.

Other CQC Survey Data

CQC Children’s Survey Data – Q53

In the CQC children’s survey 2014 the trust scored 10.00 out of ten for the question ‘For most of their stay in hospital what type of ward did your child stay on?’ The measure is if children spent most of their time of a children’s ward rather than an adult ward. This was about the same as other trusts other trusts.

(Source: CQC Children’s Survey, RCPCH)
Is the service effective?

Evidence-based care and treatment

The provider used evidence based guidance to assess and care for patients. Trust policies were evidence based and referenced professional and national guidance. These were all on an electronic system which all staff could access. All care pathways were also on this system and could be printed off for individual patients.

The service carried out a number of audits, which had resulted in a change in practise and had re-audited to see the impact of the change. For example: An audit of safeguarding children; Investigation children with fractures on skeletal survey; audit of paediatric early warning scores; audit of the management of febrile neutropenia patients; audit of paediatric transfers to tertiary centres; and an audit of safeguarding children; medical letters. In the last audit, inconsistencies in child protection reports led to the implementation of a proforma.

Audits to demonstrate compliance with National Institute of Health and Care Excellence (NICE) guidelines were carried out. For example: An audit of the management of deliberate self-harm in children who present to the Emergency Department clinical guideline (CG)16 and diabetes service compliance with NICE 2015 Guidelines: Prospective Audit/ NICE NG18 & 19; Diabetes (type 1 & type 2) in children and young people: diagnosis and management including diabetic foot problems.

Sepsis screening and the management of paediatric patients was in line with national guidance. There were sepsis guidelines and inpatient sepsis was one of the Commissioning for Quality and Innovation national goals that the trust was measured on. The trust met this target in the last quarter.

All children diagnosed with sepsis were administered antibiotics within an hour. If these patients were in Maidstone hospital they had antibiotics administered before transfer to the Tunbridge Wells Hospital at Pembury paediatric inpatient ward. There were also neutropenia guidelines which meant antibiotics were provided within an hour and were managed by the lead oncology nurses who are available 24 hours a day, seven days a week. This was in line with National Institute Health and Care Excellence, NG52; Sepsis: recognition, diagnosis and early management.

The neonatal and maternity unit were awaiting full membership to Bliss. The Bliss Baby Charter was designed to standardise high quality family-centred care across the UK. It is a framework for neonatal units to self-assess the quality of family-centred care they deliver against a set of seven core principles.

There had been a large increase of children admitted under the Mental Health Act 1983 (MHA) at the Hedgehog ward at the Tunbridge Wells Hospital at Pembury as a place of safety for patients sectioned under the Mental Health Act, awaiting tier 4 placements in paediatric mental health units. Registered mental health nurse nursed all children admitted under the Mental Health Act. However, there were no formal section 136 ‘place of safety’ facilities outside the Mental Health S136 suites and the trust was not commissioned to provide place of safety beds.

The majority of mental health patients were children who have attempted, and were still a risk of suicide. Paediatric nurses had training on conflict resolution and 60% of staff had completed this
training to date. Mental health training was also provided from children’s and adolescent mental health services. Registered mental health nurses also nursed all children at risk.

One room has been modified to reduce number of ligature points in association with children’s and adolescent mental health services advice who the service met with monthly.

Staff demonstrated a regard for the Mental Health Act code of practice. There had been input from the children’s and adolescent mental health team with regard to the environment and training of staff.

There were panic buttons throughout Hedgehog ward and the staff reported that security staff were very responsive and helpful when required.

Staff at the ambulatory units at Tunbridge Wells saw patients who had come from the emergency department for assessment and treatment. Paediatric early warning assessment charts were used for all ambulatory, day cases and inpatients to identify any deterioration and follow a clear path of action to be taken.

**Nutrition and hydration**

Significant work had taken place to improve the nutrition and hydration of patients prior to surgery. Children were starved from two to four hours depending on the procedure and in accordance with national guidelines. If children were delayed, going to theatre, staff would ensure they continued to receive fluid. Nutrition was also considered and staff could sucrose to ensure children’s sugar levels were maintained in patients before surgery to assist their recovery.

Staff could refer children to a dietician to assess and manage any specific dietary needs.

The diabetic team was on site at Tunbridge Wells and diabetic specialist nurses visited all diabetic paediatric inpatients.

The neonatal unit had facilities for feeding babies. There was a breast expressing room for mothers that provided privacy and comfort and a milk kitchen where parents could prepare their babies feeds where appropriate.

**Pain relief**

Pain management was evidence-based and provided guidance on managing varying levels of pain including the use of sucrose, paracetamol and pain relieving drugs.

Children admitted to any part of the service had pain assessments. Staff used a behavioural pain assessment tool, which looks at facial expressions and postures for non-verbal patients; a self-reporting tool, which was pictures of faces ranging from a happy face to a sad face and visual analogue tool. A visual analogue scale is a tool to help patients identify a level of how they are feeling and would, for example be a score of one to 10.

We looked at a selection of records and saw staff routinely assessed children’s pain levels.

There were patient group directions in place in place for the use of paracetamol and ibuprofen and administration of local anaesthetic prior to cannula insertion. Staff had the appropriate training and had a competency assessment before being able to administer medications under a patient group direction.

The Tunbridge Wells Hospital at Pembury had a play therapist five days a week. The play therapist provided distraction techniques and prepared children for any potential painful procedures. We saw the treatment room was well equipped with toys, book and bubbles to provide distraction.
Patient outcomes

The service regularly reviewed the effectiveness of care and treatment through local and national audits. In May 2017, the service carried out an audit of paediatric endoscopy. The audit was to look at performance in terms of indications for the endoscopy and safety in performing upper and lower gastrointestinal endoscopy. The audit also looked at waiting times and the service assessed the results in line with national averages for paediatric endoscopy.

The trust completed the British Thoracic Society (BTS); National Paediatric Community Acquired Pneumonia Re-Audit in 2017 and the Irritable bowel Disease Audit in January 2017.

The trust participated in the National Paediatric Diabetes Audit, annually in line with the healthcare quality improvement partnership.

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time. The NICE Quality Standard QS6 states “People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)”.

The data below shows the 2015/16 diabetes audit for Maidstone Hospital performed similar to the England average. There were fewer patients having an HbA1c value of less than 58 mmol/mol compared to the England average and the mean HbA1c was similar the England average.

All audits compared results against expected standards in line with guidance or national averages. If the standard was not met or the score was worse than the national average, an action plan was drawn up to address the issues, which we saw in each care.

Readmission rates for surgical patients were better than the average of other hospitals in the region. Maidstone and Tunbridge Wells had a 4.4% readmission rate which was better than the regional average of 6.5%.

There was liaison with the community nursing team on site and the trust was looking at developing a strategy for home care.

National Neonatal Audit Programme

In the 2015 National Neonatal Audit Tunbridge Wells Hospital performance was as follows:

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

There were 58 babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

There were 354 first episodes of care that were eligible for inclusion in this audit measure. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 91% of the eligible episodes; this was above the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Are rates of normal survival at two years comparable in similar babies from similar
neonatal units?
There were 17 babies born at < 30 weeks born between July 2013 and June 2014 who have been assigned for two year health assessment based on their final neonatal discharge. Data was entered for 0% of the babies assigned, whilst nationally data was available for 61% of babies born at < 30 weeks born between July and June 2014

What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?
There were 129 babies born < 32 weeks who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies 23 were identified as having Significant BPD.
(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Competent staff
We saw staff were competent to perform their roles, attended regular supervision training and had regular appraisals. Leadership development training was available to staff, which was encouraged by managers.
There were dedicated anaesthetists, theatre and recovery staff to care for children and young people.
There were sufficient staff competent in advanced paediatric life support and emergency paediatric life support on duty at all times.
A clinician with the necessary skills and competencies saw every child with an acute medical problem before being discharged.

Appraisal rates
Between April 2017 and July 2017, 87% of staff working within services for children and young people (88% for staff in paediatrics and 87% for staff in neonates) within the Women’s and Children’s division at the trust had received an appraisal compared to a trust target of 100%.
The 81% appraisal rate applies to nursing and midwifery registered staff.
The 96% appraisal rate applies to medical & dental staff.
The 95% appraisal rate applies to NHS infrastructure staff.
The 88% appraisal rate applies to support to doctors and nursing staff.

The appraisal rate for staff working in children’s services in Tunbridge Wells Hospital was 96% (Source: Trust Provider Information Request P46)

On Hedgehog and Woodlands all patients were cared for by registered paediatric nurses. There were also 11 specialist nurses for specific conditions such as diabetes, gastrointestinal conditions, oncology and others. Registered mental health nurses nursed children admitted with mental health conditions.

There was documental evidence to show that appraisals and revalidation was taking place. Staff had regular clinical supervision sessions, which could be both one to one or in a group. Agency staff received an induction and the service regularly used the same agency staff as they knew they had completed the induction. Agency nurses were also required to complete a drug assessment, prior to being allowed to give drugs.

Learning needs for staff were identified through their annual appraisal and when new skills were
required for changing health care provision. For example since the increase on mental health patient admissions mental health training and conflict resolution training had been provided.

All children referred to the ambulatory care unit with an acute medical problem were seen by a consultant prior to discharge. The unit had access to a consultant during its opening hours. Specialist paediatricians were available for telephone advice.

**Multidisciplinary working**

There was evidence of good multidisciplinary working both within the trust and with external stakeholders.

We observed staff working well together during our visit. They also worked well with multidisciplinary teams within the hospital and with other outside services in order to provide the best care possible for their children and young people.

Our review of five medical records, confirmed there were effective multidisciplinary working practices, which involved nurses, doctors, physiotherapists, and pharmacy. Staff told us they felt supported by and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe.

Ward rounds were multidisciplinary and included specialist services such a dietician, physiotherapist or whichever specialist service was required for patients on the ward, for example paediatric diabetic specialist nurses if any child on the ward was diabetic.

The hospital worked alongside the community nursing team and community mental health team regarding discharges.

**CQC Children’s survey 2014 – Q36**

In the CQC children’s survey 2014 the trust scored 8.48 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the same as other trusts other trusts.

(Source: CQC Children’s Survey, RCPCH)

The unit had good communication with children’s and mental health adolescent services and community services. There was a multidisciplinary approach to paediatric care with regular meetings with external stake holders and commissioners.

**Seven-day services**

There was seven day access to diagnostic services such as x-ray, ultrasound, computerised tomography, magnetic resonance imaging, echocardiography, endoscopy and pathology.

The wards and units had access to pharmacy advice 24 hours a day seven days a week.

**Health promotion**

Staff identified children, young people and their families who may need additional support, for example, children and young people living in vulnerable circumstances and children and young people at risk of developing long term conditions. Staff were able to signpost patients and their carers to support services or directly refer them to services.

We saw posters and health promotion literature, advertising and supporting national public health initiatives were available in waiting areas..
Staff routinely asked parents about smoking and alcohol intake and could refer to smoking cessation advice if required.

We saw posters and leaflets promoting, vaccinations, Health Start initiatives which provide advice on nutrition, ‘Smoke free’ posters, ‘Change for Life’ advise on lifestyle and posters advising on how to recognise meningitis and sepsis.

**CQC Children’s survey 2014 – Q28**

In the CQC children’s survey 2014 the trust scored 8.56 out of ten for the question ‘Did a member of staff agree a plan for your child’s care with you?’ This was about the same as other trusts other trusts.

(Source: CQC Children’s Survey, RCPCH)

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

Staff demonstrated an understanding of the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005, with regard to children over 16 years and the Children Acts 1989 and 2004.

Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff understood and assessed children for Gillick competency and where appropriate signed consent forms, counter signed by their parents.

Fraser Guidelines were set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985) and apply specifically to contraception. They are used to decide whether a girl of 16 or under can be given advice or treatment without the consent or knowledge of her parents.

Staff we spoke with had a good understanding of Gillick competence, Fraser guidelines and gaining consent from children. They gave us numerous examples of where they spent time to fully explain procedures to children, before gaining consent, giving them time to consider their decisions and advising them to discuss with their parents, when this was appropriate.

We saw completed consent forms which indicated benefits and risks of treatment had been discussed. Medical staff and parents signed them.

**Other CQC Survey Data**

**CQC Children’s Survey Data**

The trust performed about the same as other trusts in all of questions relating to effective in the CQC children’s survey 2014

**CQC Children’s Survey questions, effective domain, Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Subgroup</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Did a member of staff agree a plan for your child’s care with you?</td>
<td>E1</td>
<td>0-15 adults</td>
<td>8.56</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41. Do you think the hospital staff did everything they could to help ease your child’s pain?</td>
<td>E1</td>
<td>0-15 adults</td>
<td>8.23</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34. Did you feel that staff looking after your child knew how to care for their individual or special</td>
<td>E3</td>
<td>0-15 adults</td>
<td>8.20</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
36. Did the members of staff caring for your child work well together?  
33. Were the different members of staff caring for and treating your child aware of their medical history?  
24. Did your child like the hospital food provided?  
11. Do you think the hospital staff did everything they could to help your pain?  
4. Did you like the hospital food?

<table>
<thead>
<tr>
<th>Question</th>
<th>Age Group</th>
<th>Rating</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. Did the members of staff caring for your child work well together?</td>
<td>0-15 adults</td>
<td>8.48</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33. Were the different members of staff caring for and treating your child aware of their medical history?</td>
<td>0-15 adults</td>
<td>7.33</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>24. Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>6.36</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>11. Do you think the hospital staff did everything they could to help your pain?</td>
<td>8-15 CYP</td>
<td>8.93</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>4. Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>6.93</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Key:
- ★ Better than other trusts
- ○ About the same as other trusts
- ● Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)

Is the service caring?

Compassionate care

We observed staff actively engaging with children and their families. We saw compassionate and caring interaction and staff were skilled in talking and caring for children and young people.

Care from nursing and medical staff was delivered with kindness and patience. The atmosphere was calm and professional without losing warmth. Call bells were observed to be responded to in a timely manner.

The parent and children we spoke to were very positive about the standard of care, compassion and support the staff provided.

Parents told us:
‘Staff amazing, busy, but received high quality care’.
‘They’ve all got a lot of time for us’.
‘Go above and beyond to help’.

The service was trialling a feedback form with pictures, suitable for children to complete. On hedgehog ward we saw a wall with suns and clouds, which children had written their comments on. The suns were for good feedback, the moons for things children did not like as much. Children wrote:
‘Everyone is friendly’.
‘Nurse always checked I’m Ok’.

The service had started this as children weren’t so keen to fill in the feedback forms.

CQC Children’s survey 2014

328
The trust performed about the same as others in the England average for 13 out of 14 questions relating to compassionate care in the CQC children's survey 2014. The trust performed better than other trusts for 'was your child given enough privacy when receiving care or treatment'.

CQC Children's Survey questions, compassionate care, Maidstone and Tunbridge Wells NHS Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Overall… (please circle a number)</td>
<td>C1</td>
<td>0-15 adults</td>
<td>8.28</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>35. Were members of staff available when you or your child needed attention?</td>
<td>C1</td>
<td>0-15 adults</td>
<td>8.12</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>8. Was your child given enough privacy when receiving care and treatment?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.72</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>9. Did you think there were appropriate things for your child to play with on the ward?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.27</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>10. Did staff play with your child at all while they were in hospital?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>5.89</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>11. Did new members of staff treating your child introduce themselves?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.27</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40. Do you feel that the people looking after your child listened to you?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.42</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41. Do you feel that the people looking after your child were friendly?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.87</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42. Do you feel that your child was well looked after by the hospital staff?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>8.75</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43. Were you treated with dignity and respect by the people looking after your child?</td>
<td>C1</td>
<td>0-7 adults</td>
<td>9.14</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9. Were you given enough privacy when you were receiving care and treatment?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.11</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18. Do you feel that the people looking after you listened to you?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.05</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19. Do you feel that the people looking after you were friendly?</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>9.44</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>20. Overall… (please circle a number)</td>
<td>C1</td>
<td>8-15 CYP</td>
<td>8.28</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Key:
- **Better than other trusts**
- **About the same as other trusts**
- **Worse than other trusts**

(Source: CQC Children’s Survey, RCPCH)

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

We spoke with parents and asked them if staff involved them in their child’s care, they told us:
‘Brilliant, always kept in the loop’.

Staff told us they asked parents to indicate when would be in and out of the wards and units, this meant they could ensure staff could involve parents in their children’s care as much as possible.

On the neonatal unit, parents were issued with a parent passport. This enabled parents to record the parenting skills they had been shown by staff.

**CQC Children’s survey 2014**

The trust performed about the same as other trusts for all 19 questions relating to understanding and involvement of patients and those close to them in the CQC children’s survey 2014.

**CQC Children’s Survey questions, understanding and involvement of patients, Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>subgroup</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Did hospital staff tell you what was going to happen to your child while they were in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.32</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>27. Did members of staff treating your child, give you information about their care and treatment in a way that you could understand?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.96</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29. Did you have confidence and trust in the members of staff treating your child?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.87</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>30. Were you encouraged to be involved in decisions about your child’s care and treatment?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.54</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31. Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.21</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32. Did staff ask if you had any questions about your child’s care?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.12</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38. Did a member of staff tell you what would happen next after your child left hospital?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.79</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43. Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>9.01</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>44. Before the operation or procedure, did a member of staff answer your questions about the operation or procedure in a way you could understand?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>9.15</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>45. After the operation or procedure, did someone explain to you how the operation or procedure had gone in a way you could understand?</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.87</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>47. Were you given enough information about how your child should use the medicine(s) (e.g.</td>
<td>C2</td>
<td>0-15 adults</td>
<td>9.46</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
when to take it, or whether it should be taken with food)?

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>48. Did a member of staff give you advice about caring for your child</td>
<td>C2</td>
<td>0-15 adults</td>
<td>8.29</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>after you went home?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50. Were you given any written information (such as leaflets) about your</td>
<td>C2</td>
<td>0-15 adults</td>
<td>7.20</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>child’s condition or treatment to take home with you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Did members of staff treating your child communicate with them in a</td>
<td>C2</td>
<td>0-7 adults</td>
<td>7.69</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way that your child could understand?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Were you told different things by different people, which left you</td>
<td>C2</td>
<td>0-7 adults</td>
<td>7.87</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>feeling confused?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. When you first arrived at hospital, did people working at the hospital</td>
<td>C2</td>
<td>8-15 CYP</td>
<td>8.23</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>tell you what was going to happen to you while you were there?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Did hospital staff talk to you about how they were going to care for</td>
<td>C2</td>
<td>8-15 CYP</td>
<td>8.83</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>you in a way that you could understand?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Before the operation or procedure, did someone tell you what would</td>
<td>C2</td>
<td>8-15 CYP</td>
<td>9.36</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>be done?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Afterwards, did someone from the hospital explain to you how the</td>
<td>C2</td>
<td>8-15 CYP</td>
<td>7.78</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>operation or procedure had gone in a way you could understand?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

Hedgehog ward had a “Did your child get great care today” or “Did your baby get great care today” form for parents to complete or alternatively they could rate and review their child’s care on line.

**Emotional support**

**CQC Children’s survey 2014**

The trust performed about the same as other trusts for all three questions relating to emotional support in the CQC children’s survey 2014.

**CQC Children’s Survey questions, emotional support, Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Did a member of staff tell you what to do or who to talk to if you</td>
<td>C3</td>
<td>0-7 Adults</td>
<td>8.01</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>were worried about your child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
when you got home?

<table>
<thead>
<tr>
<th>Question</th>
<th>Category</th>
<th>Group</th>
<th>Mean</th>
<th>Trust Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you had any worries, did someone at the hospital talk with you about them?</td>
<td>C3</td>
<td>8-15 CYP</td>
<td>7.96</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did hospital staff tell you what to do or who to talk to if you were worried about anything when you got home?</td>
<td>C3</td>
<td>8-15 CYP</td>
<td>7.73</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

*Key:*
- Better than other trusts
- About the same as other trusts
- Worse than other trusts

(Source: CQC Children’s Survey, RCPCH)

Children were admitted by a children’s nurse or nursery nurse to the ward who escorted the parent and child to the operating department. The child and a parent were then transferred to the care of a theatre practitioner and the parent was allowed into the anaesthetic room until the child was inducted. Parents could wait in a waiting area, return to the ward or go to get refreshments. Staff would contact parents when the child was coming out of theatre, so they could wait in the recovery area and be there when the child woke up.

On the neonatal unit, staff used a butterfly sticker on baby’s cot to indicate if a baby had been part of a multiple pregnancy and their sibling or siblings had not survived. Staff discussed this with parents before placing the sticker. This allowed other staff members to be aware of the parent’s loss.

The neonatal unit had a bereavement midwife, for parents who had experienced a loss to access. The midwife would send a card to parents on the anniversary of baby’s birth.

Staff gave children or babies at the end of their life and their parents memory boxes. They included a box for a lock of hair and equipment for taking hand or foot prints. They could store a number of things that were meaningful to the parents.

There was a parent’s support group that met regularly and all parents we spoke with were very enthusiastic about this.

**Is the service responsive?**

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

Hedgehog Ward was a 23 bed inpatient unit caring for sick children from birth to the age of 16. Each bedroom allowed one parent or carer to stay with the child or young person overnight.

Visiting time were open for parents and parents could access a parent lounge, refreshments and hot and cold meals for all children and young people.

The Woodlands Unit was a paediatric ambulatory and day-case ward consisting of 15 beds. Children and young people would be admitted to Woodlands for day-case surgery or having been referred to paediatrics from the Emergency Department, GPs or for further investigations. If they need to stay overnight, they would be moved to Hedgehog ward. The ambulatory unit was open from 7am to midnight.

All accommodation at the hospital was all individual en suite rooms, with a pull down bed for parents.
The neonatal unit had 18 beds and provided level 2 unit care, if a mother came to the hospital and their baby required level 3 care, they would be transferred to another hospital.

The children’s and young people’s services were contained in the same area of the hospital as midwifery services. This area of the hospital had its own emergency access area. This meant mothers in labour could get to the right department easily and if mothers and babies needed to be transferred out, the could be done so easily, via this route.

The children’s outpatient was a dedicated paediatric outpatient department.

The service provided rapid access clinics, general practitioners could request advice from specialist doctors via email and there was a children’s phlebotomy service which general practitioners could refer in to.

One room has been modified to reduce number of ligature points. This was in response to an increase in the number of children and young people being admitted with increased risk of self-harm or suicide.

The majority of surgery was carried out on dedicated paediatric theatre lists except for trauma patients. Staff scheduled children first if they were on a list with adults. There were pre-assessment clinics for children scheduled to be admitted for elective surgery.

Pharmacy were available Monday to Friday during working hours, Saturdays 9:00 am until 4:00 pm and Sundays and bank holidays 10:00 am until 4:00 pm. Physiotherapists, occupational therapists, and dietary consultants were available Monday to Friday during working hours and respiratory physiotherapists were on call for emergency services at all times.

Breast feeding or milk expressing rooms were available and we saw quiet rooms were available for staff breaking bad news.

**CQC Children’s survey 2014**

The trust performed about the same as other trusts for three out of four questions relating to responsiveness in the CQC children’s survey 2014. The trust performed better than others for ‘How would you rate the facilities for patients or carers staying overnight?’

**CQC Children’s Survey questions, responsive domain, Maidstone and Tunbridge Wells NHS Trust**

<table>
<thead>
<tr>
<th>Question</th>
<th>KLOE</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Did you have access to hot drinks facilities in the hospital?</td>
<td>R1</td>
<td>0-15 Adults</td>
<td>9.48</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39. How would you rate the facilities for parents or carers staying overnight?</td>
<td>R1</td>
<td>0-15 Adults</td>
<td>8.17</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>3. Did the hospital change your child’s admission date at all?</td>
<td>R3</td>
<td>0-7 Adults</td>
<td>9.04</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children’s Survey, RCPCH)

The neonatal unit had its own blood gas analyser within the unit, which meant it could receive
rapid results for blood gas analysis.

There was an end of life pathway for any child terminally ill. There was support from specialist hospitals if a child was transferred back to the unit and paediatric hospice care if desired.

For those that did not want to use the hospice for end of life care, after death the child could be transferred to a room at the hospice to give carers more time with their child. Parents we spoke with found this very comforting.

Meeting people’s individual needs

Patient accommodation for children requiring day-case surgery or in patent care was in single rooms with ensuite bathrooms. Hedgehog ward had 23 individual patient rooms and the Woodlands Unit had a five bedded assessment unit and a 10 bed day-case single rooms.

If there were bed shortages at any time the solution was to convert some day case rooms to overnight stay rooms. As Hedgehog and Woodlands shared the same unit this worked well.

We saw there were wheelchair accessible accommodation which included wet rooms

Parents were able to visit at any time on the paediatric wards and translation services were available for patients and parents who did not speak English as their first language should this be required

A play therapist was available each day and we observed the play therapist working with children. They also ran sessions for children experiencing emotional difficulties. For example there was session for children with needle phobia that had proven to be very helpful. This was particularly helpful for those children regularly attending ambulatory care for regular injections, blood tests or intravenous therapy

There were a number of leaflets available to patients and parents on the unit and could be available in other languages on request.

Baby changing areas were available throughout the service and we saw some of those were height adjustable.

When children reached an age where to move from paediatric to adult care this was managed, taking into account their personal circumstances and needs. For example paediatric oncology patients were not transferred to adult care until their treatment was completed.

For the last three years when children were approaching transition to adult care the service have used the “ready steady go programme” for children over 11 years old, with a long-term condition.

The programme was designed to help children and carers to gain the knowledge and skills to manage their condition. Young people could access this from 11 years of age and meet health care staff who would taking their care over in the future.

We saw information available in child friendly format in the form of pictures and easy to read text.

There was accommodation available for parents whose babies were admitted to the neonatal unit within the unit, which meant mothers were close by and to assist in the care of their baby. There was also a bedroom in which parents could stay with their babies, prior to taking their babies home.

Parents had access to parent’s room in which to take refreshments, facilities for sibling were also available. A wide range of books were available for parents to read to their children or babies on the neonatal unit.
Treasure boxes were available for parents to first footprints and pictures of their babies in. Parents could also fill in diaries for their babies, in which they could record memorable moments. The neonatal unit had its own laundry facilities, so they could wash baby clothes and babies could wear their own clothes.

**Access and flow**

Children attended the ambulatory care unit in three ways. They could be referred from the paediatric emergency department or ambulatory care unit or from their general practitioner. The unit was challenged by the volume of children referred from general practitioners with diagnoses such as a cold, a headache or tonsillitis and by the volume of children returning by appointment for treatment.

Children admitted to Hedgehog ward was either via the emergency department or consultant planned booking.

The Woodlands day unit was operated as an escalation area during peak time periods when there were sufficient numbers of nursing staff.

Children were admitted for theatre in the morning for the morning list and at 12.00 hrs for the afternoon list. There were dedicated children lists but where children were scheduled on a mixed list they were prioritized to be first on the list.

Children admitted to the unit with an acute medical problem were seen by a middle grade paediatrician within four hours of admission.

Children admitted to the paediatric department with an acute medical problem were seen by a consultant paediatrician at the next ward round which is held daily.

General practitioners assessing or treating children with unscheduled care needs had access to immediate telephone advice from a consultant paediatrician.

The service provided a consultant paediatrician-led rapid access service so that any child referred for this service can be seen within 24 hours of the referral being made.

The neonatal unit operated a ‘consultant of the week’. This meant any babies admitted during that week would continue to see the consultant on discharge and at follow up.

**Neonatal Critical Care Bed Occupancy**

The critical care bed occupancy is at zero percent for the whole time period between July 2016 and June 2017.

(Source: NHS England)
There had been a large increase in the admission of children with mental health issues while waiting for tier four placements in a paediatric or adolescent mental health hospitals. We saw that one child that had remained on the unit for three weeks before a place became available.

**Learning from complaints and concerns**

**Summary of complaints**

Between July 2016 and June 2017 there were ten complaints about children’s services. The trust took an average of 51.1 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 days. Complex complaints have a completion target of 60 days.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Information was available for patients to access on how to make a complaint and how to access the Patient Advice and Liaison Service. A dedicated member of staff in the clinical area, including the matron and clinical director, reviewed all formal complaints received and concerns raised with Patient Advice and Liaison Service. All concerns raised were investigated and there was a centralised recording tool to identify any trends emerging. Learning from complaints was disseminated to the team to improve the patient experience.

Information was readily available for patients who wished to make a complaint, but who needed support to do so.

We reviewed a spreadsheet that recorded all complaints about the children and young person’s service from October 2016 to October 2017.

There was evidence that the complaints were managed appropriately and people were treated compassionately and supported. In addition to this, there was evidence the complaint was investigated thoroughly and was formally recorded.

The unit provided forms for children and parents to answer questions in accordance with the ‘Friends and Family’ test for children in an accessible way.

**Is the service well-led?**

**Leadership**

There had been significant improvement in the children and young person’s core service since the last inspection.

We found a strong leadership team, driven to improve services, who encouraged and managed change well.

The matron reported to the Associate Director of Operations for women’s, children’s and sexual health and professionally supported by the Head of Midwifery. The Associate Director of Operations and the Head of Midwifery reported to the Chief Operating Officer.

The ward managers reported to a matron who directly line managed the ambulatory unit managers, neonatal unit managers, advanced nurse practitioners, community team manager, clinical educator and specialist nurses. A business case had been put in to employ another matron.

The directorate organisational structure was that each ward and outpatient area had band 6 nurses that reported to two ward managers. There was one for ambulatory and day care across both sites and one for inpatient care at the Tunbridge Wells Hospital at Pembury.
Staff told us the matron was very visible across the directorate and the chief nurse attended pediatric directorate meetings.

The service leads demonstrated an understanding of their challenges around growing volumes and changing demands within the health economy and had reviewed the competence requirements of their staff to meet this demand. This was evident in their discussions with commissioners to work in partnership to address the issues of changing demand and needs in the community.

Vision and Strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

We saw poster displays and other publications about the vision and values as we visited the wards. These were readily available for staff, patients and the public to view. In addition to information published for staff on the trust intranet, the trust published information about its mission, values and vision on its public website.

The trust’s started purpose was to provide safe, compassionate and sustainable health services and its vision to provide the highest, consistent, quality care to patients, whether in or outside hospital setting.

We saw values statements based on the word “PRIDE”, which meant “Patient First, Respect, Innovation, Delivery and Excellence”. Staff we spoke to were able to describe these statements and give examples that described an improving safety culture, better clinical leadership and governance.

There was a children’s strategy in place and staff we spoke to demonstrated their commitment to improving child health experiences and outcomes.

There was evidence of the staff’s commitment to the mental health and emotional wellbeing of children and their carers in day to day activity within the service.

Culture

Staff we spoke with told us they were supported and felt valued. They thought highly of the matron who they said was very visible supportive and kept them well informed.

There appeared good communication between matron level and associate directors but evidence of some disconnection above this level in regard to trust wide and national strategies.

The culture was centred on the needs and experience of children and their carers and this was evident in some of the initiatives introduced both on the wards and neonatal unit.

Children, young people and their families were at the centre of everything the service did. The matron had established a matron meeting across Kent, which enabled service across the patch to share learning. The plan was to standardise services as much as possible across the sector.

Staff we spoke to both on inspection and in focus groups were proud of the trust and how it had risen to the challenges they faced.

There appeared an open and honest culture with staff prepared to say when things went wrong and what needed improving.

Staff were appraised and had opportunity to discuss their development needs. Most were satisfied with how their development needs were being met and gave us examples of how this was being achieved. They understood the limitations the trust had due to financial pressures and were
supportive of the trust. A number of staff within focus groups did feel there was a disparity in that doctors had protected training time where nurses did not.

There had been an increased awareness in the well-being and safety of staff. The trust had a counselling service available to staff and we saw examples where this had proved useful in any areas were staff may have been traumatised by a work event. The staff also praised the security staff for their support.

The service employed trauma risk management (TRiM) which involved staff having a debriefing following a traumatic event. This reduces the long term impact of a traumatic event.

**Governance**

The chief nurse led the governance structure.

Reporting to the chief nurse was the trust ethicist, the associate director for quality governance, and deputy chief nurses.

The patient safety manager, health and safety advisor, trust solicitor, complaints and patient advice and liaison services manager, audit and innovation lead and the research and development manager reported to the associate director for quality governance.

A monthly integrated performance report from the directorate was provided to the Quality and Safety Committee and we saw minutes of these meetings.

The directorate was represented at the board who received reports on safeguarding of children.

The associate director of nursing maternity, women and children’s services along with the associate director of operations for children, women and sexual health led the children’s and young person’s service and they reported to the chief operating officer (COO).

**Management of risk, issues and performance**

The management of risk issues and performance was standardised throughout the trust. Performance dashboards for each division were standard across the trust and divisions produced monthly reports which went to the board.

Staff could raise a risk to the risk lead in their area, who would put it on the electronic risk register.

Senior staff members were aware of the risks related to mental health and emotional wellbeing in relation to the service. This has been documented on the risk register.

There was a good understanding of potential risks such as seasonal fluctuations and changing demands in the health economy. There was also a good awareness of the financial challenges the trust had.

Winter management plans included children and young people services with escalation policies and processes to provide more beds and staff as required.

Reports on antimicrobial prescribing and sepsis management were escalated to the board through the trust’s governance framework.

There was a systematic programme of clinical and internal audit to monitor quality.

**Information Management**

We saw that information was cascaded upwards though the reporting lines and meetings to the senior management team and we saw minutes of meetings to this effect. There was evidence of information being shared with clinicians and other operational staff.
However, there appeared to be a break in the flow of information from the executive team reaching associate director level and beyond. We noted a number of national initiatives and information which we were aware had been circulated to chief nurses that at directorate level they were unaware of.

The directorate regularly reported on mental health to the board.

**Engagement**

Hedgehog ward had a “Did your child get great care today” or “Did your baby get great care today” form for parents to complete or alternatively they could rate and review their child’s care on line.

Feedback from children, young people and parents was actively sought through surveys. There were two types of forms for children to complete, which had words and picture answers for children. All had a section where parents and children could comment on what was good and what could be done better. These were used to review services and make improvements.

We also observed a line on the wards where children could write on a sun or cloud and pin to the line saying what was good and what they did not like. There were good comments about the staff, the play therapists and the environment. The clouds universally said “needles”.

External organisations such as the community mental health team has been very involved in helping the trust improve and sustain the care provided to patients with mental health or emotional wellbeing issues. Such as advice on environment and extra mental health training for nurses.

The service engaged with a young person’s panel. Engagement with local schools as part of this panel, led to the redevelopment of a sensory room for the service.

Staff engaged with parents and responded to feedback they gave. For example, the parent’s room had been moved so it was closer to the bedded area of a ward in response to feedback. In response to a survey, the service had altered the way they prepared children and their parents for surgery, which had been welcomed by parents.

The service used in Listening into Action to improve staff engagement and empowerment as part of a trustwide initiate. Listening into action aims to increase a service’s capacity to successfully deliver improvements in a timely and effective manner, through strengthening clinical leadership. It aims to provide a voice to staff, whatever level they are, and supports the delivery of changes that matter most to staff and patients.

The service had developed an action plan, in response to staff survey comments and changes which had been made included: ward clerk recruitment, increase in bank pay, clinical educator in post, parent passports and higher visibility of trust executives.

**Learning, continuous improvement and innovation**

As part of the Carter review, a ‘model hospital’ has been developed which will advise NHS trusts on the most efficient allocation of resources and allows hospitals to measure performance against other trusts. Maidstone and Tunbridge Wells NHS Trust used this model in order to identify areas where cost savings could be achieved. The service had used the Carter review to reallocate rooms within the in the unit to better suit patient needs.

The neonatal unit was involved in a number of research projects, national and local audits in order to drive service improvements.
Staff who had an interest in developing specialist skills were encouraged to do so and supported in accessing specialist training.

The clinical educator was involved in developing mandatory training, so that it involved training specific to paediatric staff, such as moving and handling training.