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

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buckland Hospital</td>
<td>Coombe Valley Road, Dover, CT17 0HD</td>
<td>• Diagnostic and screening procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family planning services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Maternity and midwifery services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Services for everyone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Transport services, triage and medical advice provided remotely</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Treatment of disease, disorder or injury</td>
</tr>
<tr>
<td>Kent &amp; Canterbury Hospital</td>
<td>Trust Offices, Ethelbert Road, Canterbury, CT1 3NG</td>
<td>• Diagnostic and screening procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family planning services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Management of supply of blood and blood derived products</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Address</td>
<td>Services</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| Queen Elizabeth The Queen Mother Hospital | St Peter's Road, Margate, CT9 4AN | - Maternity and midwifery services  
- Services for everyone  
- Surgical procedures  
- Termination of pregnancies  
- Transport services, triage and medical advice provided remotely  
- Treatment of disease, disorder or injury |
| Royal Victoria Hospital | Radnor Park Avenue, Folkestone, CT19 5BN | - Diagnostic and screening procedures  
- Family planning services  
- Management of supply of blood and blood derived products  
- Maternity and midwifery services  
- Services for everyone  
- Surgical procedures  
- Termination of pregnancies  
- Transport services, triage and medical advice provided remotely  
- Treatment of disease, disorder or injury |
| William Harvey Hospital | Kennington Road, Willesborough, Ashford, TN24 0LZ | - Diagnostic and screening procedures  
- Family planning services  
- Management of supply of blood and blood derived products  
- Maternity and midwifery services  
- Services for everyone  
- Surgical procedures  
- Termination of pregnancies  
- Transport services, triage and medical advice provided remotely |
The trust became an NHS Foundation trust in 2009. It has five hospitals serving a local population of around 695,000 people throughout across Dover, Canterbury, Thanet, Shepway and Ashford. They also provide some specialist services for a wider population, including renal services in Medway and Maidstone and a cardiac service for all of Kent based at William Harvey Hospital, Ashford.

The trust operates from three acute sites:
- William Harvey Hospital (WHH) Ashford
- Queen Elizabeth the Queen Mother (QEQM)Hospital Margate
- Kent and Canterbury Hospital

Across these sites they provide the following services:
- Urgent and emergency services
- Medical care (including older peoples care)
- Surgery
- Critical Care
- Gynaecology
- Services for Children and Young People
- End of life care
- Diagnostics

Outpatient, dialysis and community services are also run from Buckland Hospital in Dover as well as the Royal Victoria Hospital in Folkestone.

In addition to the services offered by the trusts at the five sites, it has services located at the trust hospitals which are operated by other care providers. These include: radiotherapy services, primary care lead urgent care, mobile PET CT scan from Kent and Canterbury Hospital; Diabetic eye screening at William Harvey Hospital; and sexual health services.

The trust has 1030 beds inpatient beds across 49 wards. This includes 30 critical care beds, 58 children’s beds and 49 day case beds. The trust receives over 200,000 emergency attendances, 158,000 inpatient spells and one million outpatient attendances. All core services are provided at both William Harvey Hospital and QEQM Hospital whilst at Kent and Canterbury Hospital there are no maternity beds and a minor injuries unit with an emergency care centre rather than a full emergency department service.

The trust has had four CQC inspections since 2014. It was put into special measure following 2014 inspection. In 2015 CQC inspected again and recommended the trust remain in special measures. The 2016 inspection was designed to test the necessity for continued application special measures. As a result of this inspection, the trust came out of special measures in March 2017 following quality summit. However, it received four requirement notices. These included: good governance (records), safe care and treatment (staffing levels), premises and equipment (maintenance) and good governance (audit programme).
The trust was placed in financial special measure in March 2017 because it was forecast to be in significant financial deficit and was not meeting its control total (the trusts yearend target against its budget). The trust was still in financial special measures at the time of the inspection although it was not in quality special measures.

Is this organisation well-led?

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

Within the inspection period we had written to the trust raising specific concerns and requesting reassurance around several issues we had concerns around during the core service inspection of the trust. We reviewed the actions and plans as part of our well-led review.

Leadership

The senior leadership team had the capability, and integrity to ensure strategy could be delivered and address risks to performance. There had been several changes to leadership since the last inspection and many interim posts were now filed permanently. However, some members of the team had large portfolios and lacked sufficient support so they may not have always had capacity to ensure performance delivery. There were some barriers to leadership development and the systems and processes to support this were not sufficiently embedded to be able to drive improvement at the time of the inspection.

As part of the inspection process, we interviewed 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 reviewed previous board meeting minutes, risk registers, board assurance framework 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.

The board of directors was comprised of nine executive directors which included the chair, chief executive, medical director, director of nursing, deputy chief executive, independent director, director of finance, director of human resources, chief operating officer and six non-executive directors. As an NHS Foundation Trust, they had 19 governors in their council of governors including representative from the public, staff, local authorities, volunteers and universities.

Non-executive directors are members of the public who live in the area that the trust serves. The Board of Governors appoints the chair and the other non-executive members. They are not employees of the trust, have no employment rights, and the terms of their appointment are set by NHS Improvement.

The trust was one of the largest hospital trusts in England, with five hospitals and community clinics serving a local population of around 695,000 people. It was accountable to local people, who could become members of the trust. Members of the trust could stand for election to become a governor and vote in governor elections. The council of governors represented the local community. There was also governor representation on several of the committees which fed into the board of directors.

The trust became an NHS Foundation trust in 2009. NHS Foundation Trusts are created to move decision making from central government to local organisations and communities. The trust was managed by the board and accountable to local people, who could become members of the trust. Members of the trust could stand for election to become a governor and vote in governor
elections. The council of governors represented the local community. There was also governor representation on several of the committees which fed into the board of directors.

Since our last inspection in 2016, the trust had made several changes to the senior leadership team. The chief executive, director of finance, several non-executive directors and the non-executive chair had all been appointed since the prior inspection. The senior management team had previously included various interim posts, but at the time of the inspection all senior leadership team members, excluding the chair, were all in substantive posts. Thus, the team was young, but more stable than at the time of the previous inspection.

The changes to the leadership were reflected in the changes in approach since the new leadership team had been in place. There was a focus on clinical leadership, progressing the transformation program in line with the vision and values and making change effective for patients the trust and the wider community. The new chair of the board had a clinical background which had provided a more clinical perspective to the board. The board had focused on engagement as reflected by the significant role that communications and engagement played in the transformation program.

The leaders we met had the skills, knowledge, experience and integrity to lead the trust. We saw the leadership team had a holistic view of the organisation. The chief executive officer (CEO) had been the CEO act another large trust for seven years before taking the role of CEO at this trust in October 2017, first as a secondment and then in the substantive post. The CEO was directly supported by the medical director and director of nursing.

The chief nurse and director of quality joined the trust as deputy chief nurse and director of quality in 2013. She was appointed interim chief nurse and director of quality in 2015 before taking on the substantive role.

The medical director joined the trust in 1995 as a consultant and clinical directors. He was appointed as associate medical director in 2010 and medical director in 2013. The medical director held several roles including head of end of life care, DIPC, Caldecott Guardian, chair of the NICE Implementation Committee, member of the Quality Committee, attendee at the Finance and Performance Committee, Member of the Management Board, chief knowledge officer, member of the Strategic Workforce Committee.

The director of finance and performance joined the trust in October 2017. He was previously the executive director of finance and then executive director of finance deputy chief executive at other NHS Trusts.

The chief operating officer joined the trust as divisional director for specialist services division in 2011. She was appointed as interim director of operations in September 2014 and chief operating officer in January 2015.

The director of human resources joined the trust in September 2014. She came to the trust with human resources experience and 10-year full voting board level experience.

The trust board members we met were a group of individuals with a wide range of experience, knowledge and skills, although many were relatively new to their posts.

The trust had eight non-executive directors in post. The non-executive directors had a wide range of experience including chairing other NHS trust boards, senior board executive and director level experience and advisory roles to NHS, government and private institutions in healthcare and non-healthcare industries. We spoke with two non-executive directors who were clear about their roles within the organisation. They expressed a confidence in their ability to provide sufficient challenge to the board.

Our review of the executive and non-executive Directors personnel files confirmed the trust was compliant with Regulation 5 §1-5 of the Health and Social Care Act 2008 (Regulated Activities)
Regulations 2014. The trust’s recruitment and appointment processes were clear and consistent with stakeholder involvement for executive director appointments. The trust had processes to ensure leaders have the skills, knowledge, experience and integrity that they needed on appointment to their roles. We reviewed personnel files for five executive and four non-executive board members. Eight out of nine files reflected a robust recruitment process including competency based interviews and checks or qualifications, professional bodies, references, employment history and occupational health. Four of the files reflected a rigorous process was undertaken to check that the board members were fit.

We saw that board members provided declarations of interest upon their appointment. The Board of Directors standard meeting agenda included an item for board member’s declarations of interest.

However, the trust did not have processes or systems to ensure leaders maintained the skills, knowledge and experience on an ongoing basis after their appointment. There was no evidence on the board members files that they had received either managerial supervision or annual appraisals in cases where the board members had been with the trust form more than a year. This meant the trust was could not be assured it was in compliance with Regulation 5 §6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which requires that the trust take action if an existing member no longer meets the criteria of a fit and proper person.

The trust did not have a board development plan at the time of this inspection. Senior staff explained that there was not a board development plan although they acknowledged they needed to create a plan. Dialogue about the specifics of the plan had not yet begun. They told us that the roles of non-executive directors and executive directors were not clearly defined and there needed to be a clear plan for the roles of the board of directors and council of governors.

Across interviews with senior staff we saw there was a drive to ensure that leadership was driven by the trust’s clinical demands. For instance, a board had a new chair with a clinical background who has set the agenda and lead discussions at board with a more clinical perspective.

Staff provided mixed feedback about whether leaders were visible and approachable. Discussions with staff as part of pre-inspection engagement and during the inspection drew mixed comments about leadership. Some staff told us that specific members of the executive team were visible other staff told us they were visible but should spend more time understanding the staff experience and some told us they had not seen senior executives and did not read newsletters or other communications to familiarise themselves with the senior leadership team. Staff in some of the more challenged departments we visited noted that members of the senior leadership team, including the CEO, visited regularly.

The trust had a succession planning & talent management for senior management positions at East Kent Hospitals University NHS Foundation Trust. This was a confidential document that considered risks and plans around succession planning. However, the succession planning document had not recently been updated and the lack of a board development plan was a challenge to having a meaningful succession plan. Some senior staff told us they did not have a clear system for identifying and training the trust’s future leaders.

**Board Members**

Of the executive board members at the trust, 14% were British Minority Ethnic (BME) and 71% were female.

Of the non-executive board members 13% were BME and 25% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>14%</td>
<td>71%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>13%</td>
<td>25%</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>All board members</td>
<td>13%</td>
<td>47%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

**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. However, there were barriers to achieving this due, in part, to delays in implementing system wide strategies.

The trust had a clear vision and set of vision and values which put quality and the patient at the centre of the trust’s vision. The values were developed with staff as part of a 2014 “we care” staff engagement programme. In 2015 “respect” was added to the values following feedback from the staff survey and “great place to work” focus groups. The vision, mission and priorities were populated and developed through staff engagement in 2016.

The trust explained that values were core to much of their training, for example the respect and resilience training specifically came from the Respect value.

The vision was ‘improving health and wellbeing’.

The mission was ‘Great healthcare from great people’

The Values were:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect sit at the heart of everything we do
- People feel confident we are making a difference

To ensure staff embedded the values from the start, the values were included in job packs so potential joiners were clear about the aims, values and expectations of the Trust. New joiners had access to the new starter portal before they started which describes the vision and values.

We saw the values displayed in the trust using a variety of communication methods including on signs, computer screen savers and on the website.

Some staff knew and understood what the vision, values and strategy were, and their role in achieving them. However, other staff provided mixed information about whether they were familiar with the trust’s vision, values and strategy and the role they played in meeting them. In some departments staff could discuss of the trust’s vision, values and strategy while in others they were not aware of them were apathetic about its application to their role.

The Strategic objectives were:

- **Patients** - Providing high quality care to **patients** with great outcomes for their health and lives - getting the basics right every time and building healthcare that is best in class.
- **People** - Attracting the best **people** to our team, who are passionate, motivated and feel able to make a difference and investing in them.
Partnerships - Work in partnerships to design health and social care which transcends the boundaries of organisations and geography.

Provision - The provision of high quality care through the use of technology, research, education, innovation and intelligence.

The board monitored and reviewed progress against delivery of the strategy and local plans and reviewed evidence reflecting progression. Committee reports to the board which we reviewed highlighted risks and their links to specific strategic objectives. For instance, the strategic workforce committee report identified risks around trainee concerns and moral and linked them to the people objective while the medicals director’s mortality report identified links to all four strategic objectives.

The trust had a transformation board which was to oversee the transformation of the trust from ward to board. The transformation Board was directly accountable to the Board of Directors it had a slot on each board meeting producing a report which was part of the board meeting pack and discussed at the board meeting. The trust was on a ‘transformation journey’ which aimed to build on the improvements which had raised the trust out of special measures.

The six priority areas for the transformation journey’s focus were:

- Getting to Good
- Higher Standards for Patients
- Healthy finances
- A great place to work
- Delivering our Future
- Right Skills Right Time Right Place

These six workstreams were used to develop change in the trust and were referred to in the board notes in reference to changes as well as being the structure used to communicate with staff and the public about change. The Trust included sustainability in its strategic and operational planning. This has been supported by the Sustainable Development Unit (SDU) and the regional network.

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 with CCGs and within the Kent and Medway Sustainability and Transformation Plan.

A focus of transformation was the new clinical strategy. The trust had been working on the Clinical Commissioning Groups (CCGs) and Sustainability and Transformation Partnership (STP), for several years to define the strategy, but it was not yet in place. The lack of a system wide strategy created a barrier to the trust’s defining its own strategy and impacted the trust’s ability to make decisions about the future, particularly about investment in estates and environments.

The trust did have a strategic vision to move toward delivering high quality care in line with their own vision and values. The Clinical Strategy Group fed into the transformation board which reported directly to the board.

The future clinical strategy focussed on urgent care and elective orthopaedics services. However, the options for change included changes to other specialist services, depending on clinical need. A list of possible strategical change plans had been agreed for full evaluation by the Joint CCG Committee. Workforce is a major consideration and senior staff reported it this issue had been
explored extensively. A full Integrated Impact assessment was currently being undertaken to assess the plans’ race and equality impact.

The new Clinical strategy was expected to be foundational for many of decisions about the trust in the future and would affect the trust's governance and leadership. As a result, the board had suspended some decisions which will affect governance and running of the trust until the Clinical Strategy is in place.

Staff were aware the clinical strategy had been in development stages for a significant period. They understood the outcome of the clinical strategy review process would directly affect many roles in the trust. This created a culture of unsurely for some staff members and departments. One of the objectives of the trust’s communication and engagement strategy was to engage the public, patients and staff so they could be involved in shaping changes to the service and influencing strategy.

**Culture**

**NHS Staff Survey 2017 – results better than average of acute trusts**
The trust had no key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

**NHS Staff Survey 2017 – results worse than average of acute trusts**
The trust has 26 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of appraisals</td>
<td>2.98</td>
<td>3.11</td>
</tr>
<tr>
<td>Quality of non-mandatory training, learning or development</td>
<td>3.97</td>
<td>4.05</td>
</tr>
<tr>
<td>Recognition and value of staff by managers and the organisation</td>
<td>3.33</td>
<td>3.45</td>
</tr>
<tr>
<td>Staff satisfaction with level of responsibility and involvement</td>
<td>3.78</td>
<td>3.91</td>
</tr>
<tr>
<td>Staff satisfaction with resourcing and support</td>
<td>3.12</td>
<td>3.31</td>
</tr>
<tr>
<td>Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Effective team working</td>
<td>3.64</td>
<td>3.72</td>
</tr>
<tr>
<td>Support from immediate managers</td>
<td>3.67</td>
<td>3.74</td>
</tr>
<tr>
<td>Percentage of staff suffering work related stress in last 12 months</td>
<td>45%</td>
<td>37%</td>
</tr>
<tr>
<td>Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>32%</td>
<td>31%</td>
</tr>
<tr>
<td>Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td>Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.62</td>
<td>3.72</td>
</tr>
<tr>
<td>Effective use of patient / service user feedback</td>
<td>3.55</td>
<td>3.71</td>
</tr>
<tr>
<td>Organisation and management interest in and action on health and wellbeing</td>
<td>3.46</td>
<td>3.61</td>
</tr>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>42.63</td>
<td>50.55</td>
</tr>
<tr>
<td>Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>41%</td>
<td>45%</td>
</tr>
<tr>
<td>Percentage of staff/colleagues reporting most recent experience of violence</td>
<td>62%</td>
<td>67%</td>
</tr>
<tr>
<td>Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.53</td>
<td>3.65</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>33%</td>
<td>28%</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>34%</td>
<td>26%</td>
</tr>
<tr>
<td>Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell</td>
<td>57%</td>
<td>52%</td>
</tr>
<tr>
<td>Percentage of staff reporting good communication between senior management and staff</td>
<td>28%</td>
<td>33%</td>
</tr>
<tr>
<td>Percentage of staff able to contribute towards improvements at work</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>Staff recommendation of the trust as a place to work or receive treatment</td>
<td>3.37</td>
<td>3.76</td>
</tr>
<tr>
<td>Staff motivation at work</td>
<td>3.81</td>
<td>3.91</td>
</tr>
<tr>
<td>Overall Engagement Score</td>
<td>3.59</td>
<td>3.79</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)
Leaders across the trust worked to promote a positive culture that supported and valued staff, to create sense of common purpose based on shared values. However, the trust had a history of disconnection across the sites and changes to culture were still developing.

Satisfaction around culture was mixed and throughout the trust staff provided mixed feedback about whether they felt supported, respected and valued. Some staff felt supported and valued by their immediate team, but not the greater trust. Some staff felt their teams worked in silos and were not connected to the rest of the trust. Some staff felt uncertain about their future at the trust. They explained that they knew the trust would make changes to how and where it delivered care. However, because there was not a wider system strategy they had no certainty about their own jobs or how they would care for patients in the future.

There were processes for staff to raise concerns, but staff did not always know how to use these processes, did not always feel empowered to raise concerns, or felt no change would happen as a result of concerns being raised.

The trust had seen improvements to culture since being put into quality special measures in 2014, and coming out of special measures in 2017. However, the 2017 Staff Survey highlighted issues of concern. Board members recognised the need to focus on and improve the culture of the organisation and was developing processes to support staff and promote their positive well-being. The board reviewed survey results at their April 2018 meeting. The recognised challenges raised by the staff survey, recognised the impact this had on the organisation and patient care. In response, they implemented the Staff Engagement Action Plan 2018.

Staff did not always feel actively engaged or empowered within the trust. Some staff reported they had not had feedback from senior management about the results of the staff survey. They told us they had not seen senior management respond to the staff survey results. We saw that senior management had engaged with some staff on site, through webinars and in a variety of written communications. This meant that even if senior management was responding to the survey, not all staff were not engaged.

Likewise, staff provided mixed feedback about whether they were proud to work for the trust. Many staff reflected they were proud to work with their team and proud of the work they did, even if they had concerns about other parts of the organisation.

The trust had appointed two Freedom to Speak-Up Guardians and 42 Freedom to Speak Up supporters in line with the principles and role profile produced by the National Guardian Office and following recommendations of the Francis report. The Guardians went through an interview process, went through specific training and had dedicated, protected time to work as a Guardian. The line of accountability was direct from the Guardians to the chief executive who delegated authority for this role to the chief nurse and director of quality. The chief nurse, director of quality and Guardians met monthly.

Both Guardians were located at the Kent and Canterbury site. It was acknowledged that there were challenges to having both Guardians located at the same site. To address this, they ensured that the trained staff supporters were located across the trust with and came from diverse backgrounds.

The Guardians were responsible for communications about the Freedom to Speak up Guardians and their role in the trust. The Guardians attended inductions so staff were aware of their presence, visited sites and hubs and had advertisements on the intranet scrolling banner.

Some staff at focus groups and during the core service inspection were aware of the freedom to Speak Up Guardians and knew how to contact them. Other staff were not aware that there was a
Freedom to Speak Up Guardian or said they knew about the Guardians and didn’t know how to contact them, but could find out if they needed to.

We were told that in the past four quarters the Guardians had had four cases. This reflected that staff might not know about the Freedom to Speak Up Guardians or how to contact them.

A recent British Medical Association poll reflected that moral was low among trainees in the trust with 42% of respondents stating that they did not feel valued and would not return to the trust.

We spoke with the safe working guardian and safe working guardians, whose role it was to engage with trainees, meeting to discuss trainee concerns and approaches to these concerns. The safe working hour guardians felt supported to do their roles. The Guardians recognised the challenges to their role including the workload across the trust. They had supportive relationships with the board and reported to the board on a quarterly basis.

Action had been taken to address behaviour and performance that is inconsistent with the vision and values. The trust had implemented the RESPECT program to address bullying and harassment in the workplace. However, some staff still had concerns about bullying and harassment in the workplace. The staff survey reflected the trust was slightly above average regarding the percentage of staff experiencing harassment, bullying or abuse from both other staff and patients, relatives or the public in the last 12 months.

Staff development was not always given sufficient priority. The trust met its targets for statutory training, in the 12 months prior to June 2018 89% of staff had completed statutory training against a target of 85%. However, in some core services we saw mandatory training rates for training that protected patients including safeguarding training, ILS, PILS APLS were below target rates. This meant that while the trust was meeting the statutory target rate, some staff did not have up to date training to protect their most vulnerable patients.

Individual staff reported there were competing priorities and there was not always time to complete training in a timely fashion. Board meeting notes reflected that the board closely monitored the overall training rates across the hospital and received a monthly update about the overall training rates, which was discussed.

Appraisals across the organisation took place inconsistently. The staff survey showed that the trust fell below the national average when staff rated the quality of their appraisals. The trust wide appraisals rate changed monthly. The April board report reflected 79% of staff had received appraisals, this appraisal rate was rag rated red (identifying risk as high) because it did not meet the trust’s minimum appraisal rate target. This was an improvement on the previous month but the rate was expected to drop in May due to an influx of appraisals that would come due. The board notes reflected that the board was keeping oversight of the rates and all departments.

The trust was working to improve its compliance with duty of candour requirements. The duty of candour requires the trust to be open and honest with patients or their representatives when something went wrong. The trust had had poor compliance with duty of candour previously, limited Duty of Candour training and low levels of attendance for the training that was offered. This issue was on the trust’s risk register and the Medical Director had responsibility for this risk. However, the trust was committed to improving staff awareness and understanding to ensure they met duty of candour. The trust was implementing a Duty of Candour Action Plan, it had circulated Duty of candour leaflets which staff reported receiving during core service inspections, more training had been put into place and Duty of Candour was a Quality Improvement Hub topic.

There was an emphasis on the safety and wellbeing of staff. Staff wellbeing was a focus of staff publications and the trust provided wellbeing resources for staff. However, staff reported there
were some teams working in silos and some staff we spoke to felt their hours and working conditions reflected their wellbeing was not a priority.

**Workforce race equality standard**

NHS commissioners and NHS healthcare providers are required to implement the Workforce Race Equality Standard. This ensures employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

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

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 34% BME 33%</td>
<td>27% 31%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 34% BME 32%</td>
<td>25% 27%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 83% BME 74%</td>
<td>87% 75%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 9% BME 17%</td>
<td>7% 15% 8% 17%</td>
</tr>
</tbody>
</table>

Of the four questions above, no questions / the following questions showed a statistically significant difference in score between White and BME staff:

- Kf21 – Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
- Q17b – In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The Trust Diversity and Inclusion Steering group is the vehicle for driving Black, Asian and Minority Ethnic staff agenda forward. This group championed the diversity and inclusion statement which was:

East Kent Hospitals University NHS Foundation Trust (EKHUFT) is committed to creating a diverse and inclusive environment where all our staff, patients and service users feel they can be themselves. We will ensure that no employee or person visiting our hospitals will be illegally discriminated against because of who they are.
We value the differences that a diverse workforce brings to the organisation and will build a culture that is personal, fair & diverse. It is the duty of each employee to share the responsibility of creating and maintaining an environment of teamwork, trust and respect.

The principles that underpin this statement are as follows:

A workforce that is valued and whose diversity reflects the community it serves, will enable EKHUFT to deliver the best possible healthcare service.

An environment characterised by teamwork, trust and respect will enable every employee in the Trust to achieve their potential.

EKHUFT views individual diversity positively and recognises that everyone is different, valuing equally the unique contribution that individual experience, knowledge and skills can bring to the organisation.

In July 2017 it created equality objectives:

1. To support the development of leadership at all levels in a way that values and promotes equality, diversity and inclusion.

   All Leadership development activity will include Diversity and Inclusion and Unconscious Bias elements.

2. To develop the Trust's Diversity Network Groups.

   East Kent Hospitals University NHS FT (EKHUFT) is proud to work with our Black Asian & Minority Ethnic (BAME) Staff Network and our Disabled Staff Council. The Chairs of the networks sit on our Diversity & Inclusion Steering Group. The Trust will turn to the networks to help with the approach to the Workforce Race and Disability Standards.

   EKHUFT is keen to support the development of other network groups including LGBT+ and Women.

3. To reduce discrimination experienced by Disabled and BME staff and applicants and Increase the percentage of BME staff in senior positions.

   We will reduce the percentage of staff reporting personally experienced discrimination at work from Manager/team leader or other colleague to 10 % by 31 March 2020.

   We will reduce the relative likelihood of White staff being appointed from shortlisting compared to BAME staff to 1 by 31 March 2019.

   We will set targets and monitor performance using the Workforce Disability Equality Standard (WDES) during 2018.

4. Improve service delivery for those patients with a disability or from a BAME background.

   The trust had a Black, Asian and Minority Ethnic Staff Network to support and empower Black, Asian and Minority Ethnic staff to achieve their potential.

   During our inspection concerns about Black, Asian and Minority staff member experience were not raised. Workforce Race Equality Standard scores reflected that there had been some improvement regarding bullying and harassment of minority staff members across the past year. However, the the Workforce Race Equality Standard scores above reflected that the Black, Asian and Minority staff member experience across the table was slightly worse than the average scores across England.
Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored about the same as the England average for recommending the trust as a place to receive care from December 2016 to November 2017.

The response rate to the Family and Friends test was 29.8%.

(Source: Friends and Family Test - link)
Sickness absence rates

The trust’s sickness absence levels from September 2016 to July 2017 were similar to the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2016 General Medical Council Survey the trust performed better than expected for no indicators, worse than expected for two indicators (induction and feedback) and the same as expected for the remaining 12 indicators.

(Source: General Medical Council National Training Scheme Survey)
**Governance**

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services. However, the trust did not have a system to ensure these were regularly reviewed and improved or that information was used to inform improvement.

The levels of governance and management functioned effectively with each other and interacted appropriately. The governance structure for the trust was complex, all elements of the structure fed in directly or indirectly to the trust board. There were governance structures for strategic development, finance, performance management, human resources, clinical quality and safety, communications, operations, and clinical services that were overseen by the chief operating officer who fed directly to the chief executive officer.

The trust clinical services were managed in four clinical divisions: urgent care and long term conditions division, which included services such as A&E, cardiology, stroke, etc; surgical service division which included services such as anaesthetics, theatres critical care and a range of specialties; clinical support services division which included laboratory medicine, outpatients, medical records, therapies, etc and; specialist services division which included cancer, child health, dermatology, etc.

Each division was governed by a triumvirate which included a divisional director, medical director and divisional head or heads of nursing. The specialist services division also included a head of midwifery and gynaecology. The clinical services had been merged horizontally, this meant that services across the trust’s sites were overseen by the same directorate triumvirate team while each site maintained its own local management. This ensured governance from ‘ward to board’ (from staff caring for patients on the ward to the trust board).

The senior management had regular interactions with line managers. For instance, there was a weekly briefing for people managers. Recent topics had included, staff survey, respect program (regarding bullying harassment, team talk briefings, schwarts, workplace contacts, resourcing leadership. There was a monthly executive lead team talk which included sessions with people leaders from all sites, recent issues, awards, celebrations, KPIS and exec actions.

Individual services were reviewed at board level regarding risks held on the corporate risk register and as they pertained to other subjects on the meeting agenda.

The board of directors had overall responsibility for the financial and operational management of the trust. The trust board received assurance from a variety of committees including the management board, the integrated audit and governance committee, the finance and performance committee, remuneration committee, nominations committee, charitable funds committee, and the quality committee. The management board and transformation board also reported to the board of directors.

Minutes and documents from board meetings reflect the board received comprehensive reports from the committees for review before board meetings and the board had the opportunity to discuss these. In some cases, it was noted that a report would not be discussed at the board where it was shared, but that board members would have the opportunity to ask questions as necessary and the report would be further discussed at a later meeting. The board saw outcomes and supporting information but did not have full details. For instance, the board did not see the details of incidents and root cause analysis so relied on reports to understand this information.

The committees were governed by Terms of Reference which outlined each committees’ objectives, roles and responsibilities. The Terms of Reference had been reviewed by the relevant committees and approved by the board. The terms of reference all required they be updated annually, however, not all terms of reference had been updated in the past year.

The trust had an Integrated Audit and Governance Committee (IAGC), which was a high-level committee with oversight of responsibility for risk. The role of the IAGC was to scrutinise and review the Trust’s systems of governance, risk management, and internal control. The IAGC was chaired by a non-executive director. It reported to the Board of Directors on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on
the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations. The IAGC reported to the board monthly and provided a quarterly report to the board for review.

The Quality committee was responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit; and the regulatory standards relevant to quality and safety. The Quality committee met, and the Quality Committee Chair reported to the board, monthly.

The Finance and Investment Committee is chaired by a non-executive board member. It oversaw the Trust’s financial strategy, financial policies, financial and budgetary planning, monitors financial and activity performance and reviews proposed major investments in line with the Trust’s Scheme of Delegation.

The Remuneration Committee included the trust chair and all non-executive directors. It determined, and agreed with the Board, the Trust’s Policy for determining the remuneration, terms of service and other contractual arrangements of the Chief Executive and Executive Directors, and monitored their performance.

The Nominations Committee is a Committee of the Board and fulfils the role of the Nominations Committee for executive directors described in the Trust’s constitution and the NHS Foundation Trust Code of Governance.

The Charitable Funds Committee, oversees the administration of the many donations, legacies and investments that are held within the East Kent Hospitals Charity.

The Strategic workforce committee provided advice and made recommendations to the Board of Directors on all aspects of workforce and organisational development, and raised concerns about significant workforce risks for escalation.

Board meeting minutes and discussions with board members reflected that the governance system provided meaningful challenge to the trust executive board members. When risks were identified at board level, the appropriate committee members took responsibility for actions to resolve concerns and mitigations to minimise risks.

However, there was no assurance that information was shared between senior departmental management teams and the board. Risks were not always identified and escalated to the board. The trust did not have overview or assurance of some issues highlighted in the core service inspection. For instance, issues around the care of children and young people were raised during the inspection. These issues were not on the trust’s risk registers, were not minuted in board meeting minutes and no mitigation had been implemented before the issues were raised during the inspection.

**Board assurance Framework**

The board assurance framework is a key tool which boards use to align management of risk with the trusts strategic objectives. The trust board had sight of the most significant risks and mitigating actions were clear.

The trust provided their Board Assurance Framework, which details four strategic objectives within each and accompanying risks. A summary of these is below.

- Patients. Help patients take control of their own health
- People: Identify, recruit and develop talented staff
- Provision: Provide the services needed and do it well
- Partnership: Work with other people and other organisations to give patients the best care

(Source: Trust Board Assurance Framework)

The strategic objectives and their associated risks were kept under review as part of the board assurance framework (BAF); the BAF included board level risk owners who managed the risks
including, risk control, identifying and taking responsibility for actions required and updating progression and risk. Most board members had a clear understanding of the risks on the board assurance framework and how the trust was managing them. However, it was not clear that all board members had a clear understanding of how the BAF aligned with and supported the trust to meet its strategic objectives.

The Integrated Audit and Governance Committee was responsible for reviewing the BAF and reporting to the board. The Board agreed its 2017/18 annual priorities at the April 2017 meeting and agreed the Board Assurance Framework should be reviewed on a quarterly basis. We saw that the IAGC reported on the Board Assurance Framework at every meeting and provided a comprehensive report titled Full Corporate/ Highest Mitigated Strategic Risks Report at meetings in Jun, August, October and December 2017. The February 2018 report included a comprehensive annual report detailing performance against annual priorities.

Management of risk, issues and performance

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous</td>
<td>Last Financial Year (2016/17)</td>
</tr>
<tr>
<td>Income</td>
<td>536.9m</td>
<td>564.5m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(35.1)m</td>
<td>(31.2)m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>572.0m</td>
<td>595.7m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(32.2)m</td>
<td>0.3m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The trust was in financial special measures at the time of the inspection. NHS Improvement (NHSI) puts trusts into financial special measures following objective criteria. NHS Improvement is then able to provide added support and hold the trust to account. The special measures approach consists of rapid planning and delivery of accelerated recovery activities using a single oversight framework. The trust was engaging with NHSI to address financial issues.
The trust corporate risk register

The trust provided a document detailing their seven highest profile risks. Each of these have a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Last review date*</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRR 2</td>
<td>Failure to maintain the quality and standards of patient care</td>
<td>Extreme (25)</td>
<td>February 2018</td>
</tr>
<tr>
<td>SRR 4</td>
<td>Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities</td>
<td>High (15)</td>
<td>January 2018</td>
</tr>
<tr>
<td>SRR 8</td>
<td>Inability to attract, recruit and retain high calibre staff (substantive) to the Trust</td>
<td>Extreme (25)</td>
<td>February 2018</td>
</tr>
<tr>
<td>SRR 12</td>
<td>Insufficient capacity and capability of the leadership team (Executive and Divisional Directors) to develop and deliver key strategies and recovery plans</td>
<td>High (15)</td>
<td>February 2018</td>
</tr>
<tr>
<td>SRR 5</td>
<td>Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime</td>
<td>Extreme (25)</td>
<td>February 2018</td>
</tr>
<tr>
<td>SRR 16</td>
<td>Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes</td>
<td>Extreme (20)</td>
<td>February 2018</td>
</tr>
<tr>
<td>SRR 10</td>
<td>Non-delivery of a timely Sustainability and Transformation Plan that can be resourced</td>
<td>Extreme (20)</td>
<td>January 2018</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register / Board assurance framework)

Systems were not always effective for identifying risks. The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected. However, some risks were not identified. For instance, inspectors on the core service inspection identified risks around children and young people; these issues had not previously been identified by the board and put on the risk register.

The Integrated Audit and Governance Committee (IAGC), had oversight of and responsibility for risk. Its chair was a non-executive director. It reported to the board monthly and provided a quarterly report to the board for review.

The trust held risk registers at divisional and corporate levels. Department specific risks were recorded and managed using the divisional risk registers and trust wide risks recorded and managed using the corporate risk register. The same risks could be recorded on both risk registers.

Divisional staff members input information at the ward or departmental level. These risks were reviewed by the divisional governance group at a monthly quality governance meeting. Each risk was reviewed and assigned a risk level and a mitigated risk level. If the risk level, after considering
mitigations, was still high, it was escalated to the risk group for review and could be put on the corporate risk register. Likewise, risks with a lower mitigated risk rating, that carried a reputational risk could be put on the corporate risk register.

The risk group, chaired by the director of nursing, managed the risk registers. The risk group reviewed risks and provided information to the board about risks and whether to escalate them to the corporate risk register. Both executive and non-executive board members had input into risk levels and risks going onto the corporate risk register. The Board of directors reviewed the corporate risk register at each meeting, the most recent reviews at the time of the well led inspection were April and May 2018. One of the non-executive members roles was to hold the executive members to account regarding the risks and risk registers.

Board members we spoke to generally understood the risks contained on the corporate risk register. These risks were in alignment with board and senior staff members own lists of concerns.

The organisation had processes to manage current and future performance. There were systems and processes to assess, prevent, deter, manage and mitigate risk throughout the organisation. There was some proactive risk management. However, we saw processes were not always adhered to and much risk management was reactive, risks were not always anticipated and it was not always clear that risks were escalated to the board.

For instance, one of the trust’s system for reviewing the quality of patient care is to review deaths for professional learning at morbidity and mortality meetings. Morbidity and mortality reviews provide the trust board with assurances that patients are receiving safe care and that hospital deaths are not caused by unsafe clinical practices.

The medical director had submitted a mortality report to the board in April 2018 in line with The NHS National Quality Board guidance on Learning from Deaths, 2017 and the 2016 CQC report ‘Learning, candour and accountability’. The report provided a comprehensive overview of the current state of mortality in the trust including overview of how the trust’s mortality rates compared with other trusts and considered changes to rates.

The trust had introduced a structured judgement review tool used on an electronic platform to review individual cases. They had reviewed 92 structured judgement reviews on cases where they expected to see problems with care provided. The structured judgement reviews identified key themes across the cases.

The top 5 themes were:
- Cross site transfers (failure to comply with policy).
- Delays in completing VTE assessments by more than 24 hours.
- Missed doses of critical drugs.
- Failure/delays in escalation of the deteriorating patient.
- Late, no or inadequate consultant review.

The report then identified how these issues were being addressed through existing processes, however, there were no specific recommendations arising from the report.

Although the trust was complying with the guidance at board level, morbidity and mortality was not always reviewed in line with processes at directorate level. The mortality report noted that individual morbidity and mortality meetings across the trust did not follow standardised methodology. The April and May 2018 Urgent care and Long-Term Conditions Quality governance meeting notes reflect that there were no morbidity and mortality updates at these meetings. The meeting minutes recorded that mortality and morbidity meetings had not been occurring as ‘they
should' in the directorate and some had been cancelled due to bed pressures. Failure to perform directorate level review could mean the board level reviews lacked relevant information.

The trust had a new program of clinical audits. The trust reported that 75% of audits were completed last year. Senior staff explained that they were trying to strengthen their patient safety culture. However, we saw that audits were not always completed. When audits were completed, learning was not always followed by action plans or action plans or followed up on. Therefore, learning from audits was not always used to inform change to the service. For instance, we requested action plans that had been created to improve the Royal College of Emergency Medicine audit results. We were provided with plans that were incomplete. The action plans did not always evidence that they had been shared at a consultants meeting, sisters meeting, departmental meetings, divisional board, quality assurance board or the patient safety board.

The trust identified and planned for some potential risks when planning services. For instance, the trust began meeting with the CCG and planning for 2017-2018 winter pressures in April 2017. This issue was a consideration with regard to various issues discussed by the board throughout the year.

However, the trust did not always proactively identify and address risks. For instance, there were risks across the environment which were identified during our core service inspection. In some instances, senior staff explained, they felt unable to allow investment in equipment and facilities due to unsure.

The root cause analysis and incident reports reviewed during the inspection reflected that information about incidents was collected and reported on. However, risks were not always considered or identified. Therefore, in these cases, the trust did not act to mitigate or resolve risks that could have been identified during the incident review processes.

During the core service inspections risks were raised about the safe treatment of children and young people in the emergency department and surgery and the children’s safeguarding training in the emergency departments, surgery and maternity unit. We raised the high-risk concerns with the trust during the inspection and the trust immediately took some actions to address these concerns. However, the only concerns that had previously raised at board level were concerns around safeguarding training.

The trust had not identified other risks to children and young people, including ensuring staff with adequate competencies were treating children and young people and that children and young people were separated from adults in the ED. Further, when we requested information about these issues, not all the information requested was accurate. These issues were not on the risk register and had not been minuted in board meetings. This reflected the systems and processes had not worked to ensure that this risk was identified, accurate information about the risk was available and that the risks had been actioned.

**Information management**

The trust collected, analysed, managed and used information to support all its activities, using secure electronic systems with security safeguards.

Information technology (IT) was managed by an IT team which provided serves across the trust. The Director of IT headed the department and was supported by the Deputy director. IT service support and services desks provided services trust wide. Each hospital had an IT incident and service engineer team comprised of five team members.
There was an understanding of performance, which sufficiently covered and integrated people's views with information on quality, operations and finances.

Information management was part of the Transformation Program. This was primarily part of the ‘Delivering our future’ T3 (transformation through technology) program which focused in the 2018-19 year on implementation of an electronic patient record, electronic prescribing and medicines administration, digital clinical information, electronic order communications and results, information coding and tracking boards. Technology played a part in other work streams, for instance part of the ‘right skills, right time, right place’ element of the transformation journey focused on ensuring the trust was using accurate data and following with appropriate actions. However, these projects were still in process and there had been delays to the completion of some elements of the program.

The trust managed data so that it was accessible and functional. It used an information management system developed as part of an NHS and private collaboration. The system could manage performance, financial and patient information in one system. It used real-time information which allowed staff to plan and resource clinical services to meet hourly fluctuations in patient flow. This information was then used to develop performance dashboards that gave hospital managers and clinicians a real-time view of activity in the hospital at all times.

The trust could produce standard reports from the portal to utilise data immediately. Staff could also produce specialised reports such as Hospital Standardised Mortality Ratio (HSMR) reports and performance data reports.

Staff had access to relevant information. The system’s immediate updates meant patient level data could be accessed by health care professionals across the trust directly, almost in real time. Staff could use a mobile application ‘app’ to access data and reports from the information portal on their mobile devices. The app allowed staff access to some information and reports but protected personal patient data so no patient data was accessible from the app.

Some of this information was also available to the public. For instance, members of the public could access the trust’s website to find out how many patients were in each emergency department and the estimated waits for minor injuries. The trust also had a mobile application ‘app’ which provided travel times from the user’s location as well as wait time information.

Information technology systems were sometimes used to enhance the quality of patient care. For instance, early in 2018 the trust saw an increase in 52-week elective care pathway breaches. The trust implemented the use of new Interactive Patient Tracking Technology to allow real time recording of patient pathways to support the operational teams in delivery.

Quality and sustainability were both considered in the review of information management. Both quality and sustainability were drivers for the development of the trust’s information portal.

The Information Governance toolkit is the mechanism for NHS organisations and service providers to demonstrate compliance to statutory information governance requirements. The Data Security and Protection Toolkit replaced the previous Information Governance toolkit from April 2018. The Trust had completed the Information Governance toolkit for 2017/18. Its performance was satisfactory and had reduced slightly by 4% on the previous year. Board minutes reflected the trust was preparing to complete the new Data Security and Protection Toolkit in 2018.

The Caldicott Guardian worked with the IG lead and senior information risk owner (SIRO) to manage information governance. Information governance was reviewed at board level by the Information and Governance Committee which had the role of overseeing and scrutinizing all trust governance.
The trust had effective arrangements to ensure that data or notifications were submitted to external bodies as required. The director of nursing was ultimately responsible for submitting notifications, this duty was in some instances delegated to team members.

There were arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. At the time of inspection, the trust was rewriting its information strategy and working to set up a sustainability and transformation plan with other Kent and Medway providers. The sustainability and transformation plan proposed to integrate patient and social care records in a ‘Kent Care Record. They would do this by bringing together information in health and care records from different parts of the NHS, Kent County Council (KCC) and Medway Council into one, accessible record.

The trust had systems and processes to secure and protect its data. The board had oversight of the trust’s cybersecurity. This was not a regular item on the agenda or regularly minuted as an issue discussed at board meetings. The IT director had reported to the board in June 2017 about the trust’s cyber security and how they were protecting the trusts information in response to high profile cyber-attacks.

The trust’s IT Backup and Restore Standard Policy was undated, but required an annual review. It was not clear when the last policy review occurred which meant it might not be up-to-date or staff might not know if they were referring to the most up-to-date policy.

The policy provided the structure to protect data integrity and protect data to support disaster recovery and business continuity in the event of incidents. The policy ensured that trust data was backed up regularly. Backups were held securely for a specified retention period.

However, although the trust had information systems in place, information was not always used effectively to monitor and improve the quality of care or to provide assurances around the trust’s risks. The use of information to measure improvement was still being implemented. For instance, we saw that when information was audited and deficiencies were identified, learning was not always taken from the audits and re-editing did not always occur. We asked of evidence of assurance around action plans, however, the trust could not always find evidence that the actions had been completed or re-audited or that changes had created improvements.

**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.

The trust had a communications and engagement team led by the Director of Communications and Engagement, a role that was developed within the trust in 2014. Communications were viewed as an essential tool to support the quality and transformation agenda and there was a symbiotic relationship between the engagement and communications team and quality group. The Director of communications was directly involved in many communications and senior staff explained that communication and engagement priorities, approach and plan were the basis of all trust communications.

The team had developed a Communications and Engagement Strategy 2016-2020 which had been refreshed in 2018. The 2018 refresh was in response to the 2017 staff survey and implemented changes to the Trust’s communication approach and engagement plans. The strategy was meant to support other trust strategies, for instance the Council of Governors membership engagement strategy, Quality Strategy, People Strategy, Research and innovation
strategy and the Trust's charity. The Communications and engagement strategy focused on engagement with public and patients, staff, governors, members, partner organisations and other stakeholders.

Staff and patient views and experiences were gathered and acted on to shape and improve the services and culture. The trust engaged with the patients, community members, stakeholders and public, to provide information and engage all stakeholders to have a say in how the trust was run and future improvements of services.

The trust engaged with the public with the aim to both share and gain information about the trust and the care it provided. The Board of Directors Meetings included an agenda item for a staff member and/or patient to share their experiences with the board. These were compelling stories that demonstrated the impact of care on patients and the learning that can come from incidents after they occur.

The trust produced a bi-yearly free magazine about the hospital for staff and patients, *Your Hospitals Your Health*. The magazine included patient stories, provided information about the hospital and hospital it’s vision and performance. It invited patients to provide feedback about changes, decisions about how healthcare would be provided and comments, concerns, complaints and compliments about care.

The trust encouraged individuals from the community to become trust members. This gave individuals the opportunity to engage the Council of Governors to influence the trust’s development. There were different ways to become involved and members could determine the level of their engagement with the trust. Members had an annual meeting and received a quarterly newsletter. The trust had recently refreshed the website with information about how members could communicate and engage. To encourage the public to join the members were offered a discount scheme.

The trust had many patient groups working with the hospital to improve services and the way they were run. These groups did impact the way the service was run. For instance, the cancer patient group provided input to change the way they picked up their take home medicines, which had previously been complicated and time consuming.

The website also provided the public with information about how to feedback comments, complaints, concerns and compliments to the trust. Information was provided about how people could access help to make complaints if they needed it.

Staff were invited to share their views and engaged so that these views are reflected in the planning and delivery of services and in shaping the culture. The trust engaged with staff members through a variety of mediums, for example e-mails, newsletters, Team talk briefings for managers to share with staff, face to face briefings, staff intranet sight, roadshows, staff forums and through staff groups and unions.

The trust held staff consultations to discuss specific issues. For instance, we saw advertisements for staff to join the stroke consultation and consultation about East Kent reconfiguration.

Board meeting notes reflected that the board used forums to engage with staff, for instance after the staff survey results were released. Staff forums, including specialist forums such as admin and clerical forums, were set at a variety of times and locations and were advertised in the staff newsletter.

There were junior doctors’ forums chaired by the Trust Guardians of Safe Working. These forums focussed on safe working hours, particularly ‘exception reports’ when junior doctors working hours
varied significantly from the agreed schedule. The forum included the Guardian’s report and provided the opportunity for junior doctor feedback by junior doctor representatives.

The hospital had hubs which provided staff the opportunity to access a wide variety of information and services to support them in their roles at the trust. Hubs were located across the trust. Examples of some hub offerings advertised in the staff newsletter included, RESPECT anniversary (regarding bullying and harassment), falls and osteoporosis, safe use and storage of oxygen, mouthcare matters, emergency planning, medical devises, hub heroes, library, healthy eating, league of friends and end of life.

However, not all staff we spoke to felt their view was considered regarding change in the trust. Some staff told us they did not engage in forums and consultations because they felt their view would not be considered or had not been considered in the past. The staff survey reflected the trust fell below the national average regarding two questions about staff engagement: percentage of staff reporting good communication between senior management and staff and percentage of staff able to contribute towards improvements at work.

The trust had a Diversity and inclusion statement stating the trust was committed to creating a diverse and inclusive environment where staff, patients and service users feel they could be themselves. The Engagement and communications strategy noted that communications needed to be provided in a variety of formats, not just digitally, to serve community members with different needs. However, the strategy did not further address engagement with those patients, community members and staff with characteristics protected under the equality act such as age, disability, gender reassignment, pregnancy and maternity, race, religion or belief or sex.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The trust recognised the importance of working in partnership with stakeholder organisation. We saw the trust was working closely and having regular meetings and communications with stakeholders including CCGs and regulatory bodies. The trust took an active role in system wide meetings, provided a monthly stakeholder e-bulleting and had a program of engagement sessions with partner trusts, MPs and other stakeholders.

There was transparent and open communication with all stakeholders about performance. The trust included information about performance in publications including the Your hospitals your health magazine and staff publications. The Board of Directors received monthly integrated performance report from board committees to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. These reports were published monthly on the trust’s web site at the same time they were provided to the Board of Directors. This included the integrated performance report which summarised the trust’s performance as well as a more detailed report that used diagrams, graphs and other visual aids to make the report clear and accessible to the layperson.
Learning, continuous improvement and innovation

Complaints process overview

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance (As of May 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 working days</td>
<td>82%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>As agreed with the client</td>
<td>91.4%</td>
</tr>
<tr>
<td>We also have an internal stretch target for our own improvement plan</td>
<td>30 working days</td>
<td>39%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>45 working days</td>
<td>23%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab) modified by further information provided by the trust current May 2018.

Number of complaints made to the trust

The trust received 874 complaints from February 2017 to February 2018 for acute services. A breakdown can be found below of which locations these took place at and their corresponding department/ward/area.

<table>
<thead>
<tr>
<th>Location</th>
<th>Department/ ward / area</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buckland Hospital Dover</td>
<td>A&amp;E</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Acute paediatrics</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Cardiology</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Colorectal Surgery</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Community paediatrics</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>General Surgery</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Renal Medicine</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Speech and language therapy (Paediatric)</td>
<td>1</td>
</tr>
<tr>
<td>Buckland Hospital Dover Total</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Kent &amp; Canterbury Hospital</td>
<td>Gynaecology</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Renal Outpatients</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>A&amp;E</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Acute paediatrics</td>
<td>1</td>
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<tr>
<td></td>
<td>Bereavement services</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Breast screening</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Cancer</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Cardiology</td>
<td>3</td>
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<tr>
<td></td>
<td>Community paediatrics</td>
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<tr>
<td></td>
<td>Day Surgery</td>
<td>2</td>
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<tr>
<td></td>
<td>Dermatology</td>
<td>6</td>
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<tr>
<td></td>
<td>East Kent Neuro Rehab Unit</td>
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<tr>
<td>Department</td>
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<tr>
<td>----------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Endoscopy unit</td>
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<tr>
<td>ENT</td>
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</tr>
<tr>
<td>Gastroenterology</td>
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<td></td>
</tr>
<tr>
<td>General Surgery</td>
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</tr>
<tr>
<td>Haemato-oncology</td>
<td>2</td>
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</tr>
<tr>
<td>HCOOP</td>
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<tr>
<td>IT department</td>
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<tr>
<td>Main Theatres</td>
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<td>MaxFax</td>
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<tr>
<td>Neurology</td>
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<tr>
<td>Nuclear medicine</td>
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</tr>
<tr>
<td>Obstetrics</td>
<td>4</td>
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</tr>
<tr>
<td>Ophthalmology</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>1</td>
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</tr>
<tr>
<td>Outpatients</td>
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</tr>
<tr>
<td>Pain Services</td>
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</tr>
<tr>
<td>Pharmacy</td>
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<td>Physiotherapy</td>
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<tr>
<td>Renal Medicine</td>
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<tr>
<td>Respiratory medicine</td>
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<tr>
<td>Risk &amp; legal services</td>
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<tr>
<td>Strategic development</td>
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<td>Stroke</td>
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<td>T&amp;O</td>
<td>11</td>
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<tr>
<td>Urology</td>
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<tr>
<td>Vascular</td>
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<td><strong>Kent &amp; Canterbury Hospital Total</strong></td>
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<td><strong>Queen Elizabeth the Queen Mother Hospital</strong></td>
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<td>Diabetes</td>
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<td>Gynaecology</td>
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<td>Cancer</td>
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<td>Cardiology</td>
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<td>Colorectal Surgery</td>
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<td>Fire / security, health and safety</td>
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<tr>
<td>T&amp;O</td>
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<tr>
<td>Therapies</td>
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<tr>
<td>Vascular</td>
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<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth the Queen Mother Hospital</td>
<td>301</td>
</tr>
<tr>
<td>Royal Victoria Hospital Folkestone</td>
<td>8</td>
</tr>
<tr>
<td>William Harvey hospital</td>
<td>77</td>
</tr>
</tbody>
</table>

**Queen Elizabeth the Queen Mother Hospital Total**: 301

**Royal Victoria Hospital Folkestone Total**: 8

**William Harvey hospital Total**: 77
The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. The trust showed improvement with regard to identifying and applying learning. However this was not yet embedded and learning was not always taken or applied when things went wrong.

During the inspection, we assessed the complaints policy and five complaints files. The policy had been reviewed, signed off by the executive director and had been ratified within the past year.

The complaints files we reviewed demonstrated that it was easy for people to complain or raise a concern and they were treated compassionately when they did. There was openness and transparency in dealing with complaints and staff applied the duty of candour which requires staff to inform patients (or in some cases their family or representatives) when something went wrong.

Staff generally responded to complaints and concerns in a timely way, although one complaint we reviewed reflected delays by clinical staff to provide information resulting in the complaint’s escalation.

Complaints were managed on an electronic patient safety and risk management system. This ensured that complaints investigations and responses could be monitored and recorded. It also included fields for risk and safeguarding to ensure these issues were considered and information recorded. Divisions could filter complaints to identify themes and actions form the learning.

Improvements were made to the quality of care as a result of complaints and concerns. When a complaint resulted in changes, this information was included in the complaint response letter. Otherwise, the letter still included an explanation and apology. Staff could give examples of them complaints had initiated change that directly affected patient care.

However, none of the complaint files reviewed reflected that risk had been assessed by an appropriately skilled individual or the board member responsible for complaints had been informed when appropriate.
The trust recognised the importance of learning and the opportunity to improve that complaints provide. The most recent staff newsletter reminded staff of these opportunities and provided a short synopsis of how to manage complaints and provide patients with the information to escalate complaints if they would like to.

Leaders encouraged a culture of continuous learning, improvement and innovation. There was a research and development department and learning and development were integral parts of trust communications and the staff hubs. However, staff reported there was not always time for mandatory training or any other continuous learning.

Senior staff explained the trust used information from exit interviews and retrospective exit interviews to identify areas where they could improve. Areas that have been highlighted in the interviews were that the trust was not adaptable or flexible.

The trust participated in a variety of research projects. It had a Research and Development Directorate that supported researchers with the aim to ensure that all research projects or clinical studies are carried out to high scientific quality, and in accordance with the requirements of all regulatory standards.

The trust used quality improvement hubs to encourage and invite staff members to be involved in improving care and quality in the trust.

The trust had a research and innovation team which was part of the trust corporate directorate. The research and innovation team had a monthly business meeting and reported to the management board and quality board on a quarterly basis. They provided an annual report to the trust board. Additionally, the team had a regular annual meeting with an aim to engage with patients public and staff about the trusts research and development.

The research and development team had an annual budget to support the trusts research and development and had two research funding streams, one to support staff developing and external funding application and one dragons den style program where offering a research grant three times per year. Research and development projects spanned the trust and participant groups included physiotherapy, pharmacy, nurses, doctors and lab staff. There had been a diversity of recently successful applicants including an extended scope physiotherapist, anaesthetist and maxillofacial surgeon.

The Research Development Service was based at the University of Kent - Canterbury which had a Centre for Health Services Studies. Staff could access a variety of opportunities to pursue their professional research interests through this program.

The trust had a wide variety of research teams including the gynae-oncology, pharmacy, oncology, haematology, ophthalmology, renal, stroke, multidisciplinary and community/acute research teams.

The trust was involved in both local and large international research projects. There were internal studies in a variety of areas, for instance, stroke prevention, treatment, genetics and image, theatres, anaesthetics, neurological disorders, and colorectal and general surgery. The teams worked with the university of Kent and other local providers in studies looking at a variety of speciality areas, for example, diabetic foot ulcers, stroke, colon health and cancer. Some of the positive research outcomes included high cost drug savings for the NHS in excess of one million pounds and reducing serious treatment related morbidity.

The NHS National Quality Board guidance on Learning from Deaths, 2017 and the 2016 CQC report ‘Learning, candour and accountability’, guidance required all 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 to have been sent by the end of 2017.

We saw that the trust had a learning from deaths policy, and mortality was discussed at trust board meetings with information about mortality being provided in the medical director’s report. However, the first mortality report was submitted of the board for the April 2018 meeting.
The trust reviewed serious incident using root cause analysis. We reviewed 11 root cause analyses. We saw that the analyses tended to complete all sections and have a strong section about the facts around the incident involved. However, the analyses did not always include actions, actions were general or lacked specificity, actions were not always followed up on, learning was not always shared internally and externally and the audit loop was not always completed. This meant that learning from serious incidents was not always identified and when it was identified, it was not always followed up on. Further, the process did not provide assurances to the department or board that meaningful changes had been made in response to incidents.

Accreditations
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 table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Scheme Type</th>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schemes commonly, but not exclusively, applicable to acute and / or community health service providers</td>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>WHH Endoscopy unit was assessed by the JAG team on 22/09/17. Full accreditation was awarded in November 2017 upon receipt of the final report and certificate.</td>
</tr>
<tr>
<td></td>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>not accredited (usually only community provider accreditation)</td>
</tr>
<tr>
<td></td>
<td>Anaesthesia Clinical Services Accreditation (ACSA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>not accredited</td>
</tr>
<tr>
<td>Schemes commonly, but not exclusively, applicable to mental health providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189</strong></td>
<td>Cellular Pathology December 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Improving Quality in Physiological Services Accreditation Scheme (IQIPS)</strong></td>
<td>Haematology &amp; Blood Transfusion August 2017</td>
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</tr>
<tr>
<td><strong>Commission for the Accreditation of Rehabilitation Facilities (CARF)</strong></td>
<td>Haemophilia May 2017</td>
<td></td>
</tr>
<tr>
<td><strong>CHKS Accreditation for radiotherapy and oncology services</strong></td>
<td>Clinical Biochemistry and Immunology July 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)</strong></td>
<td>Microbiology September 2017</td>
<td></td>
</tr>
<tr>
<td><strong>MacMillan Quality Environment Award (MQEM)</strong></td>
<td>not accredited</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accreditation for Inpatient Mental Health Services (AIMS)</th>
<th>Quality Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMS - WA (Working Age Units)</td>
<td>Quality Network for Inpatient Learning Disability Services (QNLD)</td>
</tr>
<tr>
<td>AIMS - PICU (Psychiatric Intensive Care Units)</td>
<td>Quality Network for Inpatient CAMHS (QNIC)</td>
</tr>
<tr>
<td>AIMS - AT (Assessment and triage wards)</td>
<td>Quality Network for Community CAMHS (QNCC)</td>
</tr>
<tr>
<td>AIMS - OP (Wards for older people)</td>
<td>Quality Network for Perinatal Mental Health Services (QNPMH)</td>
</tr>
<tr>
<td>AIMS - Rehab (Rehabilitation wards)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| ECT Accreditation Scheme (ECTAS)                         | N/A |
| Psychiatric Liaison Accreditation Network (PLAN)         | N/A |
Memory Services National Accreditation Programme (MSNAP) | N/A
---|---
Accreditation for Psychological Therapies Services (APPTS) | N/A

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

**Outstanding practice:**
The trust demonstrated outstanding practice around communications. Communications were viewed as an essential tool to support the quality and transformation agenda and there was a symbiotic relationship between the engagement and communications team and quality group. The Director of communications was directly involved in many communications and senior staff explained that communication and engagement priorities, approach and plan were the basis of all trust communications. The team had developed a Communications and Engagement Strategy 2016-2020 that supported other trust strategies, for instance the Council of Governors membership engagement strategy, Quality Strategy, People Strategy, Research and innovation strategy and the Trust’s charity. The Communications and engagement strategy focused on engagement with public and patients, staff, governors, members, partner organisations and other stakeholders.

The trust managed data so that it was accessible and functional. It used an information management system developed as part of an NHS and private collaboration. The system could manage performance, financial and patient information in one system. It used real-time information which allowed staff to plan and resource clinical services to meet hourly fluctuations in patient flow. This information could be used to develop performance dashboards that gave hospital managers and clinicians a real-time view of activity in the hospital at all times.
Urgent and emergency care

East Kent University Hospitals NHS Foundation Trust (EKHUFT) delivers a range of urgent and emergency services through three hospitals in the region.

The urgent and emergency care department at Queen Elizabeth The Queen Mother hospital provides emergency care to people living in Margate and Thanet in Kent and serves a mixed population.

The emergency department at Queen Elizabeth The Queen Mother hospital has a four-bedded resuscitation bay, 10 major cubicles, a mental health assessment room, seven minor injury assessment bays, plaster room and clinical procedure room. There is an observation area which has four bays. There is a separate area for children which has a waiting area and three designated child treatment cubicles, there is also a designated child resuscitation bay in the resuscitation area. There is an x-ray facility in the emergency department.

The hospital does have an inpatients paediatric ward but does not have paediatric intensive care support. Children requiring intensive care are transferred to a specialist paediatric unit. Children under the age of six months, after registering in the emergency department, are sent directly to the paediatric ward. The department has a newly built procedure room which was used to undertake minor procedures.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them. Urgent and emergency services were last inspected in 2016 when overall, we rated it as requires improvement. We rated safe and caring as good, responsive, effective and well-led as requires improvement.

Our inspection was unannounced and we inspected using all five key questions. We spoke to 11 patients and carers and over 30 staff from different disciplines, including support and administration staff, nurses, doctors, managers and ambulance staff. We observed daily practice and viewed 30 sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.
Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

The trust has three urgent and emergency departments:

- Kent & Canterbury Hospital Minor injury unit
- Queen Elizabeth The Queen Mother Hospital
- William Harvey Hospital

(Source: Trust Routine Provider Information Request)

Activity and patient throughput

Total number of urgent and emergency care attendances at East Kent Hospitals University NHS Foundation Trust compared to all acute trusts in England.

There were 210,305 attendances from April 2016 to March 2017 at East Kent Hospitals University NHS Foundation Trust as indicated in the chart above.

(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 from 2015/16 to 2016/17. In 2016/17, rates were higher than the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

Mandatory training completion rates

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

A breakdown of compliance for mandatory courses from January 2017 to December 2017 for medical/dental staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>9</td>
<td>15</td>
<td>60%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>9</td>
<td>15</td>
<td>60%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>7</td>
<td>15</td>
<td>47%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>7</td>
<td>15</td>
<td>47%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>7</td>
<td>15</td>
<td>47%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>6</td>
<td>15</td>
<td>40%</td>
<td>No</td>
</tr>
</tbody>
</table>

No site had hit the target for mandatory training set for medical staff.

A breakdown of compliance for mandatory courses from January 2017 to December 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>73</td>
<td>76</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>71</td>
<td>76</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>67</td>
<td>76</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>71</td>
<td>76</td>
<td>89%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>67</td>
<td>76</td>
<td>86%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>57</td>
<td>76</td>
<td>65%</td>
<td>No</td>
</tr>
</tbody>
</table>

Queen Elizabeth Queen Mother hospital met the target for five out of six training modules.

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

The overall mandatory training compliance for nursing staff at Queen Elizabeth The Queen Mother hospital was 87% which was better than the trust target of 85%.
The overall mandatory training compliance for medical staff at Queen Elizabeth The Queen Mother hospital was 50% which was worse than the trust target of 85%.

The service provided mandatory training to staff, training was a mixture of on-line and face to face. Mandatory training compliance had improved since our last inspection, although it still required further improvement amongst the medical staff group.

The matron organised and managed mandatory training for nursing staff and the service manager did the same for the medical staff. Staff received email notifications when their training was due to expire.

The matron and service manager held a spreadsheet which gave oversite of mandatory training compliance. However, departmental meetings did not have a set agenda which included mandatory training compliance therefore there was no overall oversight or monitoring.

A consultant in psychiatric liaison showed us training records which confirmed doctors regularly attend teaching sessions in issues relating to mental health illnesses. For example, most recently reviewing the use of emergency psychiatric medication.

### Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, child safeguarding training compliance was low amongst both doctors and nurses but particularly low amongst doctors and significantly lower than the trust target of 85%. Only 27% of doctors had up to date level three child safeguarding training and 20% had were up to date with level two safeguarding training. This meant doctors caring for children may not have the necessary skills and knowledge to identify a child at risk. Staff gave us examples of how to recognise and report abuse.

### Safeguarding training completion rates

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

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

A breakdown of compliance for safeguarding training courses from January 2017 to December 2017 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>4</td>
<td>15</td>
<td>27%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>3</td>
<td>15</td>
<td>20%</td>
<td>No</td>
</tr>
</tbody>
</table>

Queen Elizabeth Queen Mother hospital only achieved safeguarding adult level training target.

A breakdown of compliance for safeguarding training courses from January 2017 to December
2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>76</td>
<td>76</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>62</td>
<td>76</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>50</td>
<td>76</td>
<td>70%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>9</td>
<td>15</td>
<td>60%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

All staff in urgent and emergency services, including therapies staff, had adult and child safeguarding training to level one and higher levels of training were then completed, based on the level of responsibility each member of staff had. For example, all nurses were required to complete adult and child safeguarding to level two and senior nurses and doctors completed the training to level three.

Only 27% of doctors were compliant with level 3 children safeguarding training. This meant doctors treating children may not have the necessary skills and knowledge in recognising and acting on safeguarding concerns. This was not in line with the Safeguarding Children and Young People – Roles and Competencies for Staff Intercollegiate Document updated in September 2010.

Seventy percent of nursing staff were compliant with level 3 children safeguarding training, this was worse than the trust target of 85%.

Only 20% of doctors were compliant with level 2 adult safeguarding training. This meant doctors may not have the necessary skills and knowledge in recognising and acting upon safeguarding concerns.

Sixty percent of nursing staff were complaint with level 2 adult safeguarding training, this was worse than the trust target of 85%. This meant nurses might not have the skills and knowledge to recognise safeguarding concerns.

Safeguarding training compliance was also low at the time of our last inspection. This meant there had been no improvement to ensure staff undertook the training.

There were up-to-date safeguarding policies and procedures, which were accessible to staff through the trust’s intranet site. Staff demonstrated a good understanding of the trusts safeguarding policies, procedures and what to do should a safeguarding concern arise. Staff could give examples of when they had made a safeguarding referral.

The department had a system and process in place for the identification and management of adults and children at risk of abuse (including domestic violence). The department had two safeguarding link nurses, one in paediatrics and one in adults.

Safeguarding referrals were completed electronically via the trust intranet and sent to the local authority, staff demonstrated the on-line system to us. An incident form was also completed in conjunction with raising a safeguarding alert.

The electronic patient system did not allow staff to discharge the patient from the system until it was confirmed that there were no safeguarding concerns or required staff to document details of
any safeguarding concerns identified. This reminded staff to consider any safeguarding concerns and document any safeguarding concerns identified.

Staff told us that children with a previous safeguarding referral or who were well known to the service were flagged up on triage on the computer with a symbol next to their name. This enabled staff to identify that there had been previous safeguarding involvement or concerns.

Staff were aware of the trust safeguarding leads and the department’s safeguarding link nurses. We saw there was a noticeboard within the department, which identified the trust safeguarding leads and contact details.

Staff were aware of other safeguarding issues such as child sexual exploitation, female genital mutilation and adults and children at risk of radicalisation and there were guidance and proformas available. We saw posters within the department, which detailed what action to take if a patient was identified as being subjected to female genital mutilation.

All parents and carers that attended the emergency department with a child under 16 were given a confidential patient information form to complete. This form gave consent to share details of the child’s reason for attendance with other professionals. We saw completed forms within the records we reviewed, these forms were then scanned into the electronic patient record system.

We saw details of safeguarding concerns were included in the departments communication book. This meant all staff were aware of any safeguarding concerns raised during the previous week.

The service had recently joined the child protection information sharing project supported by NHS Digital. The project helps the NHS give a higher level of protection to children who present in unscheduled care settings. A database enables healthcare staff working in these areas to identify if a child was subject to a child protection plan or was looked after by a local authority. Staff checked the database for all children who attended the department and recorded this on the electronic patient record and paper record.

If a patient was assessed to be at risk of suicide or self-harm they could be cared for in the four-bed observation area, which enabled enhanced observation of the patient.

The psychiatric liaison staff were able to provide support to patients in the department if necessary to provide additional staffing resource as well as guidance.

The psychiatric liaison services were available 24 hrs a day and the staff assessed patients within one hour of receiving a referral.

Nursing staff we spoke to did not have an in-depth knowledge of the Mental Health Act holding power, but told us they would seek advice and guidance from the psychiatric liaison service. Holding power is when a patient is kept in hospital because a doctor thinks the patient has a mental health problem and are not well enough to leave.

The psychiatric liaison service had access to policies for the management of observations and restraint in patients attending with a mental health illness.

**Cleanliness, infection control and hygiene**

We observed staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. However, there was a lack of audits to provide assurance that the service controlled the risk of infection.

We saw there were no handwashing facilities within the triage area in the main waiting room. This meant staff did not have immediate access to handwashing facilities and had to leave the triage area to wash their hands.
There were hand alcohol gel dispensers available in each cubicle, on the corridors and next to the entry and exit doors.

We did not see hand hygiene audit results displayed in the department. The trust could not be fully assured that staff were cleaning their hands effectively and in line with national guidelines. Audit findings supplied to us showed the number of staff observed during the audits varied between one staff member and ten members of staff. For example, in the audit carried out in March 2018 only one staff member was observed, this only provided limited assurances that staff were cleaning their hands effectively and in line with national guidelines. Since our inspection we have seen evidence which demonstrates effective hand hygiene audits are being undertaken.

However, we observed medical and nursing staff followed the trust policy and national guidelines for hand washing and ‘bare below the elbows’ guidance in clinical areas.

Staff adhered to the infection control policy and used personal protective equipment correctly when delivering care. There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained.

The department was visibly clean and we saw support staff cleaning the department on a regular basis.

One of the trust’s infection control and prevention nurses undertook a visit to the department in April 2018 and identified cleaning standards from both domestic and nursing need to be greatly improved. We saw an action plan was developed to address these concerns which consisted of 10 actions, only one action was still outstanding. This showed that the audit findings had been acted upon and improvements in the standards of cleanliness improved.

Decontamination products, for example sanitising hand alcohol gel, were not stored securely and in line with the control of substances hazardous to health guidelines. During our inspection we identified that the cupboard which contained the hand gel was unlocked. We informed the nurse in charge of this who said they would ensure it was locked, when we returned to the department the following day the cupboard was still unlocked. This meant visitors had access to products which could cause harm and action was not taken to prevent this once they had been informed.

There was an isolation room for patients with suspected contagious diseases. Signage was used to advise staff not to enter without appropriate protective clothing, and visitors to speak to a member of staff.

Staff received up-to-date communication from the trust’s infection prevention and control team via the departmental infection prevention and control team link practitioners. We saw information relating to infection prevention and control practices in the departmental communication book, this ensured staff were kept up to date.

We reviewed the cleaning log of the toys and play equipment in the Children’s department which showed that the toys were not cleaned every day. For example, cleaning was not undertaken on 05, 06, 09, 11 May or 06, 07, 10, 11, 12, 21, 22, 25, 26 or 27 April 2018. This meant there was no assurance that the equipment was being cleaned and could pose a risk of infection.

Environment and equipment

The environment in the emergency department did not always enhance patient safety. The service did not have suitable premises and equipment and did not ensure that equipment was available and fit for use.
The major treatment area and Children's treatment area, were too small for the numbers of patients and staff who used them. This meant staff had to constantly move patients from one space to another and that moving patients around the department was a slow and difficult process.

The Children's area was secured by swipe-cards to prevent people inappropriately entering areas where children were seen. It had a separate waiting area so that there was audio and visual separation of adults from children. The Children's waiting area also had a separate door leading directly to the paediatric cubicles so that children could be brought into the department without having to go back through the adult area.

Documented daily safety checks of the equipment within the resuscitation area were not fully completed, including for paediatric equipment. For example, on 07 May 2018 bay one and two were not checked, on the 12 May 2018 the defibrillator in bays 1 and two were not checked and on 14 May 2018 not all equipment was checked in bay three. This meant there was no assurance that emergency equipment was available and fit for use.

Documented daily safety checks of the resuscitation trolleys were not fully completed, including for paediatric equipment. For example, the resuscitation trolley in the children's department was not checked on 02,08,09 May 2018,04,09,10,17,18,21,22,26,30 and 31 April 2018. This meant there was no assurance that emergency equipment was available and fit for use.

The daily safety checks for the adult resuscitation trolley was also not fully completed. For example, there were missing documented checks on 08 and 13 May 2018. We raised this issue with staff who told us that it was recorded on the nurse in charge handover checklist to confirm the checks had been undertaken. We reviewed the handover sheets for 08 and 13 May 2018 which did not have written confirmation that the checks had been completed. This meant there was no assurance that emergency equipment was available and fit for use.

In addition, the adult resuscitation trolley did not have a tamper evident seal. This meant it was not obvious to staff if the trolley had been opened and may have been used and equipment not replaced. We raised this issue with staff during the inspection who explained that the tamper evident seals did not fit the proper correctly and when removed left plastic in the lock which meant another seal could not be fitted. The following day staff explained that they and contacted the trust resuscitation team to highlight the issue and the correct seals had been ordered.

There was a fully equipped child resuscitation bay and resuscitation trolley with all sizes of equipment.

The mental health room used for conducting mental health assessments was compliant with the Quality Standards for Liaison Psychiatry Services Fifth Edition 2017. For example, the room had no cables, heavy weight furniture and no ligature points. However, directly opposite the mental health room was an unlocked office which contained items which a patient could use to inflict harm on themselves. In addition, a patient could lock themselves in the office from the inside. We informed staff of this issue would said they would arrange for the office to be kept locked when not in use to prevent unauthorised access.

The toilets within the urgent and emergency care department all contained pull cords which could be used as a ligature point, if a patient wanted to inflict harm on themselves. We informed the matron of this issue who said they would arrange for the cords to be replaced. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation.

Clinical waste and specimens were appropriately labelled and segregated. They were stored safely and disposed of according to hospital policy.
We checked 13 items of electrical equipment all of which had a sticker which confirmed they had undergone electrical safety testing within the last 12 months and were safe to use. The adult and child waiting areas had separate male, female and disabled toilets. The department was close to car parks and had a drop off area for police and ambulances.

The department was located near the x-ray department and CT scanner to allow for easy access. All doors were unobstructed and fire escapes were clear. In the reception area, we saw that there were easy clean chairs for patients to use whilst waiting for treatment and there appeared to be sufficient seating in the waiting areas.

The department had relatives room, which met the criteria set out in The Royal College of Emergency Medicine: End of life care for adults in the emergency department 2015 recommends same guideline.

Staff told us that there could be a delay in equipment being repaired. For example, the urine analysis machine had been not working for four days prior to our inspection. We raised this with the matron who was unaware of the issue.

Assessing and responding to patient risk
Emergency Department Survey 2016

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.6</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>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.2</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>9.5</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 initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was better than the overall England median in all the months over the 13-month period from February 2017 to January 2018.

In January 2018 the median time to initial assessment was two minutes compared to the England average of nine minutes.
Ambulance – Time to initial assessment from February 2017 and January 2018 at East Kent Hospitals University NHS Foundation Trust

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

(Source: National Ambulance Information Group)

Queen Elizabeth The Queen Mother hospital

From March 2017 to February 2018 there was slight increase in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Queen Elizabeth The Queen Mother hospital. As of February 2018, 62% of ambulance journeys had turnaround times over 30 minutes.

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 February 2017 to February 2018 the trust reported 2,395 “black breaches”, with December 2017 having the highest number just over 350.
The department was not always effectively using a system to monitor acutely ill patients.

The department was using the National Early Warning Score system for the monitoring of vital signs in adult patients to highlight early signs of deterioration of a patient’s conditions. The National Early Warning System score prompted staff to take further action. For example, increasing the frequency of monitoring vital signs (for example blood pressure) and informing medical staff so they could review patients and escalate treatment if required.

We identified two occasions when patients had a National Early Warning Score that required action to be taken, but there was no documentation in the patients electronic or paper record which outlined what action had been taken. We confirmed our findings with a nurse during our inspection. This meant it was not possible to know if any action had been taken and the patients could be at risk of deterioration. We highlighted these concerns to the trust who undertook a review of the patient records and could not identify any failings in the care the patients received.

We identified on two occasions that observations had been undertaken and documented but a National Early Warning Score had not been calculated. This meant it was not possible to identify and take appropriate action if the calculated National Early Warning Score indicated the patient was either deteriorating or at risk of deterioration. We highlighted these concerns to the trust who undertook a review of the patient records and could not identify any failings in the care the patients received.

We asked the trust to provide audit data relating to compliance with completing National Early Warning Scores however, the trust provided data from 2016. This meant there was no assurance that each patient was having their vital signs monitored and a National Early Warning Score calculated. We reviewed 14 patient records and one did not have the patient’s vital signs documented.

The department was using a Paediatric National Early Warning Score system for the monitoring of vital signs in children to highlight early signs of deterioration in the child’s condition. There were different Paediatric National Early Warning Score forms used depending on the child’s age which considered differences for example in blood pressure and pulse which were different depending on the age.

We reviewed two Paediatric National Early Warning Score system forms and found they both been completed correctly and, where necessary, escalated to a senior decision maker.
Patients who walked into the department, or who were brought by families or friends, reported to
the reception area. Once initial details had been recorded patients waited in the waiting room and
then were called and triaged by a nurse. We looked at the records of 14 patients who had been
triaged the day prior to our inspection and found the assessments to be thorough.
The time between the time of arrival and triage for these 14 patients varied between 2 and 47
minutes.

Nurses told us they had completed specific training in triage and had been assessed as
competent before undertaking the role. Triage nurses could stream both adults and children to
the GP service that was located within the department or an out of hours GP service in the
community.

There was a separate triage room for children where they were triaged by a paediatric nurse.
After triage the nurse directed them to the most appropriate care setting. Children with minor
injuries were either sent to the GP service in the department or to the minors department for
assessment by an emergency nurse practitioner. Children with major injuries were directed to the
child majors area. This meant patients were cared for in the setting that was able to meet their
care needs.

If the children’s department had more than three children waiting for assessment a rapid
assessment form was used, this had been developed by one of the nurses. This allowed for a
quick assessment of children and ensured those who needed urgent treatment were not delayed
whilst awaiting triage.

Children who attended the department who were under six months old were referred to the trust
child service who either assessed them in the department or they went straight to the children
inpatient ward.

Staff used the National Early Warning Score to monitor and identify patient deterioration so that
treatment could take place as quickly as possible. This included determining a patient’s risk of
sepsis (a life-threatening infection of the blood). Suspected or confirmed cases of sepsis were
managed using the Sepsis 6 care bundle. Sepsis 6 is a nationally recognised six-step care bundle
that should be implemented within one hour. The steps are:

1. Administering oxygen
2. Taking blood cultures
3. Giving intravenous antibiotics
4. Giving intravenous fluids
5. Taking lactate measurements (a blood test)
6. Monitoring urine output

Regular audits of sepsis screening took place, previously the results from these audits showed
improvement was required. For example, in April 2017, 75% of patients with a National Early
Warning Score of four had been screened for sepsis. More recent data showed improvement in
the months between September 2017 and April 2018 except for March 2018 (85%) between 90%
and 100% of patients were screened. During our inspection we observed three patients being
rapidly screened for sepsis and receiving correct treatment (high levels of oxygen and intravenous
antibiotics) within one hour.

In the seven months prior to our inspection 100% of children had been screened for sepsis. This
meant any children presenting with sepsis received treatment quickly.
Risk assessments for nutrition and hydration, pressure ulcers, frailty and venous thromboembolism (blood clots) were not consistently completed or undertaken in a timely manner. For example, a patient in the observation area who had attended with a grade four pressure ulcer had no tissue viability assessment or a fully completed vital signs observation chart. Staff working in this area told us that the workload in this area was heavy and they did not have time to complete all the necessary assessments. This meant patients were not having their needs assessed and treatment implemented according to these needs.

Doctors told us that abdominal (tummy) and chest x-rays were not reviewed and reported on by a radiologist or radiographer. The doctors had to interpret these x-rays without the specialist training that a radiologist or radiographer had. This meant there was a risk that something on the x-ray could be missed and of the patient not receiving the correct treatment.

We asked the trust to provide an inclusion and exclusion criteria list for patients placed in the observation area. The trust provided a single sheet of paper which was undated and had a list of eight inclusion criteria for example, patients awaiting results of diagnostic tests. The document did not contain information about who agreed the criteria or who it was ratified by. Staff told us that any patients were put in this area and it was used to avoid the patient having a 12-hour breach. This meant acutely unwell patients could be placed in an area where their needs could not be met.

Every patient was meant to have a safety checklist completed whilst in the department. The safety checklist was broken down into three sections; checks undertaken within one hour, two hours and three hours of arrival in the department. The checklist included a variety of checks, which included but were not limited to; vital signs measured, identification wristband on patient, suspected sepsis (infection), blood tests and pain score. We reviewed five safety checklists and found that three were not fully completed.

Data supplied to us showed variable completion of the safety checklists between 16 February and 20 April 2018 compliance varied between 40% and 100%. The last five audits showed 100% compliance, this was not consistent with our findings during inspection.

If the department was crowded and several ambulances arrived in close succession there were not always enough nurses to look after newly arrived patients. When this happened, ambulance crews would stay with the patients after they had been triaged. This meant that they were not available to respond to other 999 calls.

A nurse triaged all patients and category assigned one to five depending on their condition. These categories were immediate resuscitation (1), very urgent or seriously ill (2), urgent patients with serious problems but stable (3), standard cases without immediate danger or distress (4) and non-urgent patients conditions are not true accidents or emergencies (5). All the patient records we viewed the patient had been assigned a category.

The majors area had 10 bays however, during our inspection patients were doubled up in each bay with one patient in front of another, staff told us this was a regular occurrence. This meant there was no suction or oxygen available for the patient who was in front. In addition, it would be difficult to access the patient at the back of the bay in an emergency and get emergency equipment to them. A member of staff told us that they were concerned how they would access a patient at the back of the bay in an emergency.

The children’s treatment area only had three bays and we observed during our inspection children were sat on chairs in the treatment area as there was insufficient space to care or observe them. The children’s waiting area was not visible from the children’s treatment area which meant children could not be observed by staff. Staff told us that this was not safe and they constantly had to sit patients in the treatment area so they could observe them.
A member of staff told us that “most of the time the department doesn’t feel safe never know where patient is” and that it was “confusing and chaotic patients are moved without communication”.

Although patients in the majors area had received treatment and were in a stable condition, there was still a risk that their condition could deteriorate unexpectedly.

The status of the department was reported live to the site management team via an electronic system. Site management meetings took place three times per day and were attended by senior staff from across the hospital, but not always by a representative from the emergency department.

Patients arriving by ambulance as a priority (blue light) call were taken immediately to the resuscitation room. Such calls were phoned through in advance so that an appropriate team could be alerted and prepared for the arrival of the patient.

The service had access to psychiatric liaison support 24 hours a day seven days a week, there was two staff members on duty throughout the 24hr period. They were available on the phone for advice or could review patients in the department.

There was a trust lead for sudden, unexpected deaths in infancy and childhood who could be easily accessed to provide support and guidance. We saw the department had sudden, unexpected deaths in infancy and childhood box, which contained items that might be required.

De-briefs were regularly undertaken for staff to provide support after involvement in distressing situations. Staff gave an example of when a child died a consultant undertook a de-brief with the staff involved including ambulance staff who had also treated the child. This provided support to staff, gave them the opportunity to ask questions and obtain further information. Staff were extremely positive about the de-briefs.

A hospital in Canterbury provided a place of safety, which the service could access. The Mental Health Act gives police powers to take people who appear to be suffering from a mental health disorder to a place of safety for assessment for up to 72 hours - in the interests of the health or safety of the person, or the protection of the public. Patients could be transported by ambulance with police escort from the department if required.

**Nurse staffing**

The trust reported their registered nursing staff numbers as below as of December 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>77</td>
<td>82</td>
</tr>
</tbody>
</table>

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

**Bank and agency staff usage (nursing staffing)**

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

From February 2017 to January 2018, the trust reported a bank and agency usage rate of 73% in this core service;

- Queen Elizabeth The Queen Mother Hospital: 77%
A team of 82 nurses, supported by a team of healthcare assistants, associate practitioners and technicians, led nursing care in the department.

There was one band seven nurse who was the nurse in charge of each shift, one band six who co-ordinated each shift, two health care assistants, four technicians and five band five nurses on each shift. We looked at the roster for the month prior to our inspection and found that the planned number of staff were on duty at all times.

Adult nurse staffing levels within the department met national guidance. The service did not always have 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. There were insufficient registered children’s nurses in post to ensure that the children’s emergency department had at least one registered children’s nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments. Between the hours of 07:30am and 10pm there was a children’s nurse within the children’s department, outside of these hours adult nurses cared for children. This meant that there was not always a nurse on duty who had undertaken additional child resuscitation training. Since our inspection the trust have provided assurance that there was now competent staff supporting children in the department at night.

Children’s nurses undertook a variety of competencies to ensure they had the skills and knowledge to undertake their role. A children’s nurse confirmed that they undertook these when they had joined the department and they were reviewed yearly as part of the appraisal process.

The staffing establishment for children’ nurses was for 5.6 whole time equivalent nurses however, only three were currently in post. The matron had been told they could not advertise for the vacant positions and there was no business case proposal for 24/7 cover.

The matron told us that adult nurses who cared for children undertook a three-monthly orientation to obtain the skills and knowledge required to care for children. We asked the trust how many adult nurses had undertaken the orientation. The trust said that they had just started to rotate nurses into the children’s department and had now started to place two adult nurses in the children’s department when they would work in addition to the usual staffing numbers. The trust also told us that they had started to develop children competency documents for adult nurses to undertake. This meant adult nurses would learn new skills and would be assessed and supervised before undertaking them unsupervised.

The lack of children’s nurse provision was not highlight on the departments risk register. This meant the risk had not been fully assessed, understood and measure put in place to mitigate the risk.

Not all the nurses were employed by the trust, some came from a temporary staffing agency. Staff told us that most of the agency nurses worked regularly in the department and were familiar with local working practices. When a new temporary nurse arrived, they were given an induction pack which briefly explained how the department worked. They discussed this with a permanent member of staff and signed to say that they had read and understood the pack. We spoke to an agency nurse who confirmed this happened when they started.

Staffing levels were reported at the hospital-wide capacity management meetings three times a day. Staff told us that during busy periods over the winter months staff from other areas in the hospital provided support to the department.

Planned staffing levels and actual staffing levels were displayed within the department. This meant that staff and visitors were aware of the staffing levels on the day.
Seasonal variations and increased demand was managed by the department’s escalation plan and the trust’s business continuity plans. The department’s current escalation level was displayed on a television screen within the department this meant staff and visitors were aware of the current escalation status.

There was a nursing handover at the end of each shift to the incoming nurse in charge. The handover included any patients in the department who were acutely unwell, the escalation status, staffing status and any pressures effecting flow within the department.

**Vacancy rates**

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

From January 2017 to December 2017, the trust reported a vacancy rate of 15% in urgent and emergency care;

- Queen Elizabeth The Queen Mother Hospital: 18%

This is in comparison to the trust target vacancy rate of 10% or less.

(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.

From January 2017 to December 2017, the trust reported a turnover rate of 17% in urgent and emergency care;

- Queen Elizabeth The Queen Mother Hospital: 21%

This is in comparison to the trust target turnover rate of 13% or less.

(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.

From January 2017 to December 2017 reported an overall sickness rate of 4% in urgent and emergency care. A breakdown by site for nursing staff is as below;

- Queen Elizabeth The Queen Mother Hospital: 3%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)
Medical staffing
The trust reported their staffing numbers for medical staffing as of December 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>15</td>
<td>4</td>
</tr>
</tbody>
</table>

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

Bank and locum staff usage (medical staffing)
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

From February 2017 to January 2018, the trust reported a bank and locum usage rate of 43% in this core service.

- Queen Elizabeth The Queen Mother Hospital: 30%

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

From January 2017 to December 2017, the trust reported a vacancy rate of 38% in urgent and emergency care;

- Queen Elizabeth The Queen Mother Hospital: 67%

This is in comparison to the trust target vacancy rate of 10% or less.

(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.

From January 2017 to December 2017, the trust reported a turnover rate of 12% in urgent and emergency care;

- Queen Elizabeth The Queen Mother Hospital: 13%

This is in comparison to the trust target turnover rate of 13% or less.

(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.
From January 2017 to December 2017 reported an overall sickness rate of 4% in urgent and emergency care. A breakdown by site for medical staff is as below;

- Queen Elizabeth The Queen Mother Hospital: 0%

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

Medical staffing was identified as a safety concern at previous inspections. There was still insufficient medical cover to provide consultant presence in the department for 16 hours a day, as recommended by Royal College of Emergency Medicine. Cover was for 14 hours a day.

The department employed four full time equivalent consultant doctors and there were two long term consultants and two substantive locum consultants. Their rota ensured a consultant presence from 8am until 10pm. There was a consultant on-call outside of these hours. The consultant provided senior medical leadership for both the adult and children’s department.

The shortage of permanent consultants or the lack of consultant cover for the department was not identified on the departments risk register. This meant the risks had not been properly assessed, understood or measure put in place to mitigate the risk.

In addition to the consultants there were two senior grade doctors and 12 middle grade doctors there was two middle grade vacancies. Outside of the hours of 8am and 10pm they provided medical leadership for both departments. Two new middle grade doctors had recently joined and received two weeks induction when they worked in addition to the usual numbers of doctors on duty.

Junior doctors or doctors in training did not work within the departments as there were insufficient permanent consultants to support their training needs. Middle grade doctors spoke positively about working in the department. They told us that the consultants were supportive and always accessible. In-house teaching was well-organised and comprehensive and occurred monthly.

The trust told us they had received additional support from National Health Service Improvement and National Health Service England to try and recruit consultants. There was a rolling advertising programme to try and recruit staff. The trust had recently updated their adverts for consistency across the trust, highlighting their career development opportunities in the department as an incentive.

**Staffing skill mix**

As of December 2017, the proportion of consultant staff reported to be working at the trust was about the same the England average and the proportion of junior (foundation year 1-2) staff was lower.
Staffing skill mix for the 46 whole time equivalent staff working in Urgent and Emergency Care at East Kent Hospitals University NHS Foundation Trust.

![Bar chart showing staffing skill mix](chart.png)

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>34%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate records of patients’ care and treatment. Records were clear, up-to-date. However, the electronic patient systems used by the department and the mental health service were different and did not interact together.

The emergency department and the provider of mental health services use two different electronic patient systems. The two systems did not communicate with each other. This meant the staff in the emergency department did not have the full psychiatric history of the patients attending. In practice the mental health team would access the patient’s mental health history on their system prior to assessing the patient in the emergency department. After treating the patient, they then wrote up their assessment and treatment on paper which was then scanned into the emergency departments system. This was an issue as there was not a full and immediate transfer of information between the two electronic systems.

The service used mainly an electronic patients system, with some paper records which included the National Early Warning Score form and the patient’s registration form. We reviewed 20 electronic records during the inspection apart from missing National Early Warning Scores and documented actions, records were generally clear and up-to-date.

We asked the trust to provide data on any audits undertaken on the quality of patient records however, the department had not undertaken any audits. This meant there was no assurance that the quality of records was monitored.

When not in use, paper documents were held in storage racks which were supervised at all times. When patients left the department the paper record was scanned on to the computer system to allow access to records for patients who had previously attended the department. Paper records were disposed of using a secure shredding service that ensured patient information was kept safe.
Administration staff told us that doctors did not always code the procedures or diagnosis on the electronic patient system and they were expected to do this but they had not received training. This meant patients could have treatment and diagnoses incorrectly recorded.

Patient records and information stored on computer was protected by passwords and backed-up to keep it secure. All records we reviewed contained information on patient’s physical, mental and social needs.

Discharge summaries were electronically generated and sent to the patients GP by email.

Monthly meetings were undertaken between mental health liaison team, local ambulance service, Clinical Commissioning Groups and emergency department leads to review frequent attendees. This ensured patients care plans were developed for patients and they received appropriate interventions to reduce unnecessary attendances to the emergency department.

The electronic patient system allowed alerts to be added to patients, there was a symbol next to the patient name. This meant patients with allergies or pre-existing physical or mental health illnesses were highlighted and prompted staff to look what the alert was.

**Medicines**

Staff prescribed, gave and recorded medicines well. Patients received the right medication at the right time. However, the service did not monitor that medicines were always stored correctly.

Pharmacy were responsible for checking the expiry dates of the medicines and to ensure they were safe to use. Daily support was provided by a pharmacy technician who supplemented the central monitoring checks with stocktaking.

We saw there was a protocol in place for administrating medicines to children. There was a policy, which set out specific medicines, which required two qualified members of staff to double check the preparation and administration.

There were a variety of adult and paediatric patient group directives used within the department. A patient group directive is signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines to patients using the nurses own assessment, without necessarily referring back to a doctor for a prescription. Staff were assessed before they could issue patient group directives, this ensured they had the skills and knowledge.

Associate practitioners could administer certain medicines to patients instead of a qualified nurse, for example paracetamol and Ibuprofen. They were required to complete the trust two-day medicine administration and calculation course the same as the qualified nurses. On completion of the course all staff were assessed administering medicines to ensure they did so safely.

We saw intravenous fluids had recently been relocated to a different storage area which ensured they were kept in a locked cupboard. This was in line with national guidelines.

All the medicine charts we reviewed had any allergies clearly documented. This alerted staff to the patient’s allergies.

Daily fridge temperature monitoring records were not complete. This meant there was no assurance that medicines were stored in line with manufacturer’s guidelines. For example, the fridge in the resuscitation area did not have documented checks on 03,05,07 and 08 May 2018.

We saw that empty and full oxygen gas cylinders were stored together, this meant an empty cylinder could be attached in error. In addition, cylinders were not secured to the wall which meant they could be stolen or could fall over and injure someone. This was not in line with the Health and
Safety at Work Act or Department of Health guidelines in the storage of medical gases. We informed the nurse in charge about the cylinders who said they would discuss the issue with the portering staff, when we returned the next day we saw they were still stored together. Since the inspection the trust informed us that new storage racks for the cylinders to ensure they were secure and full and empty cylinders were segregated.

Medicines (except for medical gas cylinders) were stored securely within locked rooms and cupboards with access restricted to authorised staff.

Resuscitation trolleys containing medicines and equipment required in an emergency were accessible. Checks were in place to ensure emergency medicines were available and safe to be used.

Members of the pharmacy team undertook medicine reconciliation to ensure patients’ medicines were available as well as checking for safe prescribing. Any known allergies or sensitivities to medicines were recorded on medicine charts. This information is important to prevent the potential of a medicine being given in error and causing harm.

Controlled drugs were stored and dispensed in line with the Misuse of Drugs Regulations 2001. Controlled drugs are medicines liable for misuse that required special management. We checked the controlled drug records, which were fully completed, with no omissions. However, the controlled drug ordering book was not securely stored within the resuscitation department which meant it could be stolen and potentially misused.

There were local microbiology protocols in place for the administration of antibiotics, for example for the management of sepsis. We saw these were available on the trust internet for staff to access. However, we saw the trust sepsis policy was due for renewal in March 2018. This meant the policy might not reflect the most up to date guidelines and best practice.

In the 12 months prior to our inspection the department reported 188 medicine errors. The top theme (75) in relation to the errors was an error in the administration of the medicine and 50 related to an error in the administration of a medicine.

The department held a stock of Parkinson’s Disease medicines, for patients who attended with this disease. Parkinson’s must be given at the same times every day so this ensured the department was able to administer these medicines without delay.

Incidents

The management of patient safety incidents needed improving. Staff recognised incidents and reported them appropriately. Managers investigated incidents however lessons learned were not always shared with the whole team or the wider service. For example, we were told that lessons learned were shared at handover but we could only find one example of this in the handover folder. However, we reviewed root cause analysis reports and saw when things went wrong, staff apologised and gave patients honest information and suitable support.

Staff told us that they rarely received any feedback on the incidents they had reported. This meant staff were unsure if the incident had been investigated and lessons learnt.

The matron told us that when they started in the role a year ago there was a backlog of incidents and shared learning from incidents was limited.

Staff could give us feedback and learning from an incident when the wrong child’s head wound was treated. Staff told us that they now always verbally check the identity of patients before undertaking any treatment.
Departmental meetings and forums did not follow a set agenda and meeting minutes were not produced and distributed to staff to read. We reviewed the meeting agenda from May and April 2018 of the emergency department governance and patient safety meeting which did not include incidents as a standard agenda item. This meant there was not a process which ensured incidents were discussed regularly and lessons learnt.

In the 12 months prior to our inspection, the department reported 5476 incidents. Of these incidents the most commonly reported incident (1431 incidents) related to tissue viability of pressure ulcers, the second most reported incident (429) related to patient falls and the third most commonly reported incident (188) related to medicine errors.

Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

We saw evidence that the duty of candour (DOC) regulation had been applied. The trust’s root cause analysis report and electronic incident reporting system contained a section for duty of candour. It included checks that the patient and/or relative had been given a verbal apology, they had received a trust letter and been given a point of contact as well as an offer to share the outcome of the investigation.

Monthly mortality and morbidity meetings were undertaken and attended by the multi-disciplinary team. Mortality and Morbidity meetings, review deaths as part of professional learning, have the potential to provide hospital boards with the assurance that patients are not dying as a consequence of unsafe clinical practice. We saw in the monthly meeting minutes that the meetings were used to improve patient care. For example, we saw the May 2018 meeting discussed considering early Intraosseous access in critically unwell conscious patients if IV access not secured in clinically appropriate time frame. Intraosseous access is the process of injecting medicines and fluids directly into the marrow of a bone.

**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 March 2017 to February 2018, 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 5 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from March 2017 to February 2018.

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

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (40% of total incidents)
- Treatment delay meeting SI criteria with two (40% of total incidents)
Medication incident meeting SI criteria with one (20% of total incidents)

(Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

We asked the trust to provide three root cause analysis and action plans for three serious incidents. The trust only provided these for the William Harvey hospital and not Queen Elizabeth Queen Mother hospital.

We looked at the two root cause analysis reports for the William Harvey hospital and these followed the NHS Serious Incident Framework by an independent member of trust staff. During our inspection we reviewed the root cause analysis and action plan of a serious incident which related to the treatment a diabetic patient received when they attended the department. We saw a comprehensive investigation had been completed, an action plan completed and learning identified. Each action had a member of staff allocated to it and a completion date. This meant there was somebody responsible for the action and a date when it should be completed. For example, we saw the department induction pack had been changed to contain information on treating diabetic patients and who to call if additional guidance was required.

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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, six falls with harm and eight new urinary tract infections with a catheter from February 2017 to February 2018 within urgent and emergency care.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Kent Hospitals University NHS Foundation Trust

Insert commentary on any trends.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Although the service participated in national audits, local audits undertaken were limited and results were not compared with those of other services to learn from them. For example, no records audits were undertaken. This meant the service could not be assured of compliance within these areas.

We observed the service provided care and treatment based on national guidance and evidence of its effectiveness. However, there was limited oversight which checked to make sure staff followed guidance. In addition, Clinical guidelines had not been updated which meant they might not reflect the current best practice guidelines.

The emergency department provided care and treatment that was based on national guidance. This included National Institute for Health and Care Excellence and the Royal College of Emergency Medicine standards. Clinical pathways were in place for serious conditions, such as heart attacks and strokes. Staff were aware of pathways to follow and could demonstrate how to access this information.

There was an audit programme that monitored the implementation of guidance from national clinical organisations. Action plans were put in place if any shortcomings were discovered. For example, as a result of the Royal College of Emergency Medicine procedural sedation audit patients who were given sedation whilst in the department were now given an information leaflet when they were discharged. This contained details of the type of sedation they had and what to do if they experienced any problems.
Although the department took part in national benchmarking clinical audits including Royal College of Emergency Medicine audits local audits undertaken were limited. The consultant lead told us that this was because there was a lack of permanent consultants to take a lead on them and ensure they were undertaken.

The department completed audits to monitor compliance with the guideline National Institute for Health and Care Excellence NG51 Sepsis: recognition, diagnosis and early management. This included monitoring compliance with sepsis screening and use of the Sepsis 6 care bundle. For example, in April 2017 91% of patients with a National Early Warning Score of four or above had been screened for sepsis. During our inspection we observed three patients being rapidly screened for sepsis and receiving correct treatment (high levels of oxygen and intravenous antibiotics) with one hour.

Patients were assessed using evidence-based tools, such as the National Early Warning Score and Paediatric Early Warning Score. However, the department did not undertake any audits on compliance with National Early Warning Score or Paediatric Early Warning Score and we found inconsistencies during our inspection.

We reviewed the department clinical guidelines (paper version) which had all expired the review date. A member of staff was unable to locate the electronic versions of these on the trust’s website. Clinical guidelines provide best practice guidance on how to treat injuries and illnesses. This meant the care provided might not reflect the latest best practice guidelines.

Mental health assessments, interventions and treatments offered were in line with National Institute for Health and Care Excellence guidance. Patients who were suspected to be experiencing depression were referred to the mental health liaison team.

**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 about the same as than other trusts.

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

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients’ religious, cultural and other preferences but these were limited due to the constraint of the facilities.

There were limited facilities within the department for preparing food and drink for patients and visitors. Hot drinks for patients had to made in the staff room, which could often be busy and crowded. There was no kitchen in the department therefore the kitchen on a nearby ward was used to prepare for patients. Food and drink had to be pre-ordered and delivered to the kitchen, there was a selection of sandwiches available throughout the day and night.

A member of staff told us “it’s a struggle but we do get the patients fed”. There was a limited menu available to patients in the emergency department due to the constraints of only having access to a microwave on another ward. For example, no jacket potatoes or hot deserts were available. This meant there was a limited choice for patients.

We observed staff offering tea and biscuits to a patient and their relatives and asking their preferences on how they liked their hot drinks prepared. However, two patients told us they had not been offered anything to eat or drink whilst in the department.
There was a drinks dispenser and water fountain in the waiting area for patients and visitors to use.

**Pain relief**

Three different pain assessment tools were in use. The adult pain tool was a score between 0 and 10, zero being no pain and 10 being the worst pain a patient had ever experienced. The paediatric assessment tool was picture of faces with different expressions; a smiley face meant no pain and a sad face being extreme pain. The Abbey Pain score was used for the assessment of pain in patients who could not verbalise for example patients living with dementia or patients with communication difficulties.

Patients told us they were regularly asked if they were in pain or required pain relief and it administered quickly when it was required.

The service had undertaken pain audits but the results had not been verified at the time of the inspection. We reviewed 14 patient records and found 13 had a documented pain score.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.5 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.3 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
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</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>you got it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>pain?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>department?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Patient outcomes**

We saw that the trust had participated in national audits such as those identified by the Royal College of Emergency Medicine. The results were used to benchmark and compare with other trusts nationally.

Results were varied. Although there were areas where the department performed similar to the national average, results generally did not meet national standards, except for the Royal College of Emergency Medicine Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16. Performance in the Royal College of Emergency Medicine Audit: Severe sepsis and septic shock 2016/17 was also varied.

There was a clinical audit lead in place for the department and they would lead on audit completion and compliance There was limited local audits undertaken for example, there was no hand hygiene, pain and Early Warning Scores audits. This meant there was no assurance of compliance or performance in relation to these audits.
The trust participated in the national trauma audit and research network. The national trauma audit and research network provides important information about the rates of survival for patients who have been injured and treated at different hospitals across England and Wales. It also provides information about the benefits of certain kinds of treatment.

National trauma audit and research network data showed between 01 April 2017 and 31 December 2017 that 0% of patients were seen in the department by a consultant within five minutes of arrival. This was below the trauma unit average of 14% and was had has remained at the same level compared to previous year.

The department participated in the March 2018 national trauma audit and research network: Core measures for all patients audit. Audit results demonstrated an improvement in one standard, stayed the same in one standard and deterioration in two standards.

RCEM Audit: Moderate and Acute Severe Asthma 2016/17 – Queen Elizabeth The Queen Mother Hospital

In the 2016/17 Moderate and Acute Severe Asthma report, Queen Elizabeth The Queen Mother Hospital failed to meet any of the standards.

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

- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  o Standard 5b (fundamental): within 4 hours (moderate). Hospital: 50.6%; UK: 28%.

The hospital was in the lower UK quartile for two standards:

- Standard 1a (fundamental): O2 should be given on arrival to maintain oxygen saturations 94-98%. Hospital: 2%; UK: 19%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

  Hospital: 32.4%; UK: 52%.

The hospital’s results for the remaining four metrics were all between the upper and lower UK quartiles.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Hospital: 21.8%; UK: 26%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 14.9%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Hospital: 77.3%; UK: 77%.
- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
- Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
- Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). Hospital: 10%; UK: 19%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17 – Queen Elizabeth The Queen Mother Hospital

In the 2016/17 Consultant sign-off audit, Queen Elizabeth The Queen Mother Hospital failed to meet any of the standards.

The hospital was in the upper UK quartile for three standards:

- Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the department with the same condition within 72 hours of discharge. Hospital: 27.3%; UK: 12%.
- Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 24.5%; UK: 10%.

The hospital’s result for the remaining one standard was between the upper and lower UK quartiles.

- Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Hospital: 13.1%; England: 11%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17 – Queen Elizabeth The Queen Mother Hospital

In the 2016/17 Severe sepsis and septic shock audit, Queen Elizabeth The Queen Mother Hospital was in the upper UK quartile for three standards:

- Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 76.4%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 61.8%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 58.2%; UK: 44.4%.

The hospital was in the lower UK quartile for three standards:

- 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. Hospital: 0%; UK: 69.1%.
• Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 7.6%; UK: 30.4%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 0%; UK: 18.4%.

The hospital’s results for the remaining two metrics were all between the upper and lower UK quartiles.

• 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. Hospital: 63.6%; UK: 64.6%.

• Standard 4: Serum lactate measured within one hour of arrival. Hospital: 63.6%; UK: 60%.

(Source: Royal College of Emergency Medicine)

Sepsis Six data showed over 90% of patients had been screened for sepsis for the last consecutive seven months except for November 2017 (82%). Audit data showed varied performance in relation to patients receiving antibiotics within one hour. Between January 2017 and March 2018 compliance varied between 35% (January 2017) and 96% (March 2018). Performance showed improvement over the last seven consecutive months except for November 2017 50%. This meant improvement was still required to ensure patients received antibiotics within one hour.

In January 2017 the trust was identified as being a mortality outlier alert for ‘septicaemia’ (blood infection) (except in labour). Since this the trust had undertaken a thorough review in the management of patients with sepsis and had created an action plan. The progress of the action plan and implementation of changes was undertaken by the Deteriorating Patient Group and the emergency department governance and patient safety meeting which met monthly. Actions implemented included health care assistants undertaking Bedside Emergency Assessment Course for healthcare staff and clinical induction for all new clinical starters (doctors, nurses, health care assistants, allied health professionals).

It was possible to add an alert to a patient on the computer system for patients with or suspected sepsis, this acted as a visual reminder for staff. In addition, it alerted consultants when reviewing patients within the department.

RCEM Audit: Vital signs in children 2015/16 – Queen Elizabeth The Queen Mother Hospital

In the 2015/16 Vital signs in children audit, Queen Elizabeth The Queen Mother Hospital failed to meet any of the standards.

The hospital was in the lower England quartile for two fundamental standards and four developmental standards:

• Standard 1. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
  o Standard 1a (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Hospital: 10.3%; England: 37.6%.
  o Standard 1b (developmental). Capillary refill time. Hospital: 2.6%; England: 22.5%.
• Standard 2 (developmental). 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. Hospital: 0%; England: 4.4%.

• Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Hospital: 46.4%; England: 69.7%.

• Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital: 53.6%; England: 73.2%.

• Standard 5 (developmental). 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). Hospital: 0%; England: 60%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16 – Queen Elizabeth The Queen Mother Hospital

In the 2015/16 Procedural sedation in adults audit, Queen Elizabeth The Queen Mother Hospital failed to meet any of the audit standards (which were all 100%).

The hospital was in the lower England quartile for two fundamental standards:

• Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Hospital: 56.8%; England: 90%.

• Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  o Standard 7a. (fundamental): Return to baseline level of consciousness.
  o Standard 7d. (fundamental): Absence of significant pain and discomfort.

Hospital: 0%; England: 2.6%.

The hospital’s results for the remaining five metrics were all between the upper and lower England quartiles.

• Standard 1 (fundamental): Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
  o Standard 1a. ASA grading
  o Standard 1b. Prediction of difficulty in airway management
  o Standard 1c. Pre-procedural fasting status

Hospital: 21.6%; England: 7.6%.

• Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Hospital: 27.8%; England: 51.8%.

• Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  o Standard 4a. A doctor as seditionist
  o Standard 4b. A second doctor, ENP or ANP as procedurist
  o Standard 4c. A nurse

Hospital: 18.9%; England: 40.8%.
• Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
  o Standard 5a. Non-invasive blood pressure
  o Standard 5b. Pulse oximetry
  o Standard 5c. Capnography
  o Standard 5d. ECG
  Hospital: 10.8%; England: 23.9%.

• Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Hospital: 32.4%; England: 41%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast 2015/16 – Queen Elizabeth The Queen Mother Hospital

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit, Queen Elizabeth The Queen Mother Hospital failed to meet one of the audit standards (which were both 100%).

The hospital was in the upper England quartile for one of the two standards:

• Standard 1 (fundamental): If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. Hospital: 100%; England: 100%.

The hospital’s results for the remaining metric was between the upper and lower England quartiles.

• Standard 2 (developmental): 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. Hospital: 2%; England: 2%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within 7 days

From February 2017 and September 2017, the trust’s unplanned re-attendance rate to the department within seven days was generally better than the national standard of 5% and generally better than the England average. From October 2017 to January 2018 the rate was worse than the national standard and England average.

In January 2018, trust performance was 9.4% compared to an England average of 7.6%.
The service generally made sure staff were competent for their roles. Managers appraised staff’s work performance however supervision meetings with them to provide support and monitor the effectiveness of the service were limited. For example, the emergency nurse practitioners did not have regular supervision to ensure they were competent to fulfil their role.

Children were looked after by adult nurses after 10pm this meant they may not have the necessary skills and knowledge to look after children. This meant children treated after 10pm did not receive care and treatment from an appropriately trained nurse. In addition, staff told us that during busy periods adult nurses triaged children. Since our inspection the trust have provided assurance that there was now competent staff supporting children in the department at night.

The trust told us that adult nurses who worked in the Children’s department underwent a three-month orientation programme. However, the trust was unable to supply us with information regarding the number of nurses who had undertaken this. Since our inspection the trust informed us that there was a rolling programme to ensure adult nurses were orientated to the Children’s department to gain the necessary skills and knowledge to care for children.

Two of the four consultants working in the department was on the General Medical Council Specialist Register and had completed and passed their specialist medical training in emergency medicine. The Specialist Register is a list of doctors who are eligible to take up appointment in any fixed term, honorary or substantive consultant post in the NHS excluding foundation trusts. East Kent NHS trust is a foundation trust.

Doctors working in the department attended teaching sessions in the care and treatment of children. The last training session was on paediatric (children) and neonatal (new born children) emergencies. Doctors were also able to attend, the paediatric simulation day organised by the
paediatric department. In addition, the department monthly simulation sessions which included adult and child simulations.

The department had a clinical facilitator who supported new staff to the department.

Middle grade doctors were positive about the learning and teaching opportunities within the department. They had access to scheduled monthly and weekly teaching sessions. We saw a variety of subjects were covered at these teaching sessions for example twice weekly usually undertaken by one of the department’s consultants and we observed consultants undertaking bedside teaching.

The department employed technicians who undertook tasks including but not limited to closure of minor wounds, taking blood samples, electrocardiographs (recording the electrical activity of the heart, dressing of wounds and application of plaster casts. Technicians undertook competencies in these roles to ensure they had the correct skills and knowledge. They were observed five times and then a qualified nurse assessed their competency and signed to say they could undertake the task.

The department employed associate practitioners who supported qualified staff, they undertook a two-year foundation degree course which gave them the skills and knowledge to undertake their role.

There was an induction programme for all permanent staff, we reviewed this and saw it was comprehensive. Agency and locum staff also received induction to the department and we saw completed induction plans. We spoke to an agency nurse who confirmed they had a comprehensive induction. Locum doctors were used within the department, the same staff were used who were familiar with the department and its policies.

Nurses caring for patients in the resuscitation department did not have a Trauma Immediate Life Support training. This meant nurses might not have the necessary skills and knowledge to care for trauma patients. There was a plan to ensure all nurses had received this training by November 2018.

**Appraisal rates**

From April 2017 to December 2017, 72% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 85%

Queen Elizabeth The Queen Mother Hospital had an 88% appraisal completion rate. This was better than the trust target and had improved since last year.

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

**Multidisciplinary working**

The multidisciplinary team worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide care. However, staff told us that there was no support and a lack of engagement from specialist teams for example the specialist medical team. Staff felt specialist teams did not review patients in a timely manner which meant patients had to wait unnecessarily in the department.

Cross-site bed meetings were undertaken at least three times a day, these were undertaken via teleconference with the equivalent staff roles at the other hospital sites within the trust. The purpose of this call was to discuss patient discharges, admissions, staffing, infection control and extra resources required.
A frailty team made up of nurses and geriatricians supported the department. The frailty team assessed acutely unwell patients and identified the most appropriate care pathway. Staff could make direct referrals to the frailty team.

The integrated discharge team made up of physiotherapists and occupational therapists supported patients who required additional support to be discharged home. They worked in the department alongside the team and assessed patients before they were discharged home. They liaised with care agencies and social services to ensure patient had the necessary care in place before being discharged home.

The department had established links with mental health services, learning disability, autism and dementia services within both the trust and external agencies. We saw there was a resource folder with a contact list to assist staff in making referrals.

The mental health team had well established links with the local mental health trust and the local police liaison. The mental health team had recently completed a project with local General Practitioners in the local area to support and manage frequent attendees at the emergency department and had identified a caseload of 32 that they were currently reviewing with the aim to reduce attendance at hospital.

We observed excellent multidisciplinary working within the department, friendly interaction between all grades of staff and the culture was non-hierarchical.

A dedicated pharmacist and technician worked in the department who provided oversight of medicines management and support for staff.

**Seven-day services**

The department was operational 24 hours a day, seven days a week.

Emergency department consultants provided cover in the department 8am and 10pm Monday to Friday and 8am and 7pm on Saturday and Sundays. Outside of these hours consultants were on-call at home to provide support and advice.

Patients could access diagnostic imaging services at all times, in line with the NHS Services Seven Days a Week Priority Clinical Standards. The department had access to radiology support 24 hours a day seven days a week. There was rapid access to computerised tomography scanning when indicated.

Mental health liaison nurses were available 24-hours, seven days a week. They were provided by an external organisation and were permanently based in the hospital. A doctor was available overnight and provided additional support for patients with mental health needs.

There was an intravenous (into a vein) access team who supported the department taking blood samples and inserting cannulas (thin tube into a vein to give medicines or fluids). They provided the service between 6am and 10pm seven days a week.

A play specialist was available to support the Children’s department between 8am and 5pm seven days a week.

The integrated discharge charge provided support to the department between 8am and 6pm seven days a week.

**Health promotion**

We saw there were posters in the department informing patients and visitors about a particularly dangerous type of ecstasy tablets that were in circulation in the local area.
Staff took the opportunity, if it arose and was appropriate, to discuss smoking cessation, weight reduction, and drug and alcohol misuse with patients. There were leaflets and contact details of relevant organisations that may be able to offer support and advice to patients. There was information on recognising sepsis and a variety of information leaflets regarding specific conditions and treatment.

**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.

There were no patients detained under the Mental Health Act at the time of the inspection however the staff were aware of the links with the mental health team and how to access the Mental Health Act support if required. There was a procedure which clearly identified the responsibilities of the mental health team in relation to arranging a Mental Health assessment.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients was on their treatment was varied. We observed several interactions between staff, patients and relatives. Staff were always polite, respectful and professional in their approach in the interactions we observed. We observed staff responding compassionately to patient’s pain, discomfort, and emotional distress in a timely and appropriate way.

However, we observed and heard of instances when patients’ dignity and respect had been compromised. For example, during busy periods we saw patients in the majors area doubled up one patient in front of the other. We saw patients were having blood taken and have cannulas (tube into a vein to give fluids and medicines) inserted in full view of other patients and visitors in the majors area.

Feedback we received from patients was varied for example, one patient said, “It was awful I was treated on a chair in front of everyone”. Positive comments from patients included “I can’t fault it” and “I have been well looked after, nothing to complain about”.

One nurse told us “I couldn’t be a nurse over the winter months, I didn’t have time to be a nurse over the winter months felt not caring for patients properly”. Another staff member told us “care was compromised during busy times and have to examine patients in the corridor”.

There was no privacy and little confidentiality for patients waiting on trolleys in the majors area corridor. Staff were frustrated about this situation and were as discrete and considerate as possible. Patients were moved to a more private cubicle when intimate care was needed.

Confidentiality was provided to patients at reception by means of signs asking people to stand at a distance from the reception desk. Receptionists were welcoming and took trouble to inform and reassure patients and their families.
Communication with children was well thought out, age appropriate and effective. We observed a nurse explaining to a patient about the possible sources of their infection and what the different antibiotics were for.

We observed staff asked patients what name they wished to be called by whilst in the department and checked if patients were warm enough. Staff displayed an understanding and non-judgmental attitude towards patients.

Friends and Family test performance

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from January 2017 to December 2017.

As of January 2017, the trust performance was 73% compared to the England average of 87%.

A&E Friends and Family Test Performance - East Kent Hospitals University NHS Foundation Trust

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients to minimise their distress.

We attended a hub meeting between all the services in the hospital, we observed all discussions identified patients’ emotional needs.

We heard one patient kept apologising to nursing staff “for being a pain”, the nurses caring for the patient frequently reassured the patient that they weren’t being a pain and holding their hand to reassure them.

We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.

Multi-faith chaplaincy services were available twenty four hours a day seven days a week for people who would benefit from spiritual support.
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 and their families told us they were kept informed of all care and treatment due to be carried out.

We observed that staff spoke to children in a way that they could understand and tried to make things fun and used toys as a distraction.

Posters throughout the department reminded patients to check they had understood their discharge instructions before leaving the department and in what circumstances they should return.

We observed staff asked patients if they wanted them to inform their family that they were in accident and emergency. For example, a member of staff asked a patient who was in the resuscitation area if they wanted them to contact their husband.

The integrated care team worked closely with family members to ensure discharge packages were appropriate, and they were comfortable with the arrangements.

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 20 of the 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>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.4</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>8.7</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>6.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or</td>
<td>7.9</td>
<td>Worse than other</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>treatment was given to you?</td>
<td></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>7.1</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>8.6</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>7.4</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>5.6</td>
<td>About the same as 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>7.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.6</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>9.4</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>4.9</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>5.0</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>4.9</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</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
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<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>watch for after you went home?</td>
<td></td>
<td>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>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

Is the service responsive?

Service delivery to meet the needs of local people

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

The department had acknowledged the mental health needs of the local population and had access to mental health services 24 hours a day seven days a week via the mental health liaison team.

There were no learning difficulty or dementia champions in the department to support the additional needs of these patients. However, the hospital had two substance misuse advisors and a learning difficulty lead who staff could access if required.

There was an ambulatory care service that staff could refer to for patients who needed an urgent review but did not need to be admitted to hospital. A referral was made and the patient usually returned the following day to the ambulatory care service for assessment. We saw staff making referrals to the service during our inspection.

To meet the needs of local people when Queen Elizabeth Queen Mother emergency department hospital was full, ambulances were diverted to the Kent and Canterbury hospital. There was a protocol for ambulance crews to follow that involved contacting Queen Elizabeth the Queen Mother staff prior to diverting, to establish how many extra ambulances they could accept.

There were dedicated disabled toilets available in both the adult and paediatric waiting areas. There was a hearing loop available for use by patients with a hearing impairment. A relatives’ room was available for private conversations.

There was a pathway for children, which ensured children attending were triaged, assessed and treated away from adult pathways.

There was a standard operating procedure was in place between the air ambulance service and the department to provide rapid transfer of trauma and severely medically unwell patients by helicopter.

The department had access to interpreting services for people whose first language was not English. Staff we spoke with told us that family members were never used for interpreting. Staff demonstrated to us how they would obtain access to translation services.
The waiting area had been designed with adequate seating and patients were offered a chair to use when booking in to the department. Signage and information in the department was clear which enabled patients and visitors to navigate the department.

The service took account of individual needs such as learning disabilities and dementia during triage and we saw they were noted in assessments. Carers, families and escorting mental health professionals were involved in information gathering to ensure patient needs were documented.

There was a box within the department, which contained resources to help provide emotional support to parents who had lost a child.

Patients had access to shower facilities within the department and basic personal care items were available.

**Meeting people’s individual needs**

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

During busy periods the department was not always able to meet the needs of the patients and we saw and were given examples of this during our inspection. For example, two patients not offered food and patients undergoing treatment in a corridor area.

The children’s department was not responsive to the needs of children. The treatment area was not big enough to accommodate patients who needed treatment. It had a dedicated waiting area, which had been thoughtfully designed with young people in mind but it was not in view of staff. This meant children in this area were not supervised and could deteriorate in this area without being noticed by staff. This area contained appropriate toys for young patients. This waiting room was overseen by nursing and reception staff that were based in this area.

The facilities in the department for preparing refreshments did not meet the needs of the patients. A restricted menu was available for patients and hot drinks had to be made in the staff room.

There was a variety of resources available to support the needs of children, there were toys, games, stickers, bravery certificates and small gifts for when they had completed their treatment.

There were no leaflets displayed in languages other than English but staff told us they had access to leaflets in other languages if they were required. Many of these were available to be printed off the Royal College of Emergency Medicine website.

There were gynaecology (deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system) and surgery clinics. Staff could refer patients to either of these clinics to be assessed by a specialist best able to meet their needs.

The department had worked with the mental health provider to improve services for people with mental health needs who presented to the emergency department. As part of this the emergency department collected data for the Commissioning for Quality and Innovation scheme, which is intended to deliver clinical quality improvements and drive transformational change.

The service was meeting and identifying the communication needs of patients with a disability or sensory loss. Medical records were flagged to indicate if a patient had additional or complex needs to ensure that staff responded appropriately.

The service used a communication aid book from a nearby ward, which contained useful images and advices to help staff with people with a variety of needs. The book contained pictures for example, the process of taking an x-ray, which could be shown, to a patient to help them understand. In addition, staff used wipeable boards which patients could write on to communicate with staff.
The service took account of individual needs such as learning disabilities and dementia during triage and we saw they were noted in assessments. Carers, families and escorting mental health professionals were involved in information gathering to ensure patient needs were documented.

Equipment was available for bariatric (high body mass index) patients all trolleys took up to the weight of 25 stones. A trolley, which was capable of taking a weight of more than 25 stone, was available.

The department had a room to provide a peaceful environment for the families and friends of patients that were critically ill, or recently bereaved.

A butterfly symbol was added to patient records which helped clinical staff identify immediately if they were living dementia.

A triangle stamp was used on the paper records of diabetic patients. This provided staff with a visual reminder that the patient was diabetic. This had been introduced since an incident involving a diabetic patient.

Patients who were at risk of falls wore a yellow identity band this acted as a visual reminder to staff that the patient was at risk of falls.

The department had access to a hospital chaplain. Multi-faith support was available to meet patient’s individual needs.

The Children’s emergency department had access to play specialists, located in the children and young people’s department at the hospital. This enabled specialist staff to assist patients in the use of distraction techniques and play.

The trust league of Friends volunteers visited the department daily with a trolley which included items such as newspapers, magazines, toiletries drinks and snacks that patients could purchase if required.

**Emergency Department Survey 2016**

The trust scored “worse than” other trusts for two questions of the three Emergency Department Survey questions relevant to the responsive domain and “about the same” as other trusts for the remaining one questions.

<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>6.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

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

**Access and flow**

**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 did not meet the standard for ten months over the 12-month period from February 2017 to January 2018.
Performance against this standard showed improvement from October 2017. As of January 2018, the median time to treatment was 58 minutes compared to the England average of 57 minutes.

**Ambulance – Time to treatment from February 2017 to January 2018 at East Kent Hospitals University NHS Foundation Trust**

![Graph showing time to treatment from February 2017 to January 2018]

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

**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 emergency department.

The trust did not meet the standard from February 2017 to January 2018.

The trust breached the standard 12 times from February 2017 to January 2018.

From October 2017 the trust showed signs of improvement but this declined in the winter months.

**Four hour target performance - East Kent Hospitals University NHS Foundation Trust**

![Graph showing four hour target performance]

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

**Percentage of patients waiting more than four hours from the decision to admit until being admitted**

From February 2017 to January 2018, East Kent Hospitals University NHS Foundation Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until
being admitted started the reporting period better than the England average but has decreased since October 2017 to worse than the England average with January 2018 showing signs of improvement.

**Percentage of patients waiting more than four hours from the decision to admit until being admitted - East Kent Hospitals University NHS Foundation Trust**


**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from February 2017 and January 2018, eight patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in August 2017 (two patients), December 2017 (two patients) and January 2018 (two patients)

<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>Feb-17</td>
<td>322</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>242</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>210</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>386</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>224</td>
<td>1</td>
</tr>
<tr>
<td>Jul-17</td>
<td>423</td>
<td>1</td>
</tr>
<tr>
<td>Aug-17</td>
<td>447</td>
<td>2</td>
</tr>
<tr>
<td>Sep-17</td>
<td>554</td>
<td>0</td>
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<tr>
<td>Oct-17</td>
<td>586</td>
<td>0</td>
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<tr>
<td>Nov-17</td>
<td>624</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1082</td>
<td>2</td>
</tr>
<tr>
<td>Jan-18</td>
<td>877</td>
<td>2</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 February 2017 to January 2018 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average.

As of January 2018, the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 3.9%, compared to the England average which was 3.0%.

Percentage of patient that left the trust without being seen - East Kent Hospitals University NHS Foundation Trust

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

Median total time in A&E per patient (all patients)

From February 2017 to January 2018, the trust’s monthly median total time in department for all patients was consistently similar the England average. In January 2018, the trust’s monthly median total time in A&E for all patients was 169 minutes, which is worse than that of the England average which was 153 minutes.
People could access the service when they needed it. We observed there was not enough room and resources to cope with the number of patients attending the department. Patients were frequently doubled up in the majors weighting area and there was insufficient room in the Children’s treatment area.

A lack of flow through inpatient areas resulted in the urgent and emergency department being regularly overcrowded. Overcrowding within the urgent and emergency care department was the top risk on the department’s risk register. The risk was added to the register in July 2017 but there was no documented review date. This meant the risk had not been reviewed for nearly two years and the risk may have changed since then. In addition, it was not possible to tell if the measures put in place to mitigate the risk had been effective as there had been no review. The measures in place to mitigate the risk were limited and included a staffing review (undertaken in 2017), two extra agency staff on each shift, increased support staff and to encourage early discharge on the ward. We observed the flow of adult patients through the department required improvement. Adult patients experienced significant delays whilst awaiting specialist review or to be placed on a ward.

Mental health patients who had been assessed as requiring input from the mental health team were reviewed within one hour of referral. This was set out in the standard operating procedure between the trust and the mental health provider.

Staff in the Children’s department told us that when they transferred a patient to the Children’s ward they had to leave the department sometimes without a nurse for extended periods of time. During our inspection, we accompanied a nurse and patient to the ward and timed how long it took. The time taken was 22 minutes, this meant the department was left with one nurse which influenced the flow through the department as only one nurse was available to triage and treat patients.

NHS England’s seven-day services priority standard number two, states that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. We asked...
the trust to provide us with data on this standard however, they told us that their electronic systems did not allow them to collect this data. This meant the trust did not know how long it was taking for patients to be reviewed by a suitable consultant.

The doctor in charge, nurse in charge and service manager undertook four hourly board rounds within the department. The board rounds not only reviewed each patient in the department but also helped alleviate bed pressures and flow issues. They assessed every patient and their records and where possible when they could identify patients who would benefit from an alternative treatment they would ensure that the plan for this patient was reviewed and treatment changed as necessary.

There was an electronic application (phone app) that patients and visitors could download which provided information about wait times for the department and neighbouring services such as the minor injury unit. This meant patients and visitors were aware of which service had the shortest wait times and could make a choice of where they attended if clinically appropriate. In addition, it gave patients and visitors an idea of how long they would be waiting and managed their expectations.

Bed meetings took place three times a day they were attended by multidisciplinary staff and senior managers. Waiting times were reviewed and breaches and potential breaches discussed. Wait times were available live via an electronic system which everyone in the hospital could access. This meant staff had information regarding wait times and breach times.

The nurse in charge visited each area every hour at a different time. For example, they attended the triage area at 10 minutes to each hour. The purpose of this was to review how busy the area was, if the staffing was sufficient and to support staff in these areas.

The leadership team received a daily report on the previous day’s performance. All patients who had breached the four hour target were validated to ensure they were in fact a breach and not excluded because of clinical exception. This also provided oversight of reasons for breaches and identified any trends to facilitate improvements.

Staff told us that the four bedded observation area was used to place patients to avoid a 12 hour breach whilst they were awaiting review by a specialist or awaiting further investigations.

Data supplied to us showed that on average 240 patients attended the department daily. Of these 40 were referred onto the General Practitioners in the department. Twenty percent of patients were children, 30% were patients with minor injuries/illnesses and 50% were patients with more serious injuries/illnesses.

Learning from complaints and concerns

Summary of complaints

We asked the trust to provide a breakdown of the complaints received for the department but the trust has not provided these.

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Complaints, comments, concerns and compliments could be made via telephoning, emailing or visiting the trust the Patient Advocacy and Liaison Service or the patient experience team. We saw information within the department, which informed patients on how to access these departments.
The matron told us that when they joined the department 12 months ago that complaints were not investigated. Therefore, the matron had created an electronic tracking database of all complaints which provided oversight of all the complaints and what action had been taken. For example, if statements had been received from staff.

We were told that staff who had been the subject of a complaint would be spoken to, to pass on feedback and learning points. Staff who had been subject to positive feedback through a plaudit would also be given the positive feedback.

There was no set agenda for departmental meetings or minutes and therefore discussion on complaints and learning from complaints was limited. The matron told us that these meetings would soon have a set agenda and discussion on complaints would be a standard agenda item.

We reviewed three complaints, all complaint responses showed a good understanding of the complaint and answered all points raised in the complaint and explanations given. Responses were written in plain English and did not contain any medical jargon, this meant complainants could understand the response.

Patients and relatives who had made a compliant were invited to complete a survey on how they felt their complaint was managed. This provide the trust with feedback and possible areas of improvement.

Responses signposted complainants to Parliamentary and Health Service Ombudsman. This meant patients and relatives knew whom to contact if they were not satisfied with the trust’s response to their complaint.

Staff told us they always tried to deal with complaints when they happened to avoid complaints being escalated to formal complaints.

We were given an example of learning from a complaint during our inspection. A patient was suffering from a miscarriage and complained that the surroundings were not suitable to their needs. Therefore, all patients who attend now with a miscarriage were transferred to the inpatient ward where they were better able to meet their needs.

**Is the service well-led?**

**Leadership**

The urgent and emergency care department was in the Urgent Care and Long-Term Conditions Division and the Divisional Director was the overall lead for the division. The Divisional Director was supported by a Head of Nursing for Long Term Conditions, a Divisional Medical Director and a Head of Nursing for Urgent Care. These were supported by the Deputy Divisional Medical Director, General Managers, Senior Matron, Matron, Clinical Governance manager and senior nurses.

The trust did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. There had been no emergency department matron between February 2015 and September 2017 therefore the senior matron had been acting down to cover this role. A matron was appointed in September 2017 and the Senior Matron worked across both sites but is predominantly based at Canterbury hospital. Therefore, there was limited nursing support for the matron.
Staff were positive about changes that had been made since the matron had been appointed who acknowledged there was still a lot of work to be done and that they were at the beginning of their journey.

Staff and managers told us that the trust’s senior leadership team made changes without discussing them with the staff and they were just implemented. For example, the escalation protocol for the department which staff were not consulted on and felt it did not consider the everyday working of the department.

The clinical lead who was a consultant in emergency medicine and the matron, were highly visible in the department and often worked clinically to maintain their skills and support their staff. They clinically supported junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose. They demonstrated the skills, knowledge, integrity and experience needed for their roles. However, more senior nursing leadership was required to support the matron and team.

Staff felt as they had been without a matron for two years and they “had been neglected” but were positive about the future of the department.

The management team told us that historically complaints and incidents had not been investigated and lessons learnt. During the inspection, we saw progress had been made however there was a lack of structure to ensure staff received feedback and lessons learnt were shared.

Local clinical leaders were responsible for all governance, quality and risk management in the department. They were supported by divisional managers; however, it was evident from the lack of set meeting agendas and meeting minutes, information provided and what staff told us on inspection, that local clinical leaders did not always have capacity within their roles to focus on governance and performance to a sufficient level. This meant monitoring the quality and performance management of the department was not always a priority. For example, one of the clinical leaders told us that over the winter the division was not always able to support the root cause analysis or governance meetings so they were cancelled.

There was a new substantive chief executive appointed in March 2018 who had been interim since October 2017. Staff told us that the chief executive visited the department regularly.

**Vision and strategy**

The trust had values which defined the organisation these were

We care so that:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect sit at the heart of everything we do
- People feel confident we are making a difference

We saw the trust’s values displayed in the department and on-screen savers on computers, generally the staff we spoke to knew what the values were.

The trust had strategic objectives (4Ps):

- Patients- Providing high quality care to patients with great outcomes for their health and lives - getting the basics right every time and building healthcare that is best in class.
- People - Attracting the best people to our team, who are passionate, motivated and feel able to make a difference and investing in them.

- Partnerships - Work in partnerships to design health and social care which transcends the boundaries of organisations and geography.

- Provision - The provision of high quality care through the use of technology, research, education, innovation and intelligence.

The emergency department had an Emergency Department Standard Operational Procedure. This set out working practices and underlying vision, mission and value statement for the assessment and treatment of all patients attending the Emergency Department, which meant all patients will be treated with the same level of care and dignity as we would expect for our own families. This was ratified in March 2016 and was due for review in April 2018. This meant the vision and strategy might have changed since it was written and required review.

Although the trust had a vision for what it wanted to achieve these were not always developed with involvement from staff. Staff told us that changes were made that affected them which they were not informed of and without discussion.

**Culture**

Managers across the trust did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us that senior managers did not have a realistic view of what happened operationally within the department or the challenges they faced.

Staff told us that it had become normalised practice to “double up” patients in the majors area when the department was overcrowded. Staff did express safety concerns to us about this practice. Many staff expressed a sense of despondency and resignation about the long delays for assessment and treatment.

Staff told us how tired they were after an extremely busy winter, one staff member said, “I honestly don’t know how we got through it”. Another staff member said, “the health care assistants are amazing the keep on top of taking all the observations but it’s difficult to keep on track”.

Staff told us that the support they received from their colleagues in the department helped them to cope with the pressures which resulted when the department was very crowded. There was a sense of comradery amongst the staff.

Despite widespread frustration there was a positive culture in the department which was centred on the needs and experience of patients. We observed relationships amongst staff in the department were cooperative, supportive and appreciative. Nursing staff and medical staff shared responsibility and worked together to give the best care they could for patients.

Reception staff described a poor relationship between themselves the management team and the nurses. One member of administration staff told us “nurses just bark orders at us”. There was a vacancy rate of 50% amongst reception staff at the time of our inspection, the team described a lack of support from management.

Reception staff told us they had previously raised concerns about lone working to the management team but felt they had not been heard. Reception staff were often left on their own and there was only one security guard which covered the whole hospital.
Reception staff told us that they often went without their breaks and there was no money available to replace broken equipment in the reception area.

The trust had a Freedom to Speak Up Guardian. However, staff did not know the name of them but did know where to look to find out.

In the 2017 staff survey, 47% of staff within the emergency department at Queen Mary Queen Mother hospital said they often/always look forward to going to work. This was compared to the trust average of 53%.

**Governance**

Governance processes within the department required strengthening and embedding. We were told during the winter months meetings were cancelled as staff were working clinically. There were sporadic departmental meetings and staff forum meetings which did not have terms of reference, set agendas or meeting minutes. This meant these meetings were not effective.

The Governance and Patient Safety/Mortality and Mortality meetings did have a set agenda and meeting minutes. However, the meeting minutes we reviewed did not demonstrate incidents and risks were discussed. We therefore could not be assured that the governance arrangements supported the delivery of good quality patient care.

Managers we spoke with were clear about the challenges the department faced and they were committed to improving the patients’ journey and experience. However, we were not assured that there was a systematic approach to improving the quality of services and safeguarding high standards of care.

There was regular engagement and communication with partners and third partner parties such as the local mental health trust who were responsible for providing mental health services.

**Management of risk, issues and performance**

The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. For example, risk management processes were an area of concern. The Queen Elizabeth Queen Mother hospital emergency department had a risk register. However, the risk register only identified two risks; overcrowding and nurse staff deficits. This was not an adequate risk register as it did not identify many other risks that we highlighted during our inspection. For example, the consultant vacancy rate, consultant cover in the department and adult nurses caring for children. In addition, one risk did not include information about when it was last reviewed or a review date. This meant the risks in the department were not fully understood and measures in place to mitigate the risk.

There was performance monitoring and review at local level an urgent care dashboard contained information about ambulance handover times, triage times and the emergency access standard. However, performance monitoring of other metrics did not happen for example, how long patients waited to be assessed by an appropriate consultant and response times for specialty referrals.

Although the department participated in national audits local audits were limited. For example, no hand hygiene audits, records audits or pain were undertaken which meant they could not gain assurance in these areas.

During our last inspection, the emergency department did not meet the requirements of the Royal College of Emergency Medicine guidelines of consultant cover within the department. The requirements state that consultant cover must be provided a minimum of 16 hours a day. During this inspection, we found consultant cover within the department still did not meet these
requirements. This meant there was not always a consultant available to offer senior leadership and clinical support or advice.

There was a nursing and medical lead in the department who oversaw sepsis management within the department.

We observed during busy periods patients were “doubled up” in the majors area and patients placed in front of each other. There was no access to suction or oxygen to the patient in front. Staff were not confident that in an emergency they could access the patient behind in the bay.

Staff told us that it did not always feel safe working in the department, they described it as “chaotic” and that there was poor communication.

Staff told us during the winter they did not have time to give patients the care they required as they were so busy. Staff gave example of a patient having a urinary catheter inserted in a chair as there was nowhere else available.

Sixty-percent of staff within the emergency department at Queen Marys Queen Mother hospital said they were able to do their job to a standard they were pleased with. This was compared to the trust average of 73%.

The trust did not use a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Operational activity meant there was no time to review standards of care and identify areas of improvement.

**Information management**

Staff could access patient information using an electronic system and some paper records. Staff were positive about the electronic patient system which had been introduced since our last inspection.

The department used an electronic system to track patients from presentation to discharge. This provided a visual overview of who was in the department at any one time and provided a breakdown of patients and waiting times. The system also provided reports to track any patients approaching a breach of four or 12 hours, which fed into the daily bed meetings. Information collated was used to monitor, manage and report on quality via the quality dashboard.

The department used another system for requesting tests and diagnostics.

During our inspection we observed computer stations around the department were left locked, this meant that unauthorised persons could not gain access to patient records. We saw there was a suitable number of computers for staff to use.

The electronic patient system used by the emergency department was different to the one used by the mental health liaison team and they did not join up. This meant it was not possible to access all the relevant information easily. When patients were reviewed by the mental health liaison team they wrote hand written notes which were then scanned into the emergency departments patient record.

**Engagement**

The trust did not always engage well with staff, in order to plan and manage appropriate services. For example, Staff described an over reliance on emails as a way of communicating with staff.
Staff said especially over the winter months they did not have time to access their emails and read them. This meant staff were not kept informed of changes.

Staff knew their role within the team and how this contributed to the service.

We saw the windows in the waiting area of the department included art work by children from the local schools.

Staff undertook team building days together, the last one was when they went paddle boarding.

There were several ways patients and visitors could provide feedback. They could fill in an online patient survey, complete a ‘thank you’ form, raise a complaint or concern, rate the trust on the National Health Service choices website or complete the Friends and Family Survey.

We reviewed comments on the National Health Service choices website regarding the hospital, the hospital was rated as four stars out of five by service users. Feedback about the emergency department was varied.

The trust interacted on social media via a variety of social media networks and had a news page with real time updates for staff on the trust website.

We saw information regarding the Friends and Family Survey throughout the department, feedback could be given in person, in writing or online.

Regular staff briefings were held across all of the hospitals to engage with staff and convey key messages, new services and updates to managers and front-line staff, in person, by the Chief Executive and other members of the Executive Team.

Members of the public could become a member of the trust, received quarterly newsletters, and were invited to events for example, a cardiology open day.

The hospital and urgent and emergency care team worked in collaboration with the local Healthwatch group.

The department worked with local stakeholders such as the local mental health trust to develop management plans for patients who attended the department frequently. The work undertaken was part of commissioning for quality and innovation. Commissioning for quality and innovation made a proportion of healthcare providers income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.

The trust’s website enabled service users to leave general comments on how they might improve their service, leave compliments, complaints or concerns.

**Learning, continuous improvement and innovation**

There was an intravenous (into a vein) access team who took blood samples and inserted cannulas (thin tube into a vein to give medicines or fluids) under ultrasound guidance. Ultrasound is used to create images of soft tissue structures, organs and parts of the body. Taking blood samples and inserting cannulas under ultrasound means the position of the veins can be visualised so the staff member knows where to insert the needle. This method is often quicker than if not using ultrasound and means the patient undergoes less attempts at obtaining blood or inserting a cannula. The risk of infection was also reduced as there were less puncture wounds from needles. The team helped the efficiency of the department as it enabled colleagues to undertake other tasks.
The trust was not always committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. Operational commitments within the department was prioritised which prevented managers and staff from undertaking additional training research and innovation.

**Surgery**

**Facts and data about this service**

The trust provides this core service across three sites. The trust has 18 surgical wards and 303 inpatient beds.

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

The trust had 53,563 surgical admissions from November 2016 and October 2017. Emergency admissions accounted for 15,456 (29%), 29,881 (56%) were day case, and the remaining 8,266 (15%) were elective.

(Source: Hospital Episode Statistics)

Queen Elizabeth the Queen Mother Hospital has 90 surgical beds across four wards: Bishopstone Ward, Sea Bathing Ward, Cheerful Sparrows (male) and Cheerful Sparrows (female) Ward. There was also a Day Surgery Unit, which is open Monday to Wednesday from 7am to 8pm, Thursday to Friday from 7am to 10pm, and occasionally at weekends. The hospital mainly covers trauma and orthopaedics, and general surgery specialties.

The hospital has a dedicated emergency theatre, as well as a surgical emergency assessment unit with two trolleys where patients with surgical emergencies can be referred from their GP for urgent assessment. The surgical emergency assessment unit is open Monday to Friday, 11am to 7pm.

During our inspection, we spoke with 40 members of staff, including nurses, doctors, physiotherapists and ward clerks. We spoke with four patients and reviewed three sets of patient records. We also reviewed a variety of performance data, meeting minutes and staff competency records.

**Is the service safe?**

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

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

**Mandatory training**

Medical and dental staff failed to meet the trust’s mandatory training target of 85% for any of the six modules. Information governance had the worst completion rate, with only 54% of medical and dental staff completing this module between January and December 2017. This meant the trust could not have had assurances all medical and dental staff had up-to-date knowledge and skills in all key areas to keep themselves and patients safe.

However, mandatory training rates for nursing staff met or exceeded the trust’s 85% target in five
out of the six modules between January and December 2017. The only module that fell below the 85% target was information governance, which had a 75% completion rate. The trust informed us information governance training compliance fell during the last 12 months due to changing over of the training module used, and then IT issues relating to that training module. The trust reported this module is now fit for purpose, and the divisions is actively promoting the completion of this training.

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

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

A breakdown of compliance for mandatory courses from January 2017 and December 2017 for medical/dental and nursing/midwifery staff in surgery is shown below:

### Mandatory Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>72</td>
<td>97</td>
<td>74%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>69</td>
<td>97</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>66</td>
<td>97</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>64</td>
<td>97</td>
<td>66%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>62</td>
<td>97</td>
<td>64%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>52</td>
<td>97</td>
<td>54%</td>
<td>No</td>
</tr>
</tbody>
</table>

### Mandatory Training Completion by module – Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>116</td>
<td>120</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>114</td>
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<td>96%</td>
<td>Yes</td>
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<tr>
<td>Moving and Handling Level 1</td>
<td>115</td>
<td>120</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>110</td>
<td>120</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>106</td>
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<tr>
<td>Information Governance</td>
<td>93</td>
<td>120</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Completed induction records provided assurances new staff received a local induction to help them keep patients and staff safe. We reviewed copies of completed induction records for two members of staff that had recently joined the trust; one in theatres and one on Cheerful Sparrows (Male) Ward. Records demonstrated a thorough induction to their new working environment, which included key areas such as incident reporting, local policies and procedures, fire safety and control of substances hazardous to health (COSHH) assessments.

### Safeguarding

Apart from adult safeguarding level one training, staff did not meet the trust target of 85% for any mandatory safeguarding modules. However, all staff we asked with were able to describe the process for reporting any safeguarding concerns to the trust’s safeguarding team. Nursing staff that had been involved in raising concerns were able to describe examples of safeguarding concerns they had correctly identified and reported. This demonstrated that, although not all staff
held the relevant level of safeguarding training to their role, staff were aware of the correct processes and felt confident to report any safeguarding concerns.

**Safeguarding training completion rates**

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

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

A breakdown of compliance for safeguarding courses from January 2017 and December 2017 for medical/dental and nursing/midwifery staff in surgery is shown below:

**Safeguarding Training Completion by module – Medical and Dental Staff**

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>97</td>
<td>97</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>43</td>
<td>97</td>
<td>44%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>42</td>
<td>97</td>
<td>42%</td>
<td>No</td>
</tr>
</tbody>
</table>

**Safeguarding Training Completion by module – Nursing and Midwifery Staff**

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>120</td>
<td>120</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>98</td>
<td>120</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>12</td>
<td>28</td>
<td>47%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>21</td>
<td>92</td>
<td>32%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P18)

Medical and dental staff failed to meet the 85% trust target for safeguarding adults level two and safeguarding children level two. Nursing staff also failed to meet the target for these modules, as well as failing to meet the target for safeguarding children level three training. Only 32% of relevant nursing staff completed safeguarding children level three training between January and December 2017. This was much worse than the target of 85%. Additional data supplied by the trust showed consultants treating a mixed adult and child caseload had level three safeguarding children training in line with the trust policy. Trust data showed 63% of relevant staff had up-to-date level training as of 30 April 2018. This was worse than the trust target of 85%. This meant the trust could not have been assured medical and nursing staff had the training they needed to allow them to identify and report safeguarding concerns.

Nursing staff in day surgery theatres did not have the relevant level of safeguarding children training in line with the intercollegiate guidance, “Safeguarding Children and Young People: roles and competences for health care staff” (2014). Staff told us all nursing staff, support staff and operating department practitioners in day surgery theatres completed safeguarding children level two training. We saw a spreadsheet confirming the training courses undertaken by day surgery theatre staff, which showed the trust had not required any member of the department to complete
safeguarding children level three training as part of their mandatory training. This was not in line with the intercollegiate guidance, which states, “All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should have level three training”. Staffing rotas provided by the trust confirmed day surgery theatre staff covering paediatric operating lists did not have up-to-date level three safeguarding children training. This was not in line with the intercollegiate guidance.

However, paediatric nurses on the adjacent day surgery ward completed an annual face-to-face level three safeguarding children course as part of their mandatory training. A paediatric nurse we spoke with explained that paediatric nurses on the day surgery ward supported their colleagues in day surgery theatres with any child safeguarding concerns. We saw a comprehensive safeguarding children assessment form completed at pre-assessment for all children planning surgery at the trust. This included a clear “red, amber, green” flagging system to help staff identify and highlight any potential safeguarding concerns to the trust’s safeguarding children lead. A paediatric nurse we spoke with was able to describe the process for reporting concerns and gave examples of safeguarding concerns the day surgery team had correctly identified and reported. This included a concern identified by a member of theatre staff in day surgery theatres. The paediatric nurse told us they always received feedback from the trust’s safeguarding team following any concerns they reported.

The trust had a safeguarding children team within the child health division and an adult safeguarding team. The teams received safeguarding support from the local council. East Kent Hospitals Trust’s safeguarding teams had an arrangement to share information with the local Clinical Commissioning Groups (CCGs) and other agencies. The hospital’s safeguarding policy included guidance to staff on a range of safeguarding issues, including Female Genital Mutilation (FGM).

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. All clinical areas we visited were visibly clean and tidy. Staff used control measures to prevent the spread of infection. For example, all staff we met were “bare below the elbows” in line with the trust’s infection prevention and control policy. We saw staff cleaning their hands in line with the World Health Organisation’s “Five moments for hand hygiene”, which are; before and after patient contact, before clean/aseptic procedures, after body fluid exposure/risk and after touching patient surroundings.

In all areas we visited, we saw staff had correctly segregated clinical and non-clinical waste into different coloured bags. This was in line with the Department of Health’s Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.

We reviewed cleaning checklists in day surgery theatres and on Cheerful Sparrows (Male) Ward. These provided assurances staff had completed daily, weekly and monthly cleaning tasks to maintain cleanliness. We saw “I am clean” stickers on equipment in theatres, which provided assurances staff had cleaned items ready for the next shift. We also saw completed monthly mattress audits in day surgery theatre. These provided assurances all mattresses had been checked on a monthly basis and were intact and safe for patients to use.

We saw copies of monthly environmental and cleanliness audits for main theatres and day surgery theatres. These showed overall compliance with trust targets and assurances around cleanliness, with any areas for improvement identified and escalated.
The trust took part in the Public Health England (PHE) surgical site infection surveillance service (SSISS). This allowed the trust to benchmark its infection rates against other trusts and identify areas for improvement. The trust supplied surgical site infection data to Public Health England on repair of fractured neck of femur (surgery to repair hip fractures) for procedures carried out at Queen Elizabeth the Queen Mother Hospital. The results for January to December 2017 showed the hospital had a surgical site infection rate of 0.4%. This was better than the rate of 1.1% for all hospitals that participated in the scheme.

Trust data showed there were no infections of methicillin-resistant Staphylococcus aureus (MRSA) and six cases of methicillin-sensitive Staphylococcus aureus (MSSA) relating to surgery at Queen Elizabeth the Queen Mother Hospital between March 2017 and February 2018. The service swabbed all patients planning elective surgery for MRSA at their pre-operative assessment. The pre-operative assessment also included questions to identify patients at high risk of carbapenemase-producing enterobacteriaceae. These are bacteria that destroy carbapenem antibiotics normally reserved for the treatment of serious infections caused by drug-resistant bacteria. Patients identified as high risk of carrying carbapenemase-producing enterobacteriaceae subsequently had a rectal swab to confirm whether they carried the bacteria.

We saw the service’s management plan for the treatment of patients that were confirmed as carrying MRSA following a positive swab result. A nurse was also able to describe the management of patients carrying MRSA. The service first informed the patient and then prescribed decolonisation treatment in the form of ointment and/or body scrub to be completed four to five days before surgery. Ward nurses subsequently re-swabbed the patient after surgery to confirm whether decolonisation was successful. The management plan included a clear policy on the criteria for nursing patients in side rooms to prevent the spread of MRSA. Patients carrying MRSA were nursed in side rooms, except for those with MRSA in the nose only, on one or two body sites, or with one or two superficial wounds that were healing well and covered with dressings. These patients could be cohort-nursed on a ward with other MRSA carriers.

**Environment and equipment**

We had concerns around the safety of some equipment and the fabric of the building in main theatres. In theatre seven, we observed that one operating light failed to stay in place after a surgeon had moved it to the desired position and instead “glided” above the operating field. As a result, a member of the theatre team would need to hold the light in place throughout the operation. Alternatively, surgeons would need to operate with one fewer operating light or with the light in a suboptimal position. This presented a risk that surgeons’ ability to see clearly while operating might be compromised. There was a further operating light that failed to stay fixed in position and “glided” in theatre six, the emergency theatre. In theatre seven, we saw that another operating light was covered with a paper towel and tape. A member of staff told us this was to prevent oil and debris from falling into the operating field. This presented an infection risk to patients.

We also saw that the plastic coating on the glove racks in theatre seven had chipped away and the racks had started to rust. This presented a further infection risk as it meant it would be difficult to clean the racks effectively. There was also a risk of chipped plastic and rust from falling into the glove boxes and getting into the theatre environment. In theatres six, seven and 10, we saw chipped paint on the walls that presented a further infection risk.

In the scrub room for theatre seven, we saw a teaching skeleton positioned on a drip stand. This made the scrub room unnecessarily cluttered and presented a surface for dust to settle that could be difficult to clean effectively. We reported our concerns to theatre staff, however, staff did not take any immediate action to remove the teaching aid. One of the three sets of handwashing taps in scrub room seven was broken. We saw staff had taped a paper towel over the broken tap,
stating “do not use”. However, there were two further sets of handwashing taps in this area that staff could use to wash their hands that mitigated this risk.

The doorframe into the anaesthetic room of theatre 10 had wood that was chipped away. This meant it would have been difficult to clean the doorframe effectively, as well as presenting a splinter risk to cleaning staff.

We reviewed environmental reports for main theatres, which consistently highlighted that the concerns we identified such as damaged walls. The reports stated these issues were escalated to the estates department. This meant the trust was aware of the risks, which persisted because the trust had not invested in repair of the facilities.

Staff told us they had reported the faulty operating lights and the broken tap to the estates department. We saw records of job references where staff had repeatedly reported faulty and broken equipment. In some cases, staff had reported broken equipment some time ago, and the estates department had 'closed' the job without rectifying the problem. For example, we saw staff first reported the broken tap in scrub room seven on 20 November 2017. Six months on, the tap was still broken at the time of our inspection. In some cases, staff told us they had reported broken equipment as incidents. Additional data supplied by the trust showed staff reported 18 incidents of broken or malfunctioning equipment in main theatres between June 2017 and May 2018. We saw this included the faulty operating lights in theatre six, which staff reported as an incident on two occasions in January 2018. Despite reporting this issue, which staff described as an “unsafe situation” that had caused a delay in the middle of an emergency operation, the trust failed to take action to replace the lights. At the time of our visit in May 2018, we saw that both reported incidents involving the operating lights had still not been approved or closed four months later.

We escalated our concerns about the theatre operating lights with the executive team at the end of the core service inspection. Following this, we received written assurance from the Chief Executive on 1 June 2018 confirming the theatre lights had been repaired and replacements ordered to replace others as the trust continued to review the remaining theatre lights. We saw that the trust added our concerns regarding the operating lights to the surgical divisional risk register on 18 May 2018 and took immediate action to repair or replace the broken lights. The risk register showed the trust had replaced or repaired the faulty operating lights and audited all remaining operating lights to identify any further lights for repair or replacement. The trust completed this audit on 20 June 2018 and obtained assurances all operating lights were safe and fit for purpose.

However, equipment received an annual service and we saw stickers on equipment in theatres with an asset number and the date of the last service. All pieces of equipment we checked had received a service within the last year to provide assurances they were safe and fit for purpose. We randomly noted the asset numbers of three pieces of equipment and verified the servicing dates with the trust’s electrical medical engineering department. This showed that the dates of service written on the equipment stickers matched the dates of the engineer’s report and provided assurances of annual maintenance.

Emergency equipment was checked and maintained so it was safe and ready to use should the need arise. We checked three resuscitation trolleys: one in the recovery area in main theatres, one in the recovery area in day surgery theatres and one on Cheerful Sparrows Ward. We randomly checked 18 items of equipment and two medicines on the trolley on Cheerful Sparrows Ward, 20 pieces of equipment on the trolley in day surgery theatres and several items of equipment on the trolley in main theatres recovery area. All items were sealed and within their recommended use-by dates, which provided assurances they were safe and fit for purpose. We saw one item (I gels) on
the resus trolley in main theatres recovery area that was not listed on the checklist. We highlighted this issue to the nurse in charge so that it could be added to the checklist. In all three areas, we saw checklists which provided assurances staff had checked the trolleys daily. With the exception of one missing check on the trolley in day surgery recovery in April 2017, staff had fully completed all daily checks to provide assurances emergency equipment and medicines were present, safe and ready to use. We saw that the resuscitation cabinets in theatres had two separate sides - one side for adults and one side for paediatrics. This meant staff in theatres had access to suitable emergency equipment and medicines should a paediatric medical emergency arise.

We checked the difficult intubation trolley in main theatres and saw this was stocked and maintained in line with the Association of Anaesthetists Guidelines.

We saw biohazard spill kits and emergency eye wash kits available in main theatres and staff we spoke with were aware of their location. This meant theatres had suitable equipment to deal with spillage of biological material such as bodily fluids and any incidents of foreign bodies entering a staff member’s eye. We also saw a locked control of substances hazardous to health (COSHH) cupboard in a store room in main theatres.

We reviewed monthly back-up generator testing records for theatres. These provided assurances of regular testing to ensure an uninterrupted power supply to theatres in the event of mains power failure.

Assessing and responding to patient risk

We saw evidence of thorough risk assessment, including risk of falls, venous thromboembolism (VTE, or blood clots in veins), and pressure ulcers in the notes we reviewed. We saw prescription of VTE prophylaxis, such as anti-clotting drugs and anti-embolism stockings, where clinically indicated following risk assessment.

We saw evidence of falls assessment in patient records we reviewed. For patients at high risk of falls, the wards used measures such as non-slip socks, sensor mats and high-low beds to reduce the falls risk.

The service followed the trust’s tissue viability standard operating procedure and carried out “Waterlow” assessments to determine patients’ risk of developing pressure ulcers in line with the policy. We saw evidence of pressure area assessment in patient records we reviewed, as well as tissue viability status stickers on patients’ notes to alert staff of patients at increased risk of developing pressure ulcers. A tissue viability link nurse in theatres developed the new standard operating procedure and tissue viability alert stickers, and trust subsequently rolled this out trust wide. We saw a tissue viability board with information for staff on helping maintain tissue viability on Cheerful Sparrows (Male) Ward, as well as contact details for the tissue viability link nurses.

The service used the American Society of Anaesthesiologists (ASA) grading system to pre-assess patients’ level of risk for general anaesthesia. There were five grades within the ASA system. Grade one patients were normal healthy patients and grade five patients were patients not expected to survive more than 24 hours with or without surgery. The hospital had level two and three critical care facilities for critically ill patients to recover in following surgery. This allowed them to treat patients of all ASA grades safely.

We observed theatre staff carrying out the World Health Organisation (WHO) Surgical Safety Checklist. The World Health Organisation checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These
are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre) and debrief.

For all procedures we observed, staff fully completed all the required checks. Staff were fully engaged in the carrying out the checks and the checklist appeared embedded into the theatre teams’ routine practice. We reviewed World Health Organisation checklist audit results, which showed a high level of staff compliance with the checklist. Results showed theatre staff across the trust achieved between 97.9% and 100% between March 2017 and April 2018. This fitted with our observations of consistent compliance with the checklist in theatres. The trust randomly audited 10 sets of notes each day for main theatres and a further 10 in day surgery theatres.

However, following two procedures, we noticed staff completed the sign out step before the closure of the surgical site. While this did not compromise the immediate safety of the patient, it meant staff may need to repeat the sign out process if, for example, any equipment issues arose before the procedure was fully completed.

The service used an early warning system (EWS) to monitor patients for any deterioration. This was a simple scoring system of physiological measurements (for example, blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. Some wards used an electronic system to record early warning scores, while other areas such as the Surgical Emergency Assessment Unit recorded this information on paper charts in the patient’s file. Staff in areas that used paper charts told us they had access to electronic records made in other areas of the trust, such as the emergency department, through departmental computers. We reviewed three patient records and saw staff had monitored patients and calculated their early warning scores correctly in line with the associated guidance. We also saw staff had escalated patients with raised early warning scores for immediate medical review in line with the guidance.

We saw that the early warning system charts included “red flag” criteria for sepsis. Sepsis is a rare but serious complication of an infection that can lead to multiple organ failure and death if not treated promptly. Staff described how they used the trust’s sepsis screening tool for patients with an early warning score of four or above, and for unwell patients displaying any of the “red flag” criteria. In one of the patient records we reviewed, we saw staff had promptly completed a sepsis screen for the patient in line with the trust’s policy. We saw a sepsis packs containing items needed for the diagnosis and treatment of sepsis in the main theatre recovery area and emergency theatre. Staff in all clinical areas we spoke with knew where to find everything they needed for the diagnosis and treatment of sepsis in the clinical area they worked in.

The trust audited sepsis screening rates on the surgical wards on a monthly basis. The target screening rate set by the commissioning for quality and innovation (CQUIN) framework was 90%. In the period January to April 2018, Cheerful Sparrows (Male) Ward had the best results for sepsis screening. Cheerful Sparrows (male) Ward consistently screened 100% of applicable patients between January and April 2018, except for March when the ward screened 80%. A ward manager told us they received feedback from the results of monthly sepsis screening audits and any areas for improvement.

A paediatric nurse we spoke with told us 17-year olds were often treated on the adult pathway for day surgery. These young people were treated on adult operating lists and had beds on the adult area of the day surgery ward while they recovered from surgery. A pre-assessment nurse we spoke with told us they sometimes reviewed 17-year olds in the adult pre-assessment clinic. Trust data confirmed 400 young people aged 16 and 17 had surgery on an adult surgical pathway between March 2017 and February 2018.
We asked whether 17-year olds had a risk assessment to determine their suitability to enter an adult surgical pathway. The trust confirmed no such tool was available. However, we reviewed the trust’s policy and guidelines for “Age of admission to acute paediatric services”. While there was no specific assessment tool, the policy set out the requirement for admitting consultants to assess 17-year olds “for their suitability to be placed on a children’s ward, taking into account the medical condition, treatment required, bed availability and their personal choice”.

The paediatric admissions policy also set out the need for more vulnerable young people to recover from surgery on a paediatric ward. These criteria included young people with special needs and learning disabilities up to the age of 19 who were still being treated by a paediatrician, even if this was at another trust. It also included children up to 18 years already under the care of a paediatrician with long-term conditions warranting continuing paediatric involvement. This was in line with the Royal College of Nursing’s core standards for services providing health care for children and young people, as set out in the 2013 guidance, “Defining staffing levels for children and young people’s services-RCN standards for clinical professionals and service managers”. The guidance states, “Children, young people and young adults must receive age-appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs”.

### Nurse staffing

The trust has reported their nurse staffing numbers below as of December 2017

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>107</td>
<td>121</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>107</strong></td>
<td><strong>121</strong></td>
</tr>
</tbody>
</table>

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

We observed nurse staffing shortages on Cheerful Sparrows Female Ward, where there were an additional three “unfunded” beds in bay three. The trust had opened the additional beds to help cope with additional patients as a result of winter pressures. The beds had since remained open. However, there were no additional nursing staff to cover the extra beds. This was similar to our last inspection, when there were six additional unfunded beds on Cheerful Sparrows Female Ward.

On the second day of our visit (17 May 2018), we saw the staffing levels displayed on Cheerful Sparrows (Female) Ward. The expected staffing levels were one trained nurse and one healthcare assistant in each bay, on each shift (morning, afternoon and night). We saw three out of nine healthcare assistant shifts were unfilled and two out of nine trained nurse shifts were unfilled. Trained band four associate practitioners sometimes covered band five qualified nurse shifts. Although associate practitioners had training and competencies to carry out most basic nursing tasks, they were unable to conduct drug rounds. Therefore, the use of associate practitioners to cover band five staff nurse shifts sometimes put additional pressure on other registered nurses on the ward to cover drug rounds.

A nurse told us they always escalated short-staffing to the matron, who would try and move staff from other areas to cover where possible. However, cover was rarely available on day shifts, although they occasionally managed to obtain cover on night shifts. The trust did not allow the use of private agency staff to cover shifts due to the cost implications; therefore, shifts on the ward were often unfilled. Additional data supplied by the trust showed there were 13 reported incidents of insufficient nursing staff on Cheerful Sparrows Female Ward within the 12 months
before our visit. Of these, two incidents were categorised as low harm and the remaining 11 as no harm. However, we reviewed incident reports, which included details of patients having to wait for analgesia and intravenous fluids, which may have compromised patient safety.

We reviewed nurse staffing rotas on Cheerful Sparrows (Male) Ward and saw there were regularly unfilled shifts. However, the ward manager told us staffing levels on the male side of the Cheerful Sparrows Ward had improved since the trust began funding the seven beds in bay three. The trust now used regular agency nurses to staff this area, which was an escalation bay for medical outliers. Medical outliers are medical patients placed on non-medical wards due to a lack of beds. The ward manager described how the funding of agency nurses to look after patients in this area had “made a big difference” to staffing pressures on the ward and staff morale.

Cheerful Sparrows Ward used the Association of UK University Hospitals’ dependency tool. This was a nationally-recognised acuity tool to determine staff to patient ratios according to the dependency levels of patients on the ward. This was an improvement since our last inspection, when the ward did not use an acuity level to help determine safe staffing levels. We saw staff had calculated patients’ acuity ratios using the tool, which was recorded on the whiteboard. The tool measured the level of care patients needed on a scale of level zero (where patients’ needs could be met through normal ward care) to level three (patients needing advanced respiratory support and therapeutic support of multiple organs).

Patients’ acuity levels fed into the ward’s electronic “safer staffing” tool, which staff completed daily. Staff described how the safer staffing tool flagged up in “real time” if the ward needed additional staff, for example, if there were patients with increased dependency. The ward manager told us they escalated any staffing shortages to the matron and staff reported staffing shortages as incidents.

Following concerns around a lack of registered children’s nurses in theatre recovery areas, the trust provided a written statement confirming that in main theatre recovery areas, all nurses and operating department practitioners were adult-trained but they had “cared for and managed children for many years without incident”. Although theatre recovery staff had paediatric competencies, such as paediatric equipment competencies and paediatric immediate life support training to mitigate this risk, this did not meet the Royal College of Nursing standards as set out in their 2013 guidance, “Defining staffing levels for children and young people’s services- RCN standards for clinical professionals and service managers”. The guidance stated, “At all times there should be a minimum of one registered children’s nurse on duty in recovery areas”. In the day surgery recovery area, the trust used a dedicated registered children’s nurse for paediatric operating lists to meet the Royal College of Nursing standards.

The Day Surgery Ward had a separate paediatrics area with four dedicated paediatric nurses (three of whom were dual-trained adults and children’s nurses). There were always a minimum of two paediatric nurses on the day surgery ward at any time. This was in line with the Royal College of Nursing’s core standards for services providing health care for children and young people, as set out in the 2013 guidance, “Defining staffing levels for children and young people’s services-RCN standards for clinical professionals and service managers”.

In theatres, we saw the service met the Association for Perioperative Practice (AfPP) guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list. We observed a discussion on safe staffing levels at the morning “safety huddle” in main theatres. A member of the theatre team was off sick, and we saw staff moved from different areas of theatres to maintain safe staffing levels and skill mix on each operating list.
Vacancy rates

From January 2017 to December 2017, the trust reported a vacancy rate of 20% in surgery.

- Queen Elizabeth The Queen Mother Hospital: 30%

This was worse than the trust target vacancy rate of 10% or less.

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

At the end of the reporting period January to December 2017, the nursing vacancy rate at Queen Elizabeth the Queen Mother Hospital had reduced to 18% following nurse recruitment. Although the vacancy rate improved towards the end of the reporting period, it remained worse than the trust target of 10% or below.

Turnover rates

From January 2017 to December 2017, the trust reported a turnover rate of 12% in surgery.

- Queen Elizabeth The Queen Mother Hospital: 17%

This was worse than the trust turnover target rate of 13% or less.

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

Sickness rates

From January 2017 to December 2017, the trust reported an overall sickness rate of 5% in surgery. A breakdown of nursing staff sickness rates by site is as below:

- Queen Elizabeth The Queen Mother Hospital: 7%

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

Bank and agency staff usage (nursing staffing)

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

From February 2017 to January 2018, the trust reported a bank and agency usage rate of 59% in this core service;

- Queen Elizabeth The Queen Mother Hospital: 61%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)
Medical staffing

Medical staffing

The trust has reported their medical staffing numbers below as of December 2017

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>95</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>95</td>
<td>97</td>
</tr>
</tbody>
</table>

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

Staff told us surgical patients on the wards received a daily medical review, including at weekends. We reviewed three patient records, which all provided evidence of daily medical review. Nursing staff told us doctors promptly attended to review patients when they escalated any immediate concerns.

The on-call arrangements included one consultant, one registrar and one senior house officer (SHO) for each speciality (urology and vascular). If the on-call consultant was required on site, they were contactable via their mobile through the switchboard service. Middle grade and junior doctors were on site when on-call. A consultant anaesthetist was available Monday to Friday 8am to 7pm. Outside these hours; they were available on-call through a resident registrar. During the weekend, consultant anaesthetist cover was provided between 8am and 2pm. Outside these hours they were available on-call through a resident registrar.

In the Surgical Emergency Assessment Unit, we saw an on-call medical rota. Nurses told us registrars attended promptly to review patients in this area whenever they bleeped the registrar on-call.

Vacancy rates

From January 2017 to December 2017, the trust reported a vacancy rate of 10% in surgery;

- Queen Elizabeth The Queen Mother Hospital: 10%

This was the same as the trust target vacancy rate of 10% or less.

(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.

From January 2017 to December 2017, the trust reported a turnover rate of 6% in surgery.

- Queen Elizabeth The Queen Mother Hospital: 4%

This was better than the trust turnover target rate of 13% or less.

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

From January 2017 to December 2017, the trust reported an overall sickness rate of 5% in surgery. A breakdown of medical staff sickness rates by site is as below:

- Queen Elizabeth The Queen Mother Hospital: 1%

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

Bank and locum staff usage (medical staffing)

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

From February 2017 to January 2018, the trust reported a bank and locum usage rate of 43% in this core service.

- Queen Elizabeth The Queen Mother Hospital: 43%

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

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

Staffing skill mix for the whole time equivalent staff working at East Kent Hospitals University NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept thorough records of patients’ care and treatment. Records were clear, up-to-date and available to all staff providing care. We reviewed three sets of patient records and saw staff had signed and dated all entries in line with General Medical Council and Nursing and Midwifery Council guidance and professional standards. Patients had care plans that identified all their care...
needs. We saw staff had fully completed the care plans in all the records we reviewed.

In some wards, staff completed electronic patient records, such as observation charts. Staff had access to tablets to complete the electronic records. In other areas that completed paper records, such as the Surgical Emergency Assessment Unit, staff had computers that they used to access observations recorded electronically in other areas of the hospital.

**Medicines**

The service did not have assurances staff always stored refrigerated medicines within the manufacturer’s recommended range to maintain their function and safety. On Cheerful Sparrows (female) Ward, staff had consistently recorded fridge temperatures outside of the manufacturer’s recommended range and not taken action to notify pharmacy. We reviewed fridge temperature monitoring records on Cheerful Sparrows (female) Ward. The fridge’s recommended temperature range was between two and eight degrees Celsius. Records showed the fridge temperature was out of this range on two occasions in January 2018 (1.5°C), 10 occasions in February 2018 (1.5°C), 12 occasions in March 2018 (between 1.5 and -3°C), 19 occasions in April 2018 (between 1.5 and -3°C) and five occasions in May 2018 (between 0.5°C and 1.5°C).

We raised our concerns about the medicines fridge on Cheerful Sparrows (female) Ward with staff, who escalated this issue to the estates department. The estates department subsequently condemned the fridge and ward staff shared the medicines fridge on the adjacent Cheerful Sparrows (male) Ward while waiting for a replacement.

The controlled drugs registers in main theatres did not always have all entries signed and witnessed by two members of staff. This was not in line with Controlled Drugs (Supervision of management and use) Regulations 2013. Controlled drugs are medicines liable for misuse that require special management. In theatre five, we saw three entries (two for Fentanyl on 14 February 2018 and 1 March 2018, and one for Morphine on 1 March 2018) missing a witness signature. In theatre six, we saw two further missing witness signatures for Fentanyl on 10 May 2018 and 13 May 2018. The amount of medicine administered and destroyed was also not consistently completed in the register. We raised our concerns with theatre staff, and observed staff receive feedback at the team briefing the following morning. We saw staff receive a reminder of the importance of complete and accurate documentation in the controlled drugs registers. This demonstrated the service took prompt action to address our concerns.

We looked at four patients’ medicines charts. Patients’ body weights were not always recorded on the charts. This meant patients might be prescribed an incorrect dose as body weights were not always easy to find in patients’ notes. We saw that charts had been reviewed by the pharmacist and communication to the doctor to amend a prescription had been actioned. Patients allergies were recorded and there were no missed doses.

The surgical wards received a clinical pharmacy service daily Monday to Friday. Nurses said that the pharmacy service was invaluable. For example, medicines charts were no longer sent to pharmacy as the pharmacist worked on the ward; this meant that patients could receive their medicines without delay and not have to wait for the chart to return to the ward. Pharmacy provided a weekly stock top-up service. Staff on both wards used a communication book to request medicines and advice from the pharmacy team for specific patients.

Staff were encouraged to report medicines incidents. The medication safety officer held monthly medicines management group meetings to discuss the learnings with nursing staff and junior doctors. The group had developed a new system to record any omitted doses on the medicines chart. Staff recorded the reason for the omission and any action taken. This helped to notify pharmacy and prescribers. The service audited omitted doses and the trust provided data for
each ward. Although the percentage of omitted doses on Cheerful Sparrow wards was reported as high, staff said this required further investigation as Cheerful Sparrows were also recording missed doses from other wards from which patients had been transferred.

Ward managers on Cheerful Sparrow wards produced a weekly safety briefing for staff that was read out at the start of each shift. This had been implemented as email briefings could not be accessed by student nurses and agency staff. The ward’s “improvement journey folder” was available for all staff to read and included minutes from medicines management meetings, insulin safety information and past safety briefings.

Medicines were mostly stored in locked cupboards. Although some medicines were stored out of cupboards but within clinical rooms, room doors were not always secure. On Cheerful Sparrows (female) Ward, we saw 50ml sodium chloride and 100ml sodium chloride intravenous bags stored out of the cupboards and in baskets in an unlocked clinical medicines room. Although these were not controlled drugs, leaving the room door unlocked so they were potentially accessible to anyone visiting the ward was against best practice.

Patients undergoing elective surgery had their regular medicines prescribed on medicines charts by the pre-assessment pharmacist. The pharmacist told us how they also prescribed medicines to prevent infections and blood clots and advised patients how their pain would be managed following their surgery.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them. Managers investigated incidents and shared lessons learned with the whole team to help prevent a recurrence. All staff we asked were able to describe the process for reporting incidents. Staff told us they always received feedback following an incident. Staff on the wards and in day surgery theatres showed us copies of local monthly newsletters that included feedback from incidents and lessons learned.

Staff could give examples of learning from incidents and resulting changes to practice. This included the implementation of a new discharge planning sheet to include documentation of all observations staff must complete within the hour before they discharge a patient. We saw a copy of the discharge planning sheet, which the nursing team had implemented following learning from a serious incident on Cheerful Sparrows Ward. This had helped prevent a recurrence of this incident.

On Cheerful Sparrows (Male) Ward, we saw copies of weekly safety briefing sheets delivered as part of nursing handovers. We saw staff had signed to confirm they had read each weekly briefing. We saw that safety briefings included learning from incidents, such as a reminder to staff to update patient risk assessments daily following a recent incident. This demonstrated the service routinely shared learning from incidents to help continually improve patient safety.

We saw evidence the service applied duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014 following applicable incidents. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide them with reasonable support. We reviewed copies of two letters sent to patients following serious incidents. We saw that the letters included an apology, an explanation of the incident and the opportunity for further discussion and updates of the incident investigation. This demonstrated the service met its regulatory duty in this area.

We saw copies of individual consultant presentations that they presented to colleagues on their morbidity and mortality results and cases for discussion. This allowed consultants to learn from
morbidity and mortality cases across the surgical division to help improve patient safety and outcomes.

**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 March 2017 to February 2018, the trust reported one incident classified as a never event for surgery at Queen Elizabeth the Queen Mother Hospital. This was a surgical/invasive procedure incident meeting serious incident criteria where the anaesthetic team administered a local anaesthetic block on the wrong side of the body. The team immediately recognised their error and proceeded to anaesthetise the correct side before carrying out the operation. We saw evidence of learning from this incident, such as fixing additional “stop before you block” stickers onto the nerve stimulating machines in theatres. This helped remind staff to stop and check the correct anaesthetic site before administering local anaesthetic to prevent similar incidents from occurring. We saw evidence the service had applied duty of candour following this incident.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from March 2017 to February 2018. Of these, five occurred at Queen Elizabeth the Queen Mother Hospital. The most common types of incident reported were

- Treatment delay meeting serious incident criteria with five (36% of total incidents).
- Surgical/invasive procedure incident meeting serious incident criteria with three (21% of total incidents).
- Pressure ulcer meeting serious incident criteria with two (14% of total incidents).
- Medication incident meeting serious incident criteria with two (14% of total incidents).
- Sub-optimal care of the deteriorating patient meeting serious incident criteria with one (7% of total incidents).
- All other categories with one (7% of total incidents).

(Source: Strategic Executive Information System (STEIS))
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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 24 new pressure ulcers, five falls with harm and 18 new urinary tract infections in patients with a catheter from February 2017 to February 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and new urinary tract infections in patients with a catheter at East Kent Hospitals University NHS Foundation Trust

On the surgical wards, we saw “safety crosses” displayed. Staff updated the safety crosses chart each day to document whether there had been any falls or new pressure ulcers on the ward each day. The safety crosses on Cheerful Sparrows Ward showed the ward was performing well in the month of our visit, with no pressure ulcers and only one patient fall. Displaying the safety crosses gave staff and patients assurances around the level of harm-free care on the wards. Trust data
showed the harm-free care rate for surgical services at Queen Elizabeth the Queen Mother Hospital ranged from 96.85% to 100% between March 2017 and February 2018.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. We reviewed a sample of surgical policies and procedures. All policies we saw referenced relevant national guidance. This included the National Institute for Health and Care Excellence (NICE) and the Royal College of Surgeons (RCS). For example, we saw patients with a fractured neck of femur (fractured hip) followed a pathway based on NICE clinical guideline CG124- Hip fracture: management. Staff could access policies and procedures electronically through the trust intranet and knew how to do this.

The service audited staff compliance with trust policies and national guidance. This included regular audits on the World Health Organisation Surgical Safety Checklist and sepsis screening audits. Audits provided assurances around staff compliance and helped identify areas for improvement. Staff told us they received feedback on audit results to help drive continuous improvement.

We reviewed three patient records, which all showed evidence of regular observations, for example, blood pressure and oxygen saturation, to monitor the patient’s health post-surgery. Staff had completed all observations in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.

We reviewed the National Joint Registry implant register in theatres. We saw this was up-to-date, with all implants recorded as well as batch numbers of the instrument trays used. This allowed traceability, for example, in the event of any issues with a particular batch of implants.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The trust used the Malnutrition Universal Screening Tool (MUST) to identify patients at risk of malnutrition. We saw the service made adjustments to ensure patients received adequate nutrition and hydration, for example, by providing special diets for patients with conditions such as diabetes. The service had access to dietitians for patients needing specialist support. Patients we spoke with told us they received sufficient food and drink that met their needs, and we saw patients had water available at their bedsides.

The service followed the Royal College of Anaesthetists’ guidance on fasting before surgery. This included advising patients on an afternoon operating list to have a light breakfast up until 7.30am on the day of surgery, and clear fluids up until two hours before their operation. The service began auditing pre-surgery fluid intake in March 2018, and results showed the service achieved 100% compliance with the standard of clear fluids two hours before surgery in March and April 2018. In May 2018, the results showed three incidences of patients not having water up until two hours before surgery. We saw the service logged the reasons for this to help identify areas for improvement. Since beginning this study, the staff reported that patients appear more comfortable no longer report they are thirsty or complain of headaches.

Pain relief

We saw the use of a pain assessment tool in the patient notes we reviewed. During routine
observations, staff asked patients to rate their pain between one and 10. One meant no pain and 10 represented extreme pain. Patients we spoke with told us staff promptly offered pain relief when they reported pain.

There were different methods of managing patient’s pain. Pain relief was given by mouth (oral), injection, suppositories, epidural and patient controlled analgesia (PCA). Patients had access to an outreach pain team for acute pain. There was a separate chronic pain team.

The service was pro-active in preventing post-operative pain. Pre-assessment nurses advised patients to take paracetamol on the day of their operation. The trust introduced this initiative after a consultant carried out a study, which found this helped reduce patients’ post-operative pain. Patients felt staff managed their pain well and provided regular analgesia to keep them comfortable while they recovered from surgery.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From November 2016 to October 2017, patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Trauma & orthopaedics patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

Patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- General surgery patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & orthopaedics patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**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.
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 (November 2016 – October 2017))

Queen Elizabeth, The Queen Mother Hospital

From November 2016 to October 2017, patients at Queen Elizabeth, The Queen Mother Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Trauma & orthopaedics patients at Queen Elizabeth, The Queen Mother Hospital had a similar to expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Queen Elizabeth, The Queen Mother Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Colorectal surgery patients at Queen Elizabeth, The Queen Mother Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

Patients at Queen Elizabeth, The Queen Mother Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at Queen Elizabeth, The Queen Mother Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & orthopaedics patients at Queen Elizabeth, The Queen Mother Hospital had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Colorectal surgery patients at Queen Elizabeth, The Queen Mother Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
Elective Admissions - *Queen Elizabeth The Queen Mother Hospital*

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.

Non-Elective Admissions - *Queen Elizabeth The Queen Mother Hospital*

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: Hospital Episode Statistics)*

**National Hip Fracture Database**

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate for Queen Elizabeth, The Queen Mother Hospital was 7% which was as expected. The 2016 figure was 4.7%.

- The proportion of patients having surgery on the day of or day after admission was 59.9%, which was worse than the national standard of 85%. The 2016 figure was 68.5%.
- The perioperative medical assessment rate was 92.7%, which failed to meet the national standard of 100%. The 2016 figure was 92.5%.
- The proportion of patients not developing pressure ulcers was 97.3%, which falls in the middle 50% of trusts. The 2016 figure was 97.1%.
- The length of stay was 18.6 days, which falls in the middle 50% of trusts. The 2016 figure was 15.6 days.

*(Source: National Hip Fracture Database 2017)*

**National Bowel Cancer Audit**

In the 2017 National Bowel Cancer Audit for East Kent Hospitals University NHS Foundation Trust, 60.2% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate of 69.5%. The 2016 figure was 51.4%.

- The risk-adjusted 90-day post-operative mortality rate was 3.7% which was as expected. The 2016 figure was 3.5%.
• The risk-adjusted 2-year post-operative mortality rate was 20.0% which was as expected. The 2016 figure was 18.5%.

• The risk-adjusted 30-day unplanned readmission rate was 7.7% which was as expected. The 2016 figure was not reported.

• The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 76.0% which was a negative outlier. The 2016 figure was 75.6%.

(Source: National Bowel Cancer Audit 2017)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.0% for Abdominal Aortic Aneurysms, indicating that the trust was as expected. The 2016 figure was 1.6%.

Within Carotid Endarterectomy, the median time from symptom to surgery was seven days, which was better than the national standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was as expected at 1.5%. The 2016 figure was 0.5%.

(Source: National Vascular Registry 2017)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer National Audit (NOGCCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 3.6%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure had poor quality data.

The trust was not eligible for the 90-day post-operative mortality rate metric in either 2015 or 2016.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 40.0%, which was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

In the 2017 National Emergency Laparotomy Audit (NELA), Queen Elizabeth, The Queen Mother Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 190 cases.

• Queen Elizabeth, The Queen Mother Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 149 cases.

• Queen Elizabeth, The Queen Mother 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 97 cases.
- Queen Elizabeth, The Queen Mother Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 60 cases.
- The risk-adjusted 30-day mortality Queen Elizabeth, The Queen Mother Hospital was within expectations, based on 190 cases.

Green ratings show a positive outlier (below 99.8% control limit), whereas red ratings show a negative outlier (above 99.8% control limit).

(Source: National Emergency Laparotomy Audit 2017)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was about the same as the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was better than the England average.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. The service provided all new staff with a local induction. We saw copies of completed induction records in staff folders on Cheerful Sparrows (Male) Ward. This provided evidence of induction in a range of key areas including local policies and procedures, infection control, incident reporting and fire procedures. This
provided assurances new starters understood local policies and procedures.

We reviewed five staff competency folders; three in day surgery theatres and two on Cheerful Sparrows (Male) Ward. We saw evidence of competency assessment in key areas including hoisting patients, carrying out patient observations, medicines administration (for registered nurses) and intravenous medicines. In theatres, we saw additional competency assessments for areas such as patient collection, identification and pre-operative checklists for non-registered theatre support workers. This demonstrated the service had assurances staff had the necessary skills for their role.

A few months before our visit, the trust introduced new competency booklets for nurses, associate practitioners and healthcare assistants. We saw the booklets were comprehensive and kept a record of each staff member's equipment, clinical, administrative and managerial competencies. The booklets also contained records of education and development to support professional revalidation.

The trust supported staff through revalidation with the Nursing and Midwifery Council and General Medical Council. We saw evidence of continuing professional development towards Nursing and Midwifery Council revalidation in the staff competency folders we reviewed.

Nurse educators wrote bespoke training plans for new staff to enable them to develop their knowledge and skills. New staff underwent assessments to ensure they were competent to administer intravenous medicines. Nurse educators also met to share ideas and learning through a forum.

The service had recently introduced an “improvement journey” programme to support nurses recently promoted from band five staff nurses to band six junior sisters/charge nurses. We saw a copy of the improvement journey booklet to provide a record of newly-promoted band six nurses’ development in their new role. The booklet was comprehensive and provided links to further guidance and support, as well as a record of training, development and reflective practice to support appraisal and revalidation. Staff told us there was a weekly band six nurses meeting attended by the education link nurse to support band six nurses with their development. This included learning topics such as management of complaints and conducting safety briefings. The improvement journey was beginning to help the service develop and retain staff, as well as providing assurances newly-promoted nurses were competent to fulfil their new role.

Appraisal rates

From April 2017 to December 2017, 89% of staff within surgery at the trust had received an appraisal. This was better than the trust target of 85%.

Queen Elizabeth The Queen Mother Hospital had a 92% appraisal completion rate, which was better than the trust target of 85%.

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

We saw appraisal records in the staff competency folders we reviewed, and saw appraisals were linked to the trust’s values. This helped ensure staff brought the values to life through their day-to-day work.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. We saw positive examples of multidisciplinary working between different staff groups, including doctors, nurses and therapists.
On Cheerful Sparrows (Male) Ward, we observed a multidisciplinary “board round”, which included physiotherapy and occupational therapy. Patient records we reviewed demonstrated input into patient care from a range of specialists, such as dietitians and physiotherapists. We also saw evidence of specialist psychiatry input for a patient with mental health concerns.

The service held weekly orthopaedics and trauma teaching sessions. Staff told us the weekly education sessions were multi-professional and attended by different staff groups.

On Cheerful Sparrows (Male) Ward, we saw discharge planning sheets that included onward referrals to services such as district nurses. The form prompted nurses to check specialist reviews had been completed or referrals made before discharge where relevant, such as dietetics, tissue viability and occupational therapy. This helped ensure patients had the support they needed for effective discharge. The discharge checklists provided assurances patients were given information about their medicines to take home.

On Cheerful Sparrows (male) Ward, the ward manager described how the service aimed to identify patients the evening before for “golden discharge” the following morning by 10am. To help facilitate early discharge, healthcare assistants had started taking patients’ bloods early in the morning to ensure they received the results earlier in the day. The ward manager reported this was helping with patient flow, as well as helping avoid discharges late in the day.

The hospital worked with an external service to provide nursing support to patients in their own homes for the first three to five days following discharge. This helped avoid prolonged hospital stays for patients medically fit for discharge but in need of some further support as they recovered from surgery. The hospital’s integrated discharge team, which had specialist input from social workers, worked with the external service to assess patients before discharge. The integrated discharge team also attended board rounds on the wards to help identify patients that were fit for discharge. The external service’s nursing staff subsequently assessed patients in their home.

Although working with the external service helped avoid extended hospital stays for some patients, capacity was limited. The external service could only take five patients for assisted discharge from each hospital site each day.

On Sea Bathing Ward, a discharge coordinator told us they contacted patients in the first three to four days after discharge to check on their wellbeing. Surgical ward clerks had recently taken over post-discharge telephone calls to patients to ease nurses’ workloads. We saw a “post discharge telephone support form” completed by the ward clerks to document these calls. The form included set questions with clear “red/amber/green” ratings for different responses. There were clear criteria for escalating any areas of concern to the nursing team, including the need for immediate escalation of any “red flags”. A senior matron described how this system was working well to identify any post-discharge concerns and relieve nursing staff to perform other tasks on the ward.

**Seven-day services**

Staff on the wards told us surgical patients had a daily review from a clinician, seven days a week. Patient records we reviewed provided evidence of daily ward rounds, including reviews with senior clinicians. Records we reviewed showed all inpatients had a medical review on a ward round within 12 hours of admission. The service had an emergency theatre, which was available seven days a week for urgent operations.

The hospital’s diagnostic imaging department provided a 24-hour, seven-day on-call service. This allowed surgical staff to access to consultant-directed diagnostic services such as x-ray, ultrasound, CT and MRI, seven days a week to support clinical decision-making. This was in line with; NHS services, seven days a week, priority clinical standard five (2016).
Health promotion

On the surgical wards, we saw a range of patient information to help patients manage and improve their own health. This included display boards on Cheerful Sparrows Ward giving information on preventing falls and avoiding pressure ulcers. We also saw a range of leaflets including local stop smoking services, information for patients with bowel cancer, and leaflets to help patients reduce their risk of deep vein thrombosis (blood clots in veins) and pressure ulcers.

Patients having elective orthopaedic surgery attended a pre-operative “joint school”. This was an information session run by physiotherapists to help patients feel fully informed about their planned surgery and the subsequent recovery period. Physiotherapists demonstrated exercises and started patients on their exercise programmes pre-operatively with the aim of helping them recover more quickly after surgery. We spoke with two patients who had attended joint school, and both told us it was an informative and useful session.

At the time of our visit, the trust was in the final stages of developing a smartphone application called “my journey” for orthopaedic patients. The application, which was due to be rolled out two weeks after our visit, supported patients on their journey from pre- to post-operative. The application reminded patients of their medications and exercises to support them as they prepared for, and recovered from, surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients who lacked the capacity to make decisions about their care. Staff told us about occasions they had completed capacity assessments, with senior support if needed. They also described multi-disciplinary best interests’ meetings they had attended. We saw two examples of completed capacity assessments in patient records we reviewed. Both patients were assessed as lacking capacity to consent for their operations, and therefore best interests’ decisions were made. We saw that the patients’ consultants had completed “consent form four - statement of healthcare professional for adults who are unable to consent to investigation or treatment”. This documented the best interests’ decision-making for patients who lacked capacity in accordance with the Mental Capacity Act 2005.

We saw written consent for surgery in patient records we reviewed. We saw consultants had given the patients sufficient information and documented the risks and benefits of surgery, in line with Royal College of Surgeons’ guidance. We saw patients and consultants signed consent forms before surgery. This was in line with guidance from the Royal College of Surgeons Good Surgical Practice 2014, which states staff should “Obtain the patient’s consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision”. Patients and consultants then provided an additional signature on the day of surgery to confirm their consent to proceed in line with best practice guidance.

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 spoke with four patients, who were all happy with the care they received from staff. Patients described staff as “kind”, “polite” and thoughtful.

We reviewed patient thank you cards displayed on Cheerful Sparrows Ward, which provided
further evidence of compassionate care. Patient comments included, “You have all been brilliant and made my stay extremely pleasant”, “The nurses are always friendly, cheerful and helpful, despite their workload”, “You looked after me so well” and “Your good humour helped to make me feel better”.

On the new surgical emergency assessment unit, which opened in September 2017, we saw further examples of positive patient feedback. Patient comments included, “I got seen quickly and felt reassured that I was being looked after by the very kind nurse”, “Wonderful, cheerful staff. Excellent care” and “The care and attention received has been impeccable”.

We saw staff always respected and maintained patients’ dignity. We observed staff keeping patients covered in theatres and drawing curtains around their bed space before talking to them and carrying out routine observations. All interactions we observed between staff and patients were considerate and sympathetic.

Friends and Family test performance

From December 2016 to November 2017 the Friends and Family Test response rate for surgery at Queen Elizabeth, The Queen Mother Hospital was 55% which was better than the England average of 29%.

Quex Ward had the highest response rate with 76% and St. Augustine’s ward had the lowest response rate with 32%.

A breakdown of the friends and family test performance by ward for surgical wards at the trust with total responses over 100 is below. The monthly and annual performance figures represent recommendation percentages. This demonstrates that, on average, between 93% and 98% of patients would recommend the service to their friends and family.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp. Rate</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
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<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
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<tr>
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<tr>
<td>Cheerful Sparrow's Female</td>
<td>781</td>
<td>59%</td>
<td>92%</td>
<td>97%</td>
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<tr>
<td>Cheerful Sparrow's Male</td>
<td>610</td>
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<td>97%</td>
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</tr>
<tr>
<td>Seabathing</td>
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<td>95%</td>
<td>91%</td>
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<td>80%</td>
<td>95%</td>
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<tr>
<td>St Augustines</td>
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<td>100%</td>
<td>63%</td>
<td>86%</td>
<td>93%</td>
<td>60%</td>
<td>94%</td>
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</tr>
</tbody>
</table>

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard. Note: sorted by total response

(Source: NHS England Friends and Family Test)

Emotional support

We observed staff in theatres talking with patients in the anaesthetic room to lessen their anxiety. We saw a member of staff stay with a patient who had their operation under local anaesthetic throughout the procedure, explaining what was happening at each stage and providing support.

Patients had access to the hospital’s chaplaincy services to provide emotional and spiritual
support. We saw patient leaflets on Cheerful Sparrows Ward providing information about the chaplaincy service, which was available to everyone, not just those of a Christian faith. The hospital also had a multi-faith prayer room for patients and those close to them.

**Understanding and involvement of patients and those close to them**

The service actively involved patients and those close to them as partners in their care. Patients described how staff introduced themselves and put them at ease. A patient’s feedback we reviewed on the Surgical Emergency Assessment Unit described how “the friendly welcome put one at ease” and “all was explained”. We saw a consultant asking a patient whether they wanted their reading glasses so they could read all the information on their consent form more easily. Patients we spoke with on the wards described how nursing staff responded promptly when they rang their call bells for assistance.

A member of staff we spoke with described how a consultant had given their own money to buy some new clothes for a homeless patient so they could be discharged with dignity. Staff also described how they had brought in some of their partners’ old clothes for elderly patients on the wards that had no family nearby to bring clean clothes into the hospital for them.

We reviewed the pre-assessment section of the adult surgical care pathway. We saw that staff asked patients whether they had any questions or concerns. A nurse we spoke to described how they explained the process to patients and ensured they had all the information they needed to prepare for their operation. We saw that pre-assessment included a discussion of all the arrangements for the patient’s hospital stay, including ward visiting times and time off work. This helped patients and their relatives feel fully prepared for surgery.

**Is the service responsive?**

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

On arrival at the hospital for elective surgery, patients went to the Surgical Admissions Lounge to change and prepare for their operation. Once patients were ready to go to main theatres, they sat in the waiting area. We saw male and female patients sitting in the waiting area in their theatre gowns. This may have compromised the dignity of some patients. However, we saw written information given to patients at pre-assessment that included a reminder to bring a dressing gown and slippers. Dressing gowns may have helped preserve patients’ dignity while waiting to go to theatres.

Patients having day surgery went to the Day Surgery Unit on admission. They waited in the waiting room before nurses escorted them to their bed space on the Day Surgery Ward to change and prepare for surgery. Therefore, patients having day surgery did not have to wait in an area with other patients in their theatre gowns.

Patients having emergency surgery were usually admitted through the hospital’s emergency department. The trust opened a new Surgical Emergency Assessment Unit in September 2017. The unit accepted patients through a direct GP referral. The unit, which had two beds, was open from 11am to 7pm, Monday to Friday. The unit had clear referral criteria, which we saw. This included no patients under the age of 18, an early warning score of three or below, and a surgical referral from a GP. Nurses assessed patients in this area before review by a registrar. Patients had any necessary investigation such as blood tests and ultrasound scans. They subsequently completed consent forms for surgery with their consultant before going to theatres. Patient feedback about the Surgical Emergency Assessment Unit was highly positive. The service hoped to expand the unit in the future to help ease pressures on the emergency department.
The service had a dedicated emergency theatre. This enabled the service to prioritise urgent surgery for patients with the greatest need.

The facilities and premises on the Day Surgery Unit were suitable for children and young people. There was a four-bedded paediatrics bay on the Day Surgery Ward that had doors separating it from the adult areas of the ward. The paediatric area had a children-only bathroom adjacent to the bay, as well as a separate children’s waiting room. This ensured children were not sharing waiting areas, bathrooms or bays with adults. The children’s waiting room had a range of toys to provide comfort and distraction to children.

**Average length of stay**

**Trust Level – elective patients**

From December 2016 to November 2017, the average length of stay for all elective patients at the trust was 3.0 days, which is lower compared to the England average of 3.9 days.

- For trauma & orthopaedics elective patients at the trust was 3.8 days, which is as expected compared to the England average of 3.9 days.
- For urology elective patients at the trust was 1.7 days, which is lower compared to the England average of 2.5 days.
- For general surgery elective patients at the trust was 2.6 days, which is lower compared to the England average of 3.9 days.

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

![Average length of stay chart](chart.png)

*Note: Top three specialties for specific trust based on count of activity.*

**Trust Level – non-elective patients**

The average length of stay for all non-elective patients at the trust was 4.6 days, which is as expected compared to the England average of 5.0 days.

- The average length of stay for general surgery non-elective patients at the trust was 4.0 days, which is as expected compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at the trust was 9.1 days, which is as expected compared to the England average of 8.8 days.
- The average length of stay for urology non-elective patients at the trust was 1.2 days, which is lower compared to the England average of 2.9 days.
Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.

Queen Elizabeth, The Queen Mother Hospital - elective patients

From December 2016 to November 2017 the average length of stay for all elective patients at Queen Elizabeth, The Queen Mother Hospital was 4.1 days, which is as expected compared to the England average of 3.9 days.

- The average length of stay for trauma & orthopaedics elective patients at Queen Elizabeth, The Queen Mother Hospital was 4.5 days, which is as expected compared to the England average of 3.9 days.
- The average length of stay for general surgery elective patients at Queen Elizabeth, The Queen Mother Hospital was 3.2 days, which is as expected compared to the England average of 3.9 days.
- The average length of stay for colorectal surgery elective patients at Queen Elizabeth, The Queen Mother Hospital was 6.7 days, which is as expected compared to the England average of 7.1 days.

Elective Average Length of Stay - Queen Elizabeth, The Queen Mother Hospital

Note: Top three specialties for specific trust based on count of activity.

Queen Elizabeth The Queen Mother Hospital - elective patients

The average length of stay for all non-elective patients at Queen Elizabeth, The Queen Mother Hospital was 6.2 days, which is higher compared to the England average of 5.0 days.

- The average length of stay for general surgery non-elective patients at Queen Elizabeth, The Queen Mother Hospital was 4.4 days, which is higher compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at Queen Elizabeth, The Queen Mother Hospital was 8.5 days, which is as expected compared to the England average of 8.8 days.
- The average length of stay for colorectal surgery non-elective patients at Queen Elizabeth,
The Queen Mother Hospital was 5.5 days, which is higher compared to the England average of 4.5 days.

Non-Elective Average Length of Stay - Queen Elizabeth, The Queen Mother Hospital

![Graph showing average length of stay](image)

*Note: Top three specialties for specific trust based on count of activity.*

*(Source: Hospital Episode Statistics)*

### Meeting people’s individual needs

The service took account of patients’ individual needs. Patients living with dementia had “this is me” passports. The passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient’s individual needs. We also saw “I am a carer” forms. The carer forms allowed carers of patients living with dementia to visit the patient in hospital whenever they chose. This enabled carers to provide stimulation, comfort and help with the patient’s recovery, as highlighted in the national “John’s campaign” for hospitals to allow open visiting for carers of patients living with dementia. “Dementia visitors” were at the hospital every Tuesday and Thursday. These were trained volunteers that were available to spend time with patients living with dementia to provide comfort and support while they recovered from surgery. Nurses could refer patients to the trust dementia nurse specialist for extra support.

We saw “forget me not” blue flower magnets in use on the wards. Placing the magnets above patients’ beds and on the patient whiteboard provided a discrete way of easily identifying patients living with dementia so all staff could take action to meet their individual needs. We also saw “dementia packs” for patients living with dementia. These included a checklist to ensure all patients living with dementia had fluid, food and mouth care charts, “forget me not” flower magnets, “this is me” passports, and carers’ visiting forms while on a ward. On Bishopstone Ward, we saw Makaton picture charts. Staff told us they used these to help patients with communication difficulties articulate their needs.

In theatres, staff told us relatives or carers of patients living with dementia or learning disabilities could accompany the patient into the anaesthetic room. This allowed a relative or carer to provide familiarity and comfort to the patient immediately before their operation. Staff subsequently called for the carer or relative once the patient was in recovery so they could provide comfort and support after the operation. During our visit, we saw the relative of an elderly patient with some confusion accompanying the patient in theatres.

The service had access to interpreters of a wide range of languages. Staff told us they rarely needed to use interpreters as most patients spoke English. However, staff could describe the process for requesting interpreters and gave examples of times they had done this.

The service was able to meet the needs of bariatric patients (those with a high body mass index). In main theatres, we saw equipment such as trolleys and operating tables that could accommodate bariatric patients. Staff were able to tell us the maximum weights different pieces
of equipment could hold. We saw staff competency records, which provided evidence of bariatric training as part of manual handling training. This provided assurances the service had the equipment and staff training to treat bariatric patients safely.

We saw there were no mixed-sex accommodation breaches on the surgical wards during our visit. A mixed-sex accommodation breach is when male and female patients share the same sleeping areas and bathrooms, which compromises patient privacy and dignity. Staff on the wards described how they placed a patient of the opposite sex in a side room with their own designated bathroom if they needed to place a female patient on a male ward, or vice-versa. We saw this in practice on Cheerful Sparrows (male) Ward, where a female patient had a side room with an adjacent bathroom clearly marked for her specific use only. This ensured there were no mixed-sex accommodation breaches.

**Access and flow**

Operating lists generally started on time. Data displayed in day surgery theatres showed in March 2018, 92.9% of theatre lists started within 30 minutes of the designated start time. This was better than the trust target of 90%. This was an improvement from our previous inspection, when 85% of operating lists started on time in day surgery theatres.

In main theatres, 88.8% of operating lists started on time in February 2018. This was slightly worse than the target of 90%.

We saw few medical outliers on the surgical wards during our visit. Medical outliers are medical patients placed on surgical wards because of a lack of medical ward beds. On Cheerful Sparrows (male) Ward, staff placed all the medical outliers in a dedicated bay. This helped ensure medical outliers were easily identifiable to prevent medical reviews being missed.

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

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery. This was generally worse than the England average and was shown to be stable during the reporting period.

As of December 2017, 57% of this group of patients were treated within 18 weeks, which was worse than the England average of 72%. More recent data for January to April 2018 showed referral to treatment rates had remained the same and not improved.

(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, all of the specialties were worse than the England average.
<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>63%</td>
<td>77%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>62%</td>
<td>72%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>45%</td>
<td>61%</td>
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<tr>
<td>Neurosurgery</td>
<td>0%</td>
<td>71%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0%</td>
<td>83%</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 showed no noticeable trend, and was generally lower than the England average.

As of quarter three 2017/18, this trust cancelled 150 surgeries. Of the 150 cancellations, 5% were not treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - East Kent Hospitals University NHS Foundation Trust**

![Graph showing the percentage of patients whose operation was cancelled and were not treated within 28 days over two years. The trust shows a lower percentage than the England average.](image)

**Cancelled Operations as a percentage of elective admissions - East Kent Hospitals University NHS Foundation Trust**

![Graph showing the percentage of cancelled operations as a percentage of elective admissions over two years. The trust shows a lower percentage than the England average.](image)

Over the two years, the percentage of cancelled operations at the trust was better than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)
Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with relevant staff. We reviewed five formal complaints relating to the service between March 2017 and February 2018 and the trust’s responses. We saw evidence of investigation, explanation and apology. We saw the trust was honest in its responses, for example, if staff had made mistakes or should have done things differently. This was in line with the regulatory Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. We saw the trust had shared learning with staff involved. Staff we spoke with told us they routinely received learning from complaints, which managers shared with them in monthly bulletins. We saw evidence of shared learning in the bulletins we reviewed. This showed the service took action to use complaints as an opportunity to drive improvement.

On Cheerful Sparrows (Male) Ward, we saw a “You said, we did” board. This showed action the ward had taken in response to patient feedback. For example, a patient had wanted fans during hot weather, and the ward was trying to arrange charity funding to buy fans.

Summary of complaints

The hospital received 100 complaints relating to surgery between March 2017 and February 2018. Of these, five complaints were still open and under investigation at the time of our visit. Of the 95 closed complaints, 81 had an initial 30-day agreed timeframe and 14 had an initial 45-day agreed timeframe with the complainants.

Of the 81 complaints with an initial 30-day agreed timeframe, the trust responded to 75 (93%) within the agreed timeframe. Of the 14 complaints with an initial 45-day agreed timeframe, the trust responded to 100% within the agreed timeframe. This demonstrated the service investigated and responded to complaints in a timely way.

Is the service well-led?

Leadership

A leadership team consisting of a divisional head of nursing, a divisional director and a divisional medical director led the trust’s surgical services across the three hospital sites. Surgical and theatre matrons were responsible for nursing staff. The matrons reported to one of the three senior surgical matrons, who reported to the divisional head of nursing. Each branch of surgery (for example, orthopaedics, anaesthetics, urology and gastrointestinal) had a consultant clinical lead. The clinical lead for each surgical specialty reported to the divisional medical director. There were five general managers covering different surgical specialties, who each reported to the divisional director for surgery. Operations managers, who were responsible for non-clinical staff, reported to the relevant general manager.

All staff we spoke with felt well supported by their line managers. Staff told us they felt confident to escalate any concerns to their managers. We saw the matrons were visible in clinical areas and approachable to staff. Senior managers spoke positively about the executive team. They described the new chief executive as having “drive” and energy and spoke about monthly meetings they had attended with the chief executive. Most staff we asked had not seen the executive team in their clinical areas. However, they could identify the executives and enjoyed reading the chief executive’s weekly blog.
Vision and strategy

Most staff we asked were unable to tell us the trust values, despite them being included in staff appraisals. Two therapists we spoke with felt the values were “not essential” to their staff group. This suggested the values might not have been fully embedded across the service.

Senior managers we spoke with told us the service was working hard to meet its strategic goals. These included improving patient flow throughout the hospital and improving referral to treatment times. We saw some improvements in patient flow since our last visit, for example, improved theatre start times in day surgery theatres and no overnight patients in the recovery area.

Culture

Managers across the trust promoted a positive culture that supported and valued staff. Despite staff telling us they often felt tired due to the lack of staff on some of the wards, staff generally spoke positively of the culture. They described positive working relationships with colleagues and managers. One staff member said, “People care about each other”.

Staff felt confident to raise concerns and report incidents and told us their managers encouraged them to do so. Staff described having an “open culture” and showed awareness of the need to be honest with patients when things went wrong. This was in line with the regulatory Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014.

Governance

The divisional governance team was led by a matron and a clinical lead for governance, patient safety and quality. The matron and clinical lead for governance reported to the divisional director. The divisional manager for governance, patient safety and quality at Queen Elizabeth the Queen Mother Hospital reported to the matron.

We found governance was not given sufficient priority. We requested copies of the last three clinical governance meeting minutes, and the most recent minutes the trust could supply were from 21 November 2017. This meant there had not been a surgical divisional governance meeting for six months before our visit. The minutes from 21 November 2017 showed poor attendance. Only six staff attended the meeting, with no clinical representation from most surgical specialties.

The trust provided us with the following statement relating to our request for governance meeting minutes: “The Queen Elizabeth the Queen Mother governance meetings have been under review due to the poor attendance from wide range of staff groups. Clinical engagement is key to the success of this group. All clinical leads on site have been invited but timings of meetings were proving challenging to ensure they were available to attend. The divisional business partners have been put on a rotational basis and given a specific slot to feedback. The clinical audit team will attend twice a year to update on the audit programme and highlight any concerns. Specific areas for focus will be sent through to general manager to highlight in meetings if required. Ward managers are invited to take part so they can raise their concerns and report back on best practice. The next meeting is planned for 15 June 2018”.

In the governance minutes we reviewed, we saw the divisional governance, patient safety and quality manager presented the latest quarterly governance report. This included a discussion of governance issues such as incidents, complaints and safety thermometer indicators. We saw the attendees had discussed particular cases and identified learning for dissemination to relevant staff.
Management of risk, issues and performance

We reviewed the surgical divisional risk register and saw senior staff regularly reviewed and updated risks. We saw items on the register matched the things senior staff told us were on their “worry list”, such as bed capacity. The risk register also aligned with risks we identified, such as referral to treatment rates.

However, other issues we identified as areas of risk, such as maintenance of the facilities and equipment in main theatres and nurse staffing shortages did not feature on the risk register. This meant the service might not have had sufficient oversight, or taken action to mitigate these risks. However, after raising concerns about the safety of some of the operating lights in main theatres, we saw the trust added this issue to the surgical risk register on 18 May 2018 and took immediate action to mitigate this risk.

We saw the hospital’s surgical quality dashboard. This measured and monitored the service’s monthly performance in key areas against trust targets. This included monitoring of harm-free care, readmissions, infection rates, referral to treatment times, incidents, complaints, staff turnover and vacancy rates. The dashboard had a “red, amber, green” rating system to allow staff to see at-a-glance whether the service was meeting its targets. We saw that the service compared performance to the previous month to identify trends. This meant managers were able to identify emerging concerns, and obtain assurances they were performing well or improving.

The service’s internal audit programme helped provide assurances around staff performance and compliance with policies and drive continuous improvement. This included regular audits on the World Health Organisation Surgical Safety Checklist and sepsis screening audits. Audits provided assurances around staff compliance and helped identify areas for improvement. Staff told us they received feedback on audit results to help drive continuous improvement.

Information management

We saw quarterly divisional governance reports and the quality dashboard that contained sufficient information to monitor quality across the service. The ‘live’ electronic dashboards were regularly updated so the service had oversight of quality and safety data in a timely manner.

The service collated and submitted data to a range of national audits. These included the national hip fracture database, the national emergency laparotomy audit and the national vascular registry. This allowed the comparison of data against national averages and standards to help drive continuous improvement.

Senior staff also had access to information through trust smartphones, for example early warning scores, so they could be alerted when a patient was deteriorating.

Engagement

The service took action to actively engage with staff and seek their views. In day surgery theatres, we saw a poster advertising staff focus groups with the theatre matron. One member of staff we spoke with said they had attended a session and found it useful. Staff also told us about quarterly open forums held by the divisional directors, which provided opportunities for staff feedback.

The service also used a “claims, concerns and issues” exercise to capture staff feedback and make immediate improvements. Senior managers described how this exercise allowed them to identify and make improvements to the working environment for administration staff. The service was planning to repeat this exercise at staff development days in the coming weeks to extend improvements into other areas.
The service used the NHS Friends and Family test as a means of capturing patient feedback. Results for the period December 2016 to November 2017 showed most patients would recommend the service to their family and friends.

**Learning, continuous improvement and innovation**

The service had a strong focus on training and developing its own staff. The service hoped this would help fill some of the nursing vacancies by helping improve staff retention. Staff we spoke with gave examples of courses they had attended funded by the trust, such as anaesthetics. Three members of theatre staff had recently attended a course to allow them to develop scrub competencies. Theatres ran nursing apprenticeships for staff, supported by college courses to give staff the necessary theoretical knowledge.

One member of theatre staff described how a practice educator encouraged them to complete a university foundation degree in health care studies. This had allowed the staff member to progress from a band two to a band four position. The staff member told us completing the course gave them confidence. They said, “I’ve gone from minimum wage to band four and I feel I’ve got a future”. This demonstrated staff felt valued through the opportunities for training and career development.

The new Surgical Emergency Assessment Unit was a recent area of improvement to improve emergency surgical patient flow through the hospital. We identified the tool for ward clerk post-discharge telephone calls and the “my journey” smartphone application for orthopaedic patients as areas of innovation.

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**Maternity**

**Facts and data about this service**

The trust has 50 maternity beds across two sites; Queen Elizabeth The Queen Mother Hospital and William Harvey Hospital.

The Queen Elizabeth The Queen Mother Hospital in Margate delivers approximately 2,800 births a year. It offers specialist obstetric care for women with complications and anaesthetists providing a 24-hour epidural service for women who prefer this for pain relief as well as for women who require anaesthesia for operative and assisted births. The Special Care Baby Unit takes babies born after 28 weeks. Those babies born unexpectedly earlier or who are very sick are transferred to William Harvey Hospital. In general, women with very high-risk pregnancies or likely to deliver before 28 weeks were transferred prior to delivery.

The hospital provides specialist obstetric care for pregnancy, childbirth and the post-partum period. The labour ward is consultant led and has an obstetric theatre. Obstetric relates to childbirth and the processes which go with it.

The midwifery led unit is next to the labour ward and is a midwife run unit. The unit supports birth in a less clinical environment. The unit has four multifunctional rooms, two with birthing pools, which is used for labour, delivery and postnatal care.

Kingsgate ward provides consultant led antenatal (before birth), labour and in patient postnatal (after birth) care for women with high risk pregnancies and those who chose consultant led care.

Next to the maternity unit is the fetal medicine and antenatal clinic which is open between 8am to
8pm. The clinic arranges all first trimester scans, books antenatal and postnatal appointments as well as running a range of midwifery and consultant led clinics.

During the inspection, we spoke with mothers and their families, cleaners, midwives, midwifery health care assistants, consultants, matron, the head and deputy head of midwifery.

Prior to the inspection, we held focus groups for staff and reviewed the trusts performance data.

Since the previous inspection there has been a change in leadership team with a new head of midwifery and deputy as well as the introduction of the clinical governance midwife.

The trust had also introduced the maternity transformation programme, birthing excellence success through teamwork (BESTT)

(Source: Trust Provider Information Request – Acute sites)

From October 2016 to September 2017, there were 6,645 deliveries at the trust.

A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below:

Number of babies delivered at East Kent Hospitals University NHS Foundation Trust – Comparison with other trusts in England.

A profile of all deliveries from October 2016 to September 2017 can be viewed below:
# Proportions of deliveries by recorded delivery method

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>East Kent Hospitals University NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,946</td>
<td>29.3%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>690</td>
<td>10.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,997</td>
<td>60.2%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>12</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>6,645</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non-assisted) deliveries

Notes: To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with “*” (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below:

**Number of deliveries at East Kent Hospitals University NHS Foundation Trust by quarter.**

SOURCE: HES - Deliveries (October 2016 - September 2017)
The number of deliveries per quarter during this reporting period has remained about the same with no trends of increase or decrease.

Is the service safe?

SAFE SECTION

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

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

Mandatory training

Mandatory training completion rates

The trust provided mandatory training in key skills as shown in the table below via online e-learning and face to face sessions. Staff knew how to access online training and where to book face to face sessions.

Mandatory training matrix reports are produced and a copy is emailed to the maternity unit matron, which identifies staffs outstanding mandatory training.

The trust set a target of 85% for completion of mandatory training and within the nursing/midwifery team at Queen Elizabeth the Queen Mother all key skills but one were met, information governance.

We saw examples of staff training records showing completed training, training due and training outstanding. There was a clear system to track and monitor staff statutory and mandatory training, which staff demonstrated to us.

From May 2017, the trust introduced a maternity specific training programme with each staff member undertaking five core-training days in key obstetric skills in fetal monitoring, essential life support skills in obstetrics, human factors, simulation and maternity update day. The five-day programme has overlapping themes featuring serious incidents. The trust aims for all obstetric staff to have completed the training by June 2018.

Fetal monitoring face to face training takes place, which is line with MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK and Each baby counts. Following on from the training, the department now has midwifery fetal monitoring champions working ‘on the shop floor’.

Practical essential life support and simulation training cover topics such as; MBRRACE, Each baby counts, management of major obstetric haemorrhage and maternal collapse, vaginal breech delivery, shoulder dystocia, neonatal collapse.

The trust data provided showed us that both medical and midwifery staff were attending the training. The trust aimed for 98% of staff to have completed the training by June, which is the trust target.

All obstetric staff will complete a number of key training topics within a maternity induction programme these being, emergency skills in obstetrics, human factors, fetal Monitoring, charts including SEPSIS and bladder care, clinical systems, medicines management, child and adult safeguarding and mental capacity act and breast-feeding support.
Staff also undertook specific sepsis training and had access to trust policy on sepsis, which included the use of sepsis screening tools and use of sepsis care bundles that were specific to maternity services.

We requested a breakdown of compliance for mandatory courses, within the Queen Elizabeth the Queen Mother hospital acute birth settings for medical staff. The breakdown, from 30 May 2018, showed a compliance rate of 67% to 87% for mandatory training modules with an average of 80% compliance. This was below the trust target of 85%.

A breakdown of compliance for mandatory courses, within the Queen Elizabeth the Queen Mother Hospital acute birth settings, from January 2017 to December 2017 for nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>62</td>
<td>65</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>61</td>
<td>65</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>61</td>
<td>65</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>56</td>
<td>65</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>54</td>
<td>65</td>
<td>86%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>51</td>
<td>65</td>
<td>80%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P14)

**Safeguarding**

**Safeguarding training completion rates**

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

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 safeguarding children’s team were placed within child health and work closely with the Kent child exploitation team. An experienced safeguarding midwife was part of the safeguarding children’s team and worked within the trust.

Information was shared between the safeguarding team and maternity staff and a flag was applied to the patient administration system for safeguarding concerns including a pre-birth child protection plan. The child protection information-sharing project had been introduced into other core service areas within the trust with plans to also introduce the system into maternity services.

Midwives told us that each woman attending antenatal had a green pre-birth plan. Inside the green plan there is a small discreet box which can be ticked if a woman has disclosed any domestic violence. We saw the domestic abuse policy which had recently been reviewed and gave clear guidance to staff. There were folders seen in the midwife’s office with women who have safeguarding needs and there is a baby alert sticker and annotation in red on the white board placed inside the office to identify these women.
The safety huddles occurred daily and were attended by ward and community midwives to highlight any safeguarding concerns or new referrals. They discussed the pre plan for any admissions into the hospital to ensure that the woman’s additional needs were met.

A female genital mutilation (FGM) policy was in place and followed the guidance set out by The Department of Health requirements for reporting female genital mutilation to other agencies. This document was included into the Trust safeguarding policy.

Staff were able to explain the process of referral if suspecting or identifying a woman has female genital mutilation (FGM).

The children’s safeguarding team were contacted when a pregnant woman or a woman with children was identified or suspected to have had female genital mutilation. An electronic incident report form was completed as well as a referral to social services and reported to the police. The information was reported in the electronic notes system and information collated monthly and submitted to The Department of Health. Information is reported to the GP, health visitor and other appropriate health agencies using the local information tool called ‘concern and vulnerability form’. Health professionals used the red books to record information on baby’s birth and health, including feeding assessments, new born checks and new born hearing screening.

Trust data provided showed there had been 12 cases of identified women with female genital mutilation recorded from April 2017 to April 2018.

The trust followed criteria set out by the Kent Safeguarding Children Board, so any pregnant young person under the age of 13 were automatically referred to social services, as an Offence under the Sexual Offences Act 2003 would have occurred. Any young person who was looked after by the local authority, on a child protection plan or concealed pregnancy were referred to the local authority and safeguarding teams.

Staff were aware of trust policy in regard to young and vulnerable mothers. Young people between the ages of 13-18 years were assessed on a case by case basis, dependent on age, vulnerable indicators for example schooling, family support, age of partner and stage at which they are assessed for their maternity care. Staff we spoke to were aware of the process of referring young people and told us that they had a demographic of young mothers. Community midwives completed a maternity support form at antenatal booking and information was shared between teams. During the inspection we observed a conversation and saw a chronological timeline of discussions for a young mother planning to have her baby in the hospital between communities midwives, safeguarding midwife, social services and the health visitor.

The trust set a target of 85% for completion of safeguarding training. The table below shows that all midwifery staff met the trust target.

A breakdown of compliance for safeguarding courses from January 2017 to December 2017 for nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>65</td>
<td>65</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>59</td>
<td>65</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>57</td>
<td>65</td>
<td>89%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Queen Elizabeth The Queen Mother Hospital
We were not given a breakdown of compliance for safeguarding level two and three courses, within the Queen Elizabeth the Queen Mother hospital acute birth settings for medical staff. Therefore, we were unable to determine whether medical staff had met the trust target for completion of safeguarding 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. However, we did see some area where the maternity unit looked tired.

The completion rate for staff infection control training was 96% compliant, which is above the trust target of 85%.

Cleaning was sourced to an outside company and we saw evidence that domestic staff followed guidance of the required cleaning standards, practices and frequency of cleaning. Cleaning schedules and monthly cleaning scores were on display.

We saw weekly cleaning audits completed by the contracted company as well as environmental audits of the maternity unit completed by the clinical team. Infection control audits are also completed monthly and the clinical team, contractor and ward managers carried these out. Clinical audits observed showed us that staff were 98.35% compliant in ensuring infection control.

We saw posters in sluice and cleaning rooms, which highlighted colour codes of mops and cloths to suit the cleaning task in line with the NHS national specifications, and housekeeping staff were able to describe the colour coding system.

We saw staff followed the trust policy on infection control, for example, long hair was tied back, no wrist watches observed and “bare below the elbows” at all times allowed effective hand washing.

There were hand hygiene posters displayed around the unit with dedicated hand hygiene sinks available for staff to use before and after patient care. Gloves were available to protect staff and patients against infection and we saw that staff adhered to use of gloves where clinically indicated.

All departments within the maternity unit were considered high risk or very high risk for infection control. The hospital was compliant with the Department of Health guidance recommending: ‘All patients admitted to high risk units and all patients previously identified as colonised with or infected by Methicillin-resistant Staphylococcus aureus (MRSA) should be screened for MRSA. Patients were screened for methicillin-resistant staphylococcus aureus (MRSA) automatically at pre-clerking for an elective or emergency caesarean section.

Sanitisising hand gel dispensers were mostly available throughout the unit and there were signs above gel dispensers encouraging staff and visitor to use the gel to clean their hands. At the main entrance to the unit where staff, patients and visitors passed through regularly there was a hand gel poster with guidance but no hand gel system in place.

The hand hygiene audit tool was used to measure compliance with hand hygiene before and after contact with patients. We observed staff using hand gel before and after patient contact which showed staff were following National Institute of Care and Excellence guidance, QS61 statement 3: ‘People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.’
The maternity unit safety thermometer results showed us that staff were 94.4% compliant with hand hygiene and 90.67% compliant with bare below the elbow practice.

We saw correct segregation of clinical and non-clinical waste. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations.

Sharps boxes were seen in each area we visited, most were assembled and disposed of in accordance with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 (The Sharps Regulations). However, we saw sharps boxes which were not labelled correctly and one which was overfilled, this posed a potential needle stick injury risk to staff and patients.

Environment and equipment

The maternity unit was well situated in the hospital with an entrance and a car park directly outside, therefore accessible to patients.

The maternity unit had one obstetric theatre, we were told it was used for emergency caesarean sections only. This meant all planned caesarean sections were taken to general theatres. The time to travel to the general theatre was between five and six minutes. This raised concerns in relation to patient safety, as well as privacy and dignity, if there were to be two emergency cases at one time and one had to be transferred to general theatres. Staff and the head of midwifery were aware of the potential risks to having one obstetric theatre used for emergency cases, but due to the current configuration of the unit they told us it was not currently possible to have a second obstetric theatre.

We saw some areas where the environment of the maternity unit was not welcoming and looked tired.

The fetal medicine and early pregnancy unit had its own reception and situated next door to the maternity unit. The unit and rooms were clean and had all the necessary equipment available.

We found the counselling room situated in the day unit to be an inappropriate area to have difficult discussions with patients and families. The room contained only a sofa and cupboard, the walls were bare and there were no literature or leaflets provided. However, we were told that there were plans to apply for funds to improve the counselling room. At present patients were seen in the clinic rooms.

The maternity unit consisted of Kingsgate ward for antenatal and postnatal care and labour ward, which had induction rooms and quick access to obstetric theatre. The midwifery led unit worked independently from labour and Kingsgate ward.

The visitor/patient toilet on Kingsgate was not in a poor condition. The toilet brush and tissue was seen on the floor. We saw comments in the patient feedback box that they were unable to get toilet paper out from the dispensers. The showerhead in the shower room opposite the toilet was hanging on by a rubber band.

The previous report highlighted that there was a lack of ensuite bathrooms in the unit and this is still the case with not all rooms in the labour ward having access to a bathroom. We saw that two rooms on the ward had access to one bathroom. The lock to one of the room doors was broken and offered no privacy to patients needing to shower.

However, the rooms in the midwifery led unit were clean, bright, well equipped and all had ensuite facilities.
In all clinical areas, the curtains did not either have a disposable date or date when next to change them. Therefore, this could pose an infection control risk.

The Royal College of Obstetricians and Gynaecologists ‘Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour’ states equipment must be maintained in good working order. Equipment was maintained in accordance with the trust’s medical devices and systems policy, which covered repairs and planned preventative maintenance.

We checked 10 pieces of equipment within the maternity unit and all equipment apart from a monitor in the obstetric theatre had an asset barcode and log number which ensured it had been registered onto the trust’s medical devices log and had up to date servicing and electrical safety testing.

Staff knew how to report faulty equipment and how to source a replacement for any essential items. We saw cardiotocography (CTG) machines were available throughout the unit and resuscitaire’s in all labour rooms and obstetric theatre. A cardiotocography machine records the fetal heartbeat and the uterine contractions during pregnancy. A resuscitaire is where babies are cared for whilst being assessed and if necessary, resuscitated.

We observed that equipment was not always checked daily and there were no ‘I am clean’ stickers on equipment other than on one resuscitaire within the labour suite. This sticker however was out of date and last checked on the 6th April 2017.

There was the correct emergency equipment on the delivery suite including drug boxes for specific emergencies such as sepsis. We observed two resuscitation trolleys one was fully equipped, with drugs in date, however the paediatric resuscitation trolleying the obstetric recovery room had two items out of date and on both trolleys, daily checks had not always taken place. We alerted labour manager ward regarding the out of date items and we were told that this would be looked into and items replaced.

The department had CCTV in place and staff monitored movement onto the labour ward. Visitors and patients were monitored arriving onto the unit, but there was an unrestricted departure point so the system was not robust and not in line with the Royal College of Obstetricians and Gynaecologists 2008, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour 2.2.26 ‘Security is an issue of importance for staff, mothers and babies. A robust system must be in place for their protection. Babies born in hospital should be cared for in a secure environment to which access is restricted.’

The temperature during the last inspection was reported to be intolerably hot for patients. Staff told us that the temperature within the unit was difficult to control due to the design of the building and they had been encouraged to complete an electronic reporting incident form each time the temperature went above a safe level. The World Health Organisation standard for comfortable warmth should be between 16 to 20°C. We were told that ongoing temperature audits of the maternity unit were completed although we were not given any current information. A temperature audit completed in October 2017 showed us through May to June 2017 temperatures exceeded above 20°C, with the highest temperature recorded in June 2017 of 28.5°C.

**Assessing and responding to patient risk**

Systems and procedures were in place to assess, monitor, and manage risks to patients

Patients were continually risk assessed using a maternity obstetric early warning score (MEOWS) is to determine the degree of risk of an unexpected deterioration in the condition of a patient.
Patient notes we reviewed showed comprehensive completion and evidence of escalation if a patient were seen to be deteriorating.

There were completed risk assessments for patients with actions taken that were clearly documented. There was adequate use of the venous thromboembolism (VTE) score checklist, partogram (a composite graphical record of key maternal and fetal data during labour), World Health Organisation (WHO) checklist used in theatres, charts for growth and early warning scores. Following the previous inspection, venous thromboembolism scores were now being placed onto the maternity dashboard, however the amount of assessments completed were 92.5%, which do not meet trust target of more than 95%.

A communication tool ‘Situation, Background, Assessment and recommendation’ (SBAR) had been introduced for staff handovers and advice calls between midwives and doctors at the last inspection.

A daily huddle took place daily within the maternity unit. The huddle discussed patients, monitoring risks and safety. A handover sheet was used each day that gave full details of patient, event, and any concerns or complications.

We observed the following staff taking part in the huddle, three obstetric consultants, consultant anaesthetist, labour ward manager, community midwife, midwife co coordinator, midwife Kingsgate ward, gynaecology SHO, general theatre senior charge nurse, SHO on call and an obstetric registrar.

Baby observations were completed frequently using the new born weight tool (NEWT). Baby observations were recorded at the bedside and regular monitoring took place.

Obstetricians were involved in multidisciplinary discussions regarding emergency caesarean sections in accordance with the Royal College of Obstetricians and Gynaecologists ‘Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour’.

We saw the protocol used for the assessment of foetal growth and staff could tell us how risk assessments take place at booking, during pregnancy and serial growth scans were arranged if there was an increased risk of fetal growth problems or if fundal height measurements were not accurate.

There was an escalation policy for patients with presumed or confirmed sepsis who required immediate review. Staff told us they used the inpatient maternal sepsis screening tool with the ‘sepsis six’ pathway. This was a maternity specific tool to ensure women were treated in line with recommended National Institute Health and Care Excellence guidelines, for example receiving antibiotics within an hour.

We saw comprehensive risk assessments carried out for women who used services and risk management plans were developed in line with national guidance. Women were risk assessed on each visit to the department even if they arrived from the early pregnancy unit on to the wards. This ensured the continuous monitoring of risk. Risk assessments contained information on women’s social and medical assessments and referral, as well as assessment of maternal mental health. Patients were triaged before arrival onto the unit. Patients with additional needs were flagged at this point so staff were aware at pre-admission if any extra care was needed.

Women were able to call the triage line with any concerns or worries and for advice. Women could also access an early pregnancy unit if they had bleeding and/or pain before 12 weeks and six days. The early pregnancy unit helped women identify the cause of symptoms and offered advice, support and any necessary treatment.
**Midwifery and nurse staffing**

Staff told us they felt staffing had improved recently and maternity leads structured their day with an early start so they provided hands on patient care if needed. The head of midwifery told us that the staffing policy was due to be updated as well as a review of current medical and nursing staffing within the unit, taking staff skills and skill mix into account with a staffing acuity tool.

National Institute of Clinical Excellence NG4 Safe Midwifery Staffing states women in labour should receive 1:1 care. The risk register for the hospital showed us the unit was reaching 96.2% for the last year for 1:1 care in labour and falling short of the 100% target.

There were insufficient staffing levels across the trust and this meant the labour ward co-ordinator was not supernumerary on each shift. This meant their ability to provide leadership support, deploy resources, and oversee the quality of care in the department may be affected. Matrons, specialist midwives and community midwives were used in times of heightened activity and staff flexed between antenatal, post-natal and delivery suite.

There was an escalation policy to manage staffing when numbers were compromised.

The trust provided some specialist services for maternity in-line with National Institute of Care and Excellence guidance, including, Practice Development Midwife, Perinatal Mental Health Midwives, Infant Nutrition Midwife post which had just become vacant, Bereavement Midwife, Midwifery Preceptorship Facilitator, Maternity Practice Education Facilitator and Safeguarding midwives.

The trust has reported their staffing numbers below for the period March 2017 to December 2017.

- Maternity had a staffing rate of 79% across both acute sites.
- Queen Elizabeth the Queen Mother Hospital had a staffing rate of 81%, indicating that the unit had to function with 14 less WTE nursing staff in post than what was planned for.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>71</td>
<td>58</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
<td><strong>58</strong></td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From January to December 2017, the trust reported a vacancy rate of 4% in maternity, better than the trust target of 10% or less.

- Queen Elizabeth The Queen Mother Hospital: Had a vacancy rate of 7%

Queen Elizabeth the Queen Mother had vacancy rates better than the trust target of 10% or less.

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

**Turnover rates**

From January to December 2017, the trust reported a turnover rate of 13% in maternity; in line with the trust target of 13% or less.
Queen Elizabeth the Queen Mother Hospital had a turnover rate of 15% higher than the trust target of 13% or less.

(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.

From January 2017 to December 2017 reported an overall sickness rate of 7% in maternity. A breakdown by site for nursing staff is as below;

- Queen Elizabeth The Queen Mother Hospital: 4%

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

**Bank and agency staff usage**

The maternity unit at Queen Elizabeth Queen mother has had 322 shifts covered by bank or agency staff over the last year. Matron informed us that the unit will try and cover shifts with own staff. Where not possible and bank and agency staff were used, we were shown local induction policy which is to be completed by each agency or bank staff member.

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

**Midwife to birth ratio**

As of September 2017, the trust had a ratio of one midwife to every 28 women. This is around the same as other trusts.

The midwife to birth ratio at the time of the inspection was 1:30. This was above the national benchmark of 1:28.

Trust ratio is around the same as other trusts and in line with evidence-based guidance set out in the intercollegiate document, Safer Childbirth (2007): Minimum Standards for the Organisation and Delivery of Care in Labour. The intercollegiate guidance suggested this ratio was sufficient for the acuity level of the service provided at Queen Elizabeth Queen Mother to ensure the capacity to achieve one-to-one care during labour.

(Source: Electronic Staff Records – EST Data Warehouse)

**Medical staffing**

The department used a ‘hot’ week’s system where a consultant was allocated periods in advance to provide continuous care over one week at a time. This offered a rota system of continuity for both patients and trainees.

The trust data provided for medical staffing which was limited and we were unable to review current permanent staffing data. However, December 2017 data showed us that the proportion of consultant staff and junior grades working within the unit was around the same as the England average.
Vacancy rates

Trust information provided showed us that current vacancies are one middle grade doctor on gap leave, one doctor is currently on maternity leave and one doctor who does not cover on calls for Queen Elizabeth the Queen mother hospital.

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

Turnover rates

This information was requested from the trust but not provided and therefore we could not review data.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

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

Sickness rates

This information was requested from the trust but not provided and therefore we could not review data.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data and we are awaiting updated information.

Once this has been received in the correct format we will be able to populate the analysis to complete this section.

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

Bank and locum staff usage

This information was requested from the trust but not provided and therefore we could not review data.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests. Once this has been received in the correct format, we will be able to populate the analysis to complete this section.

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

Staffing skill mix

In December 2017, the proportion of consultant staff reported to be working at the trust was around the same as the England average and the proportion of junior (foundation year one to two) staff was around the same.
Staffing skill mix for the 57.8 whole time equivalent staff working in maternity at East Kent Hospitals University NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept most records of patients’ care and treatment accurately and concise. We checked 10 patient paper records and found them to be legible, dated and signed and contained full clinical details in line with the Royal College of Physicians ‘Standards for the clinical structure and content of patient records 2013’.

The maternity unit was currently in the process of moving from paper records onto an electronic recording system. Staff told us that they no longer used a paper book to record births as all births are now booked into the electronic recording system, this information is then shared with the community midwives and community services for discharge.

Patient records were completed and showed us that each woman had individualised care plans for pregnancy and labour and had received antenatal screening and assessment of risk to promote safe treatment. Our review of care records showed women were advised of their options at every stage of their pregnancy including when complications occurred. Staff recorded consent was obtained before carrying out procedures in line with women’s care. However, we found that not all of the notes reviewed had an allocated named midwives or consultants to women.

Patient records and notes were kept safely in a locked cupboard or in a locked and secure notes trolley. However, we found filing of old notes waiting archiving to be erratic with loose pieces of paper and no order to them. Staff told us that patient records were audited each week by two band seven midwives.

A trust wide record keeping audit was completed in November 2018 which found not all areas of record keeping within obstetrics met with trust targets. Labour care records were good achieving 91% or above completed accurately. However, the worst documentation reviewed was the community feeding assessments. The trust found the assessments were poorly documented and a low compliance of 25% completed.
Discharge information for low risk babies and mothers were sent electronically to community midwives. Mothers were given a Personal Child Health Record (known as the Red book) on discharge. Health professionals used the red books to record information on baby’s birth and health, including feeding assessments, new-born checks and new-born hearing screening.

**Medicines**

The service generally prescribed, gave, recorded and stored medicines well. We completed random checks of medication records we found patient information and allergies were recorded correctly. We found that prescribed antimicrobials on patients medication charts had noted when medication was started. However, we saw on charts we reviewed that there was no stop or review date documented.

We saw that medicines, including intravenous fluids, were stored correctly. However, medication stored in fridges in Kingsgate ward and labour ward were all found to have not always been checked daily. Temperatures were recorded which were not in the required range and we could not see documentation to state that this had been reported to pharmacy.

We saw good identification of infection and diagnosis to antibiotic times. Patients were prescribed an antimicrobial as clinically indicated and we saw dose and duration of treatment documented in their clinical record. This was in line with National Institute for Health and Care Excellence, QS121 Statement 3: People prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record.

Daily checks of controlled medication had been carried out on the maternity ward and delivery suite. However, we observed that the giving of controlled medication was not always checked and signed by two members of staff and not all changes were made clear or signed. This was not in line with trust policy.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them in line with trust policy. 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.

The governance lead had been in post for eight months and felt that incident reporting had improved, with staff encouraged to complete an electronic incident reporting form. We saw learning shared in daily huddles. The maternity unit had incorporated ‘take five’, which was a method of taking five key themes to discuss with staff. Themes for example were electronic reporting system, incidents, talking, and disseminating information to staff.

A message of the week was disseminated to staff in handovers, safety huddles and learning. Staff told us they liked this new process.

We reviewed the trusts major incident response plan, which established the framework for the trust’s response in the event of any major emergency, regardless of cause. We spoke with a matron that was aware of their duty in respect to a major incident.

The Duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014, where as soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred a health service body must notify the relevant person that
the incident had occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

Staff had good knowledge of duty of candour, gave us examples of when duty of candour had been applied and knew their roles and responsibilities. The Duty of candour is a regulatory duty under the Health and Social Care Act (Regulated Activities Regulations) 2014, where as soon as reasonably practicable after becoming aware that a notifiable safety incident had occurred a health service body must notify the relevant person that the incident had occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Duty of candour training was incorporated into trust route cause analysis and incident management training programmes, which formed an important part of the leadership training.

**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 March 2017 to February 2018, the trust reported one incident which was classified as a never event for maternity. There was one never event reported to the Strategic Executive Information System at the Queen Elizabeth the Queen Mother. NHS England describes a never event as “Serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.”

The incident involved a retained tampon following a procedure. Staff completed the investigation of the never event in line with NHS England ‘Never Events Policy and Framework’. A route cause analysis was completed as well as a letter detailing the never event with agreed actions. Each staff member had been asked to sign the trust swab, needle and instrument count guideline. Whiteboards within all hospital intra partum settings to be used for swabs counts and following final counts, all swabs to be sealed in a clear plastic bag to ensure that they cannot be accessed for further use. A trust never event workshop took place for staff and a weekly audit occurred to ensure the correct counting and checks were completed when checking swabs following procedure. This provided assurance that all clinical staff were aware of the incident and lessons learnt achieved.

The trust reported that safety briefings before handover, monthly mortality meetings and updates on the intranet was used to share the lessons learnt from investigations with staff. We saw evidence of this in a shared staff file and staff were able to give examples of learning from previous incidents.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2017 to February 2018.

Of these, the most common types of incident reported were

- Maternity/Obstetric incident meeting SI criteria: baby only (this included fetus, neonate and
(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. There were different topics to review depending on the specialism. We were told that the maternity service was looking to develop a maternity specific safety thermometer to provide a monthly data about obstetric and neonatal outcomes compared against national averages. The information about safety was displayed in a notice board on unit and was accessible to patients and the public.

The trust recorded all birth information on the maternity dashboard. This covered organisational aspects, such as closures, activity, workforce and clinical indicators. The dashboard was reviewed at the monthly quality meetings and reviewed monthly at board level during executive meetings.

The maternity dashboard showed us that the total number of women with a blood loss of over 2500mls was in line with the target set by the trust for less than 1% from April 2017 to March 2018. It was also reported that the total number of women with a third or fourth degree perineal tear was in line with the target set by the trust.

Is the service effective?

Evidence-based care and treatment

We found from discussions and observations with staff and patients that care was being provided in line with The National Institute for Health and Care Excellence (NICE) quality standard 22. This standard covers the care of all women up to 42 weeks of pregnancy. It covers all areas of antenatal care including community and hospital settings. We saw women accessing antenatal care and being supported in their birthing choices, staff were able to support women whose first language was not English by using a 24-hour translation and interpreting service, a 24-hour triage service for patients was in place.
The trust offered fetal anomaly screening in accordance with current UK National Screening Committee programmes. This was in line with NICE quality standard QS22: Antenatal care. The trust performance for fetal anomaly screening was 87.7%, which did not meet the acceptable testing rate of greater than 97%. However, data showed that the trust performance in time taken and completed for antenatal testing of sickle cell and thalassaemia were better than the acceptable testing rate.

There was an audit programme for obstetrics, which showed most patient outcomes were in line with national standards. Audits were based on recognised national guidance including the National Institute for Health and Care Excellence (NICE), Royal College of Obstetricians and Gynaecologists ‘Safer Childbirth: minimum standards for the organisation and delivery of care in labour’. Audits completed in obstetrics included gestational diabetes, national maternity and perinatal audit, term admission to neonatal unit, third and fourth perineal tear. The hospitals rates for 3rd and 4th degree tears assisted and unassisted were on average 1% for assisted and 1.8% for unassisted. This was within the trust target of below 5%.

Caesarean section rates were way above the expected trust target, with the total caesarean rate being in average 32.8% with target of less than 25%. Elective caesarean rates on average were 13.2%, target being less than 10% and emergency caesarean rates being 19%, target 20.7%. The head of midwifery identified these rates as a concern and told us that the department were completing an audit shortly to look at why rates were higher than the national average and above trust guidance.

The National Institute for Health and Care Excellence Quality Standard 37 was adhered to in respect to post-natal care. Examples included staff discharging patients with appropriate checks and with correct medicines. All patients we spoke with had been given breastfeeding advice and support.

The observations and discussions we made reflected that the trust was following recommendations from National Institute of Care and Excellence Quality Standard 190: Intrapartum care. Women were offered a choice of birthing locations and choice of care throughout labour. We witnessed discussions between staff over patient’s choice and how they accommodate them; this showed that were focused on the women’s needs.

The National Institute for Health and Care Excellence (NICE) quality statement seven on skin to skin contact was adhered to in post-natal care. Skin-to-skin contact with babies soon after birth had been shown to promote the initiation of breastfeeding and protect against the negative effects of mother–baby separation. There was information about this on the wards, this was promoted in theatre and all staff encouraged women to do this.

We saw the trusts current key recommendations to reduce intra partum death as part of MBRRACE (Mother and Babies: Reducing risk through audits and confidential enquiries). We found throughout the key recommendations the trust was only partially compliant in most areas of recommendations. There was non-compliance in no assessment tool for risks on admission, induction of labour or regularly throughout labour and there was no proforma in place for fetal movements as recommended in Royal College of Obstetricians and Gynaecologists national quality improvement programme Each Baby Counts.

The hospital had a dedicated midwife for diabetes as well as a dietician and a specialist diabetic doctor and could be accessed by patients within the trust.

The National Institute for Health and Care Excellence (NICE) guideline quality statement six on intrapartum care on delayed cord clamping was evidenced in theatres. Delayed cord clamping meant more blood reached the baby immediately after birth and may help to prevent anaemia. Staff told us that they promoted delayed cord clamping of baby as well as skin to skin between mother and baby.
A ‘New-born Infant Physical Examination (NIPE) smart’ system was in place and was working well to ensure that neonatal screening and referral pathways existed. This included a mechanism that meant that babies not screened within 72 hours of birth would be identified. Trust performance indicators showed us that trust had achieved 95.4% target of NIPE examinations, which was slightly better than the acceptable target of greater than 95%.

Growth was monitored from 24 weeks by measuring and recording the symphysis fundal height as highlighted by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries.

**Nutrition and hydration**

Patients were offered a choice of menu options and dietary requirements were taken into consideration. Patients we spoke with reported that food was good and options were available.

Patients were invited to help themselves to a variety of breakfast items from the day room on wards; if a woman was not mobile then staff helped her choose and delivered it to the bedside.

The trust employed a public health consultant midwife who supports feeding. The hospital also employed a band four healthcare assistant to offer extra advice, support and guidance to women experiencing difficulties with breastfeeding. The staff member also supported mothers on how to feed their babies using aids for a ‘hands-off’ approach. Leaflets were available on infant feeding and there were poster displays around the unit.

The unit did not have Baby Friendly Initiative (BFI) accreditation but were keen to work towards this. The UNICEF UK Baby Friendly Initiative was launched in the United Kingdom in 1995 to work with the NHS to ensure a high standard of care for pregnant women and breastfeeding mothers and babies in hospitals and community health settings. The trust had a policy on infant feeding and baby weighing, staff we spoke with spoke positively around supporting mothers on their feeding choices. Mothers with babies on the neonatal unit were encouraged and supported to express milk for their babies. If women wished to bottle feed sterilisers were available and they were advised to supply their own formula milk. However, we found used milk in an unlocked fridge with no date or patient name on.

We saw the trust policy on infant feeding which included weighing babies. Staff were aware of the policy and were keen to support mothers on their feeding choices and all patients we spoke to said they had received support to breastfeed soon after birth, and continued on the post-natal ward.

**Pain relief**

Women had access to a range of pain relief methods following NICE guidance CG190. This included Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour, as well as non prescribed pain relief such as TENS machine (Transcutaneous electrical nerve stimulation is a method of pain relief involving the use of a mild electrical current during labour), birthing pools and massage.

Women requiring an epidural were transferred onto the labour ward. The Association of Anaesthetists of Great Britain & Ireland states the time from the anaesthetists being informed that a woman has requested an epidural to the time the epidural is performed should not exceed 30 minutes and should only exceed 1 hour in exceptional circumstances. The trust did not provide us with recent data to show this target was met, therefore we could not be assured that the trust continued to monitor whether or not it was meeting this target.

We spoke to several women over the two days of our inspection and all reported their pain was managed well and given when requested. However, the trust did not provide results of any pain audits completed and we did not see whether pain scores were monitored or appropriate action was taken to help with patient’s pain.
Patient outcomes

National Neonatal Audit Programme

Queen Elizabeth the Queen Mother Hospital

In the 2017 National Neonatal Audit, based on data for January 2016 to December 2016, Queen Elizabeth the Queen Mother Hospital performance was as follows:

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 66 eligible mothers identified for inclusion in this audit measure, 87.1% of which were given a complete or incomplete course of antenatal steroids. This was within the expected range nationally and above the national aspirational standard of 85%.

Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were six babies identified for inclusion in this audit measure, none of which was given magnesium sulphate in the 24 hours prior to delivery. This was in the bottom quartile when compared to other trusts nationally.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised Caesarean section rates and modes of delivery

From October 2016 to September 2017, the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections were as expected and rates for emergency sections was also as expected. However, the information we gained from the Queen Elizabeth Queen mother hospital showed us that the rate of caesarean sections were high above national average.

The trust provided us with a planned action table in response to the high caesarean rate. The trust plan to research further into patient cases to identify themes and trends in the increase of sections and how information and antenatal care can be improved to reduce the number of caesarean sections taking place.
### Standardised caesarean section rates

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>East Kent Hospitals University NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.2%</td>
<td>787</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.5%</td>
<td>1,159</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.7%</td>
<td>1,946</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Source: Hospital Episode Statistics October 2016 to September 2017

Note: Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from October 2016 to September 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

### Proportions of deliveries by recorded delivery method

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>East Kent Hospitals University NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections&lt;sup&gt;1&lt;/sup&gt;</td>
<td>1,946</td>
<td>29.3%</td>
</tr>
<tr>
<td>Instrumental deliveries&lt;sup&gt;2&lt;/sup&gt;</td>
<td>690</td>
<td>10.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries&lt;sup&gt;3&lt;/sup&gt;</td>
<td>3,997</td>
<td>60.2%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>12</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>6,645</td>
<td>100%</td>
</tr>
</tbody>
</table>

<sup>1</sup>Includes elective and emergency caesareans

<sup>2</sup>Includes forceps and ventouse (vacuum) deliveries

<sup>3</sup>Includes breech and normal (non-assisted) deliveries

Notes: To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with *** (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

Normal (non-assisted) delivery rates about the same as the England average.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)
Maternity active outlier alerts

As of April 2018, the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.3. The comparator group was 6.44.

(Source: MBRRACE UK)

Competent staff

Staff had the right skills and knowledge to assess patient’s needs, preferences and choices. The department had a dedicated preceptorship midwife who identified training needs and supported staff. We saw clinical support and supervision for newly qualified midwives, junior doctors and students. Newly qualified midwives have a preceptorship period of 18 months and staff told us that they have been supported for longer to ensure they were confident and competent to undertake their role.

Appraisals were benchmarked against the visions and values of the trust. We saw examples of in depth well written appraisals and appraisals achieved with the trust’s visions and values in mind. There were clear objectives, aims and training needs documented.

Staff informed us that there were opportunities for one to one discussions with senior nursing staff and that they felt well supported. Staff felt that they were encouraged to complete not only mandatory training but also simulation and human factors training such as obstetric emergencies, vaginal birth after caesarean section (VBAC), breech delivery, post partum bleeding, third and fourth degree tears, shoulder dystocia, cardiotocography interpretation and sepsis.

There are two perinatal mental health midwives working trust wide across sites supporting staff and offered support to women with mental health issues during their pregnancy.

Appraisal rates

From April 2017 to December 2017, 82% of staff within maternity at the trust had received an appraisal compared to a trust target of 85%.

During the inspection we saw that 87% of staff in Queen Elizabeth The Queen Mother Hospital had received an appraisal compared to a trust target of 85%.

(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 care.

Care was delivered and reviewed in a coordinated way when different teams were involved in patients care. Staff we spoke to reported good multidisciplinary working relations between midwives, midwifery support workers, doctors in the maternity day unit, and other staff.
Midwives told us they contacted consultants if they needed advice, for example, around risk assessments, and found consultants approachable.

We saw several examples of good multidisciplinary team working within the department. We attended a safety huddle meeting which had representatives from all of the unit departments in discussion about accommodating a patient request to have an all female team during the planned caesarean section. Staff contributed freely and collaboratively with opinion and suggestion.

We saw a timeline of events with professionals supporting a young persons pregnancy and delivery. The professionals involved were a safeguarding lead, a social worker, a health visitor, a community midwife, a safeguarding midwife as well as the midwifery team.

Seven-day services

The maternity service at the hospital provided a service seven days a week, 24 hours a day. The service was supported by consultant Obstetricians seven days a week from 8am to 6pm. Outside of these hours, an on call system was in place to ensure consultant cover. We reviewed the medical rotas and found sufficient cover was in place.

The day care unit was open seven days a week with opening hours Monday to Friday from 8am to 8pm and 8am to 4pm on weekends. Patients were provided with contact telephone numbers for the maternity and labour ward for additional advice and support.

On call meant that they were no more than 30 minutes away from the hospital. This ensured women had access to consultant advice at all times. This was in-line with The Association of Anaesthetists of Great Britain and Ireland, Obstetric Anaesthetic Guidance: An anaesthetist must be immediately available for emergency work on the delivery suite 24 hours seven days a week, and National Health Service, Seven Days a Week, Priority Clinical Standards.

Fetal anomaly screening was available Monday to Friday 8am – 8pm and routine ultrasounds examinations were available on the day assessment units at all times.

Maternity services offered a 24 hour telephone triage service. This service could be accessed at any stage of pregnancy.

There was an onsite pharmacy which was accessible at all times of the day and night.

Health promotion

There was information displayed on boards throughout the unit for patients and visitors to read promoting, for example, smoking cessation, infant feeding, dietary advice and diabetes in pregnancy.

Staff told us that they promoted a healthier lifestyle choice for patients and there were leaflets on lifestyle choices in the department.

We saw a smoking cessation table set up outside the maternity wing and a new button which when pressed asked patients and visitors to stop smoking outside of the maternity unit to remind everyone that it was a non smoking zone. The smoking cessation team was comprised of a specialist midwife and had received commissioning funding and were running clinics for pregnant women. Since starting the clinics in November 2017, 16 women using the service have successfully stopped smoking.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
We saw staff verbally gaining consent before commencing any treatment. Staff were seen fully explaining procedures and the associated risks of accepting the treatment or not.

All staff were required to follow the trust policy and procedure for consent. The trust consent policy was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details of the Mental Capacity Act 2005 and checklists. We spoke with staff members about the Mental Capacity Act 2005 and staff demonstrated a good awareness of consent procedures.

There were perinatal mental health guidelines in place but they were due for review in June 2017 and therefore we could not determine if current practices were in date. Staff were able to tell us the process of referring women to mental health services and that all woman referred are seen by the perinatal mental health specialist midwives.

The trust told us women subject to detention under the mental health act were hospitalised under the care of the mental health services. Midwives attended the mental health unit to provide care as required and mental health services arranged specialist transport and escorts for visits to the maternity service for scans, obstetric appointments, labour and delivery.

We saw the consent form used for procedures and surgery. It showed details of the proposed procedure using non-jargon language, advised of benefits and risks, any other procedures that may be required and space for a patient to sign to confirm understanding.

Staff told us the community midwife completed the consent paperwork for antenatal screening at the woman’s first booking appointment. We saw copies of signed consent forms in 4 records we looked at. There was a contact phone number on the ward for emergency mental health advice.

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

Staff understood their roles and responsibility under the Mental Health Act 1983 and the Mental Capacity Act 2015.

There were best interests meetings for women who may lack capacity. The best interest meetings were supported by the safeguarding lead and were attended by professionals to discuss patient care and their needs. Staff training included an e-learning module for mental capacity act (MCA) and deprivation of liberty safeguards (DOL’s).

Mental health assessments and specific wellbeing questions were included in the booking and pregnancy assessments at 28 weeks between patient and midwife.

Women at risk were easily identified on the computer system and risk sections were visible. We saw evidence that these sections had been completed for women with concerns.

We saw evidence of multidisciplinary meetings, which included the perinatal mental health midwives, safeguarding team, community midwives and ward midwives.

Staff told us that they had completed training on mental capacity act and deprivation of liberty. However we requested trust data was not given, and we were unable to identify whether staff had reached the trust target for completion.

(Source: Trust Provider Information Request P14/P49)

Is the service caring?
Compassionate care

Staff cared for patients with compassion and kindness. We saw all grades of staff of clinical and support staff across the maternity unit talk to patients kindly, with dignity and respect.

We saw staff taking time to interact with patients and saw examples where staff demonstrated the importance of gaining the trust of women they were treating. Staff introduced themselves to patients and explained their roles within the department. This was in-line with National Institute of Health and Care Excellence guideline QS15, statement 3: Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

Staff spoke and interacted with patients in a respectful and considerate way, which was reflected in the patient feedback seen in the friends and family comment box. Positive comments we saw were ‘Quick and decisive action when complications arise, filled us with confidence’, ‘couldn’t ask for better’, ‘reception lady absolutely great when we arrived as midwives in handover’. We also saw thank you cards and photographs around the department.

Staff pulled curtains around patients before undertaking examinations or providing care, maintaining patient’s privacy and dignity and we observed staff talking and explaining care to the patient.

Staff members displayed an understanding and a non-judgemental attitude when talking about patients who had mental ill health or a learning disability.

Friends and Family test performance

The maternity Friends and Family Test response rate for antenatal, birth, postnatal and postnatal in the community at East Kent Hospitals University NHS Foundation Trust were similar to the national average. The trust completed the care quality commissions survey of women’s experiences in maternity in 2017 and found experiences were similar for 14 out of the 16 questions.

Friends and family test performance (antenatal), East Kent Hospitals University NHS Foundation Trust

From January 2017 to January 2018, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) were generally similar to the England average. The zero reports in October and January will be due to not enough respondents for the survey.
Friends and family test performance (birth), East Kent Hospitals University NHS Foundation Trust

From January 2017 to January 2018, the trust’s maternity Friends and Family Test (birth) performance (% recommended) were similar to the England average. As of January 2018, the trust performance for birth was 97%.

Friends and family test performance (postnatal ward), East Kent Hospitals University NHS Foundation Trust

From January 2017 to January 2018, the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) were similar to the England average. The performance as of January 2018 was 95%.

Friends and family test performance (postnatal community), East Kent Hospitals University NHS Foundation Trust

From December 2016 to August 2017, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) were generally similar to the England average.

(Source: NHS England Friends and Family Test)
CQC Survey of women’s experiences of maternity services 2015

The trust performed similar to other trusts for 14 out of 16 and worse than other trusts for two in questions in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Labour and birth</strong></td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>8.59</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>8.44</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>About the same</td>
<td>9.44</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>9.26</td>
</tr>
<tr>
<td><strong>Staff during labour and birth</strong></td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.09</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>About the same</td>
<td>7.34</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>About the same</td>
<td>7.71</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same</td>
<td>9.31</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a member of staff helped you within a reasonable amount of time</td>
<td>Worse than other trusts</td>
<td>8.2</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>8.30</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same</td>
<td>9.12</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>8.56</td>
</tr>
<tr>
<td><strong>Care in hospital after the birth</strong></td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>7.12</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>7.74</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>Worse than other trusts</td>
<td>8.08</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same</td>
<td>8.24</td>
</tr>
</tbody>
</table>

The trust performed worse than other trusts for the questions “Thinking about your stay in hospital, how clean was the hospital room or ward you were in?” and “If attention was needed
during labour and birth, did a member of staff helped you within a reasonable amount of time?”.  

(Source: CQC Survey of Women’s Experiences of Maternity Services 2015

Emotional support
Staff provided emotional support to patients to minimise their distress. We spoke with women who told us staff were supportive, knowledgeable and provided reassurance and information in all areas of their care.

Midwives assessed women for anxiety and depression during their initial antenatal appointment and then they were given continuous support as required once admitted. The trust employed two perinatal midwifes who worked across the trust sites.

A counselling service was available within the trust and was co-ordinated by a women’s health counsellor. Counselling sessions took place within the postnatal ward, patient’s home, counselling room or the neonatal intensive care. The counselling service also provided virtual sessions over skype or telephone. We saw patient information on these services and advice to women about support services available.

There was a debriefing service for women and their partners who wished to talk about their birthing experiences. The trust wide spiritual care and chaplaincy team were available to women, their families and supported staff. The chaplaincy service offered emotional support to women and their families as requested.

We spoke with a patient who told us ‘this is the only place you receive a truly professional and caring service, I feel like I’m their priority’.

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.

There were previous concerns that women did not feel listened to by consultants and registrars when discussing their delivery. During this inspection we found women were given the opportunity of making an informed choice about all available birth settings that are appropriate and safe for their clinical need and risk.

One patient told us that after a difficult birth with her first baby at a different hospital she decided to come to Queen Elizabeth the Queen Mother. The patient told us ‘we were given so much more time at every stage, we were informed this is what the protocol is, but this is your decision. We felt empowered to influence’. We were also told by a patient ‘on the labour wards there is a difference between doctors and midwives, they have different approaches. Midwives are more understanding, they were supportive of our decisions and choice in front of the doctor. They gave everything the best chance to work out’.

Staff communicated with women and their families, making partners feel welcome and involved and that everyone understood the treatment they were to receive and the risks associated with this in line with National Institute Health and Care Excellence, QS 15 statement 5.
Is the service responsive?

Service delivery to meet the needs of local people

The trusts maternity dashboard information provided showed us that there had been no unit closures from April 2017 to March 2018. However, there had been 14 unit diverts to another hospital which was above expected targets. This showed that the unit at times were not able to provide planned services to meet the needs of the local people. We saw the trust had a policy in place and in date for guidance on unit closures. This guidance is significant for a hospital in an area with high deprivation indicators and where the additional financial burden of travel to a more distant hospital was likely to have a detrimental impact.

The trusts maternity dashboard showed an average of 84% of women receiving antenatal care at Queen Elizabeth Queen Mother saw a midwife by 12 weeks and six days of pregnancy between April 2017 to March 2018. This was just below the trust’s target of 90%.

A 24-hour triage system was in place for patients, the maternity day care service ran from 8am to 8pm. Once the day care service has ended, all out of hour’s calls would come through to the labour ward and women would be triaged and seen appropriately. The deputy head of midwifery told us that if any woman had concerns and wanted to come to the unit then they encouraged the patient to do so. Staff told us that the triage system in place did not affect patient care when they were busy and women appreciated being able to have access to a midwife for reassurance.

We reviewed the trust website which included a range of information for women and links to a various pieces of useful information that signposted to external support. The trust had put together a series of films about the journey through pregnancy, labour and beyond.

The maternity transformation programme was launched in May 2017. The programme focused on improving outcomes for mothers and babies and developed by the Department of Health’s Safer Maternity Care action plan and used within the trusts maternity services. There were five areas focused within the plan which are leadership, learning, practice, teams, data and innovation. During the inspection we saw clear actions in place since the plan started. Episcissors were embedded into practice and a reduction in 3rd and 4th degree tears. This information is corroborated within the hospital maternity dashboard with 3rd and 4th degree tears assisted and unassisted being well within the trust target for the year. The consultant and midwife led diabetes clinic started at Queen Elizabeth the Queen Mother as well as the group education session diabetes in pregnancy.

Bed Occupancy

From quarter 2 of 2016/17 to quarter 3 of 2017/18 the bed occupancy levels for maternity were generally lower than the England average, with the trust having 57% occupancy in quarter 3 2017/18 compared to the England average of 58%.

Bed occupancy rates were higher than the England average for quarter 2 and 3 2016/17. Occupancy rates were lower than the England average for the following three quarters up to quarter 2 2017/18. During quarter 3 2017/18 bed occupancy rates were slightly lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.
Meeting people’s individual needs

Safer childbirth standard 2.2.20 states ‘Women have the right to choose where to give birth. If a woman chooses to give birth at home or in a midwifery unit contrary to advice from midwives and obstetricians, there needs to be clear documentation of the information given. Women we spoke with had been given options and were aware of available choices.

Maternity Matters guidelines suggest ‘All birth environments should be designed to offer a home-like comfortable environment with ensuite facilities, including equipment such as comfortable chairs, beanbags, mats, birthing balls, baths and birth pools. There were four midwifery led rooms, all with ensuite bathrooms and two with a birthing pool available. When talking to staff it was clear that women were given safe birthing choices. Staff were also able to explain the exclusion criteria for water births, which we found appropriate for patient safety.

Women were given a named midwife and contact number on booking. There was a welcome pack which contained information about mealtimes, visiting information, infection control, use of mobile phones and use of curtains around beds.

Community midwives identified patients who would need translation services at booking and a telephone interpreting service was used for people who did not have English as a first language. Telephone interpretation was part of a trust wide policy as there were local difficulties in obtaining face-to-face translation in this geographical area.

There was a smoking cessation lead midwife who followed public health guideline 26 (PH26) to identify women who needed help to quit smoking. All women who attended the early pregnancy unit who were diagnosed with a viable pregnancy, that smoked were referred to the smoking cessation service.
Patients with mental health issues were on a care pathway and in contact with a perinatal mental health midwife. This meant that women with a variety of mental health needs had good management of care which improved their quality of life in pregnancy.

However, when requesting further information of how care is provided for patients with learning disabilities or bariatric patients the trust provided us with information, which was out of date. Therefore, we were unable to identify whether patients with additional needs or disabilities were being managed or well cared for.

Visiting times were from 9am to 9pm for partners of patients and women. Partners could stay overnight with mother or baby in the community led unit but there were no facilities provided and overnight stay for partners was not possible within Kingsgate ward.

There was available patient car parking near delivery suite for maternity patients and there was easy access for ambulances bringing women into this part of the hospital.

We observed the new bereavement suite that was funded entirely by money raised by staff and the local community. We observed and listened to the thought and effort that had been put into creating a suite that was able to provide comfort and understanding at a sad time for a woman or family experiencing the loss of their baby. The suite was situated away from the maternity unit and had a separate entrance so that women would not have to hear babies crying or see pregnant women.

The trust had named bereavement midwives who supported women and their families following stillbirth or neonatal death. All midwives undertook bereavement training as part of their mandatory training. A bereavement midwife was responsible for speaking with women and families who had been bereaved during or after childbirth or had a late miscarriage or termination for medical reasons. There were three scheduled appointments per month arranged for each affected patient and referrals were made in the community and by hospital midwives. After the appointments had ended, women were given email details to ensure advice and support was available as required.

There were cold cots available (a cold cot is a cooling system which maintains stillborn babies and those who suffered perinatal death in a good condition and allows parents more time to grieve). There was also a keepsake where part stays with the baby and the other part stays with mother. There was also a piece of art which featured a sculptured tree. If a patient wished they had the name and date of when their baby was born placed on a leaf. However, we found the counselling room in the day care unit was not appropriate to see mothers and families.

**Access and flow**

People could access the service when they needed it. Access to care was managed to take account of people’s needs including those with urgent needs.

Appointments were readily available at the early pregnancy unit and the planned assessment unit. Women we spoke with had no problem accessing the services. We saw when delays did occur, for example discharge, the patient was kept informed throughout the process.

We did not find evidence to suggest the trust monitored the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour and staff did not provide this information. The National Institute for Health and Care Excellence states analysing a delay of 30 minutes or more between presentation and triage is a method of monitoring a midwifery red flag event. A midwifery red flag event is a warning sign that something may be
wrong with midwifery staffing. As the trust did not monitor this, there was a greater risk senior manager would be unaware of these issues.

At the previous inspection, staff had identified further training in NHS new born and infant physical examination programme (NIPE) to prevent prolonged discharge times. This is an examination of a child shortly after birth. The examination includes a general physical check as well as an examination of the baby’s eyes, heart, hips and testes in boys. Matron told us and we saw evidence that 10 staff have now been trained to complete the new born and infant physical examination check, with a list seen of further staff waiting to attend training.

**Learning from complaints and concerns**

Complaints about maternity services were reviewed at the monthly risk meetings and the information from complaints was also included in the governance report for the division. Actions from complaints were recorded on the datix electronic reporting system to ensure they were followed up and completed.

The complaints policy stated that complaints were acknowledged within three to seven days. This contact was, where possible, by phone. If this was not possible a letter was sent outlining what exactly will be investigated and complainants were asked to confirm they were happy with this process.

Staff we spoke to explained how they dealt with a patient’s concerns immediately and, wherever possible, they escalated to their ward sister or manager, when necessary.

Staff were able to signpost patients to the Patient Advice and Liaison Service department as appropriate. Staff at all levels told us complaints were discussed at meetings. We saw actions that were shared with staff via various mediums including newsletters and staff told us that complaints were discussed at ward meetings.

We reviewed five complaints which were all signed by the chief executive for the trust and had a detailed summary of the issues presented by the complainant with a comprehensive response to the concern. All complaints we read were suitably apologetic, written without medical jargon so they were easy to understand and offered clear explanations of events.

Records of complaints and action plans were held in staff information files with audit reports and action plans, which were available in the matrons office. Staff were able to give examples of complaints that had happened in their area and were aware of the findings from investigations and any actions that were needed.

**Summary of complaints**

The trust have received 45 complaints regarding obstetrics from May 2017 to April 2018.

Out of the 45 complaints five are still under investigations and 37 of the 40 complaints were completed within the trust target of 93%.
# Maternity Complaints by Sub-subject (primary) grouped by Subject (primary)

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attitude</strong></td>
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<tr>
<td>Problems with nurse’s attitude</td>
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</tr>
<tr>
<td><strong>Communication</strong></td>
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</tr>
<tr>
<td>Misleading or contradictory information given</td>
<td>3</td>
</tr>
<tr>
<td>Other communication issues (i.e. old literature, phones not working)</td>
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</tr>
<tr>
<td>Nursing communication issues</td>
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</tr>
<tr>
<td><strong>Clinical management</strong></td>
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<tr>
<td>Blood tests not carried out</td>
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</tr>
<tr>
<td>Lack of / inappropriate pain management</td>
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</tr>
<tr>
<td>Unhappy with treatment</td>
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<tr>
<td><strong>Diagnosis</strong></td>
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<tr>
<td>Tests incomplete</td>
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<tr>
<td>Mis-diagnosis</td>
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</tr>
<tr>
<td><strong>Medication</strong></td>
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<tr>
<td>Prescribing issues</td>
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<tr>
<td><strong>Nursing care</strong></td>
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<tr>
<td>Inappropriate physical handling</td>
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<tr>
<td>Problems with Nursing Care</td>
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</tr>
<tr>
<td>Totals:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>35</td>
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(Source: Provider Information Request P55)
Is the service well-led?

Leadership

Maternity sat within the specialist services division comprised of a divisional director, a medical director, a divisional head of nursing and a head of midwifery and gynaecology.

The previous inspection had highlighted a period of instability and poor governance systems and processes that were not consistently applied. During inspection we found there were new systems and processes in place and in the process of being developed. These were much improved, but not all were fully embedded.

The head of midwifery and gynaecology was new in post and alongside were two deputy heads of midwifery based at either hospital site. Deputy head of midwifery and the matron knew the unit and staff well. They knew what their wards were doing well and could clearly articulate the challenges and risks their team faced in delivering good care.

Staff told us they felt valued, listened to and respected and felt confident to raise any concerns with their line managers.

The senior team have provided an optimistic vision for the service and have appointed a clinical governance midwife, we saw that the electronic incident reporting forms, serious incidents and risks are now being assessed and disseminated in to the midwifery team such as within team meetings, safety huddle and message of the week.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action. This was developed with involvement from staff, patients, and key groups representing the local community.

The trusts vision was "Great healthcare from great people" and the trust values "People feel cared for, safe, respected and confident we are making a difference"

The maternity department showed enthusiasm for the future of the department as well as a determination to achieve what they wanted.

The trust launched its maternity transformation programme, called Birthing Excellence Success Through Teamwork (BESTT) benchmarking and agreeing actions to focus on how to improve outcomes for mothers and babies. The focus areas for the programme were drawn directly from the Department of Health’s Safer Maternity Care action plan and then localised to address collaboratively agreed areas for improvement and innovation across trust maternity services.
1. Focus on leadership
2. Focus on learning and best practice
3. Focus on teams
4. Focus on data
5. Focus on innovation

Through the transformation programme there are three safety improvement aims:

1. 50% reduction in avoidable term admissions to NICU by December 2018
2. 50% reduction in term stillbirth by December 2018
3. 30% reduction in obstetric anal sphincter injuries by December 2018

The trust and department were clear as to what they wanted to achieve with the maternity trust transformation programme and we saw evidence of this starting to be achieved within poster displays, staff feedback, simulation training and the vision and values.

Staff had an understanding of the transformation programme, were excited about the programme and felt they were using the values within their practice.

Culture

Staff told us that the culture within the unit felt very different from when the last inspection took place, with a more optimistic and positive approach coming from the leadership team and developing down to ground level. A change in culture amongst senior staff at all levels appears to have taken place within the unit, but we received feedback that the change in attitude and culture around governance although happening is a slow process.

The senior leadership team were more visible and approachable to staff, there was innovation taking place through the maternity transformation programme, the preceptorship period for newly qualified midwives and the multi professional learning and training opportunities.

However, we were also informed that some further work had to be done to strengthen the working relationships within the medical and midwifery teams.

Staff felt supported by their immediate line management and that they had good working relationships with other specialties in the hospital. New members of staff said that they were made welcome and everyone was willing to help out.

Freedom to Speak Up Guardians are in place within the trust. These are employees in healthcare who provide challenge, learning and support to the healthcare system as a whole by reviewing trusts, speaking up culture and the handling of concerns where they have not followed good practice. Staff told us senior leadership encouraged staff to raise concerns.

Governance

The service had leadership structures in place and staff were clear about their roles and accountabilities. Midwives and maternity support workers (MSWs) reported to the ward sisters who then reported into the matrons. The matrons reported to the clinical services managers who reported to the head of midwifery.

We reviewed governance meeting minutes from December 2017 to April 2018. The meetings were well attended by senior staff but we saw that the same ongoing actions continued each month with no end date and no clear direction. We were told by one member of staff ‘there are lots of meetings, but nothing is put in action’

We found some trust data and guidance to be outdated and not reviewed within the timeframe specified within the policy or guidance. This did not provide the trust with assurances that staff
were following up to date guidance or practices in certain key areas of care such as patients with additional needs.

**Management of risk, issues and performance**

The service was currently putting more effective systems in place for identifying risks, reducing risks and coping with both the expected and the unexpected with the employment of the governance midwife and the increase in electronic incident reporting forms being completed.

There had been previous poor staff compliance in completing electronic incident report forms and incidents. However, since the previous inspection staff are encouraged to report incidents and to complete electronic incident report forms. The culture of reporting incidents was improving and the trust now have a clinical governance midwife to review, evaluate and share learning by reviewing risk and incidents.

The department used a red, amber and green (RAG) rated risk register. The risk register system is a widely used method of rating for issues or status reports, based on colours used in a traffic light rating system. Identifying risks as well as the identification to reduce risks.

Risks with higher scores (red) were escalated to either the divisional or corporate risk register and the risk register is reviewed by the leadership team regularly.

We found that there were high levels of risk identified on the register. For example, we had information provided from the risk register for the last 12 months, which showed continuous high level risk for caesarean sections. There had been no current audit in place, with the last audit completed in 2016, with no current investigation taking place or recent audit the trust would find it difficult to identify any common trends or themes as to why there is a high incidence of sections. During an interview with the head of midwifery, we were informed that they had recognised the high incidence for caesarean sections and there was an initial action plan in place to review the incidence of caesarean sections.

**Information management**

There were arrangements in place to gain information to monitor, manage and report on quality and performance. However, not all of the information or guidance seen was in date nor were trends or risks identified reviewed in a timely manner.

A maternity dashboard was in place which reviewed risk and staff could access a range of data from the trusts intranet facilities.

Relevant information was displayed on notice boards within the maternity unit. We saw posters about training opportunities, development opportunities for staff, infection control, parenting advice and educational material for new parents. Back to basics boards showing outcomes of training sessions taking place as well as a topic of the week.

Guidelines were stored on an electronic resource on the intranet. Staff told us they could access policies, protocols and other information they needed to do their job through the trust intranet.

**Engagement**

We saw notice boards with displays and posters with ‘message of the week’ and other unit information displayed in the staff room, as well as around the unit in displays for patients and their families.

Friends and family surveys are completed and we saw a comment box on Kingsgate ward where patients and their families are encouraged to comment about their care and experiences.
Staff told us of a number of fundraising initiatives between staff and the local community. Through local community support the unit was able to build a purpose built bereavement suite which also featured artwork from local artists.

The trust completed a staff survey and the results in 2017 showed that 50.3% of staff trust wide participated. This was an improvement in staff engagement compared to previous years.

The trust have set up a social media page for parents encouraging woman and families to share their experiences, provide maternity information, organise fundraising events and share the units message of the week. This provided an open and informative service and encouraged community involvement.

Learning, continuous improvement and innovation

We found staff were motivated and wanted to provide good care and facilities to patients and their families.

The matron actively sourced funding and grants to improve the services and this was how the bereavement suite was built, equipment has been purchased, cold cots in place and signage has been added around the unit.

Funding was received to introduce the maternity transformation programme, birthing excellence success through teamwork (BESTT) and further funding has been obtained to develop the ‘my own maternity app’ which will be an app where women can carry their own maternity records, access information and personalise to add maternity appointments for antenatal or to discuss a condition or complication of pregnancy.

There are forty human factors trainers in the trust who are midwives, support workers, obstetricians, theatre staff, anaesthetic staff, neonatal nurses, neonatologists, Emergency department and ambulance service. This is the largest number of human factor trainers from any provider in the UK. Human factors is the study of the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work. The training was specifically designed to have both discrete learning objectives on the individual courses, but also thematic objectives which cut across all five training days. The faculty believed that this approach helped to achieve the ambition of ‘Learning together to work better together’

Essential life support (ELSO) and simulation training in obstetrics was also provided to staff. This course concluded with an assessment of each individual clinician’s competency to undertake essential skills. The trust was the only maternity unit in England to have undertaken this quality assurance process. The department had top of the range simulators and a simulation suite which staff had worked hard to raise funds for. This suite provided an opportunity for staff to experience in hospital and out of hospital emergencies. A new simulator had arrived during the inspection that was capable of simulating real birthing situations and could be taken into the clinical areas. This was to ensure that staff could experience simulated emergencies in the clinical setting for the next phase of training development.

End of life care

Facts and data about this service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and
The trust had 2,685 deaths from December 2016 to November 2017.

The Specialist Palliative Care Team delivers a face to face visiting service five days per week from 9am to 5pm Monday to Friday. Out of hours and at weekends, a telephone advisory service is available from the local hospice to support the wards.

The palliative care team consisted of a palliative care nurse consultant and a palliative care social worker across the three hospital sites within the trust. There were two whole time equivalent clinical nurse specialists based at the Queen Elizabeth the Queen Mother Hospital and one whole time equivalent end of life care facilitator. Consultant in palliative medicine cover was provided by the local hospice for two clinical sessions a week at the Queen Elizabeth the Queen Mother Hospital.

There had been 496 referrals to the specialist palliative care team based at the Queen Elizabeth the Queen Mother hospital in the 12 months preceding our inspection. Of those 496 referrals 259 (52%) were for those patients with a diagnosis of cancer, 205 (41%) for those with a non-cancer diagnosis and the remaining 32 (7%) for were patients with both a cancer and non-cancer diagnosis. Examples of non-cancer diagnoses included sepsis, respiratory disease, heart failure and stroke.

During our inspection we visited a range of clinical areas wards including; care of the elderly; surgical and medical wards. We also visited the bereavement office, the chapel and the mortuary.

We met with 17 staff including; the palliative care nurse consultant; palliative care nurses; a care of the dying nurse; chaplaincy staff; bereavement staff; a mortuary manager, technicians and clinical lead; allied health professionals; matrons; ward managers; end of life care link nurses and healthcare assistants; registered nurses; consultants and junior doctors; healthcare assistants; and, porters.

We were unable to speak with any patients or relatives. We reviewed eight patient records including; seven 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions.

### Is the service safe?

#### Mandatory training

**Overall mandatory training rates**

Mandatory training for all clinical staff in end of life care had been in place since late 2016. This was something that was not available when we last inspected the provision of end of life care in September 2016. All medical staff, nursing staff and healthcare assistants were required to attend the training. At the time of the inspection 169 staff were required to have received the training in 2018. Of that number, 115 had registered to attend, 86 (just over 50%) had attended and 29 had registered but did not attend. Of those that had attended, 13 were consultants, 19 were doctors, 40 were nurses and 14 were health care assistants. Two allied health professionals had also attended. Monthly, open training sessions were available at the hospital throughout the 2018 calendar year to allow all staff the opportunity to attend. The end of life care facilitator would contact the wards to promote this training but no formal plan to get everyone to attend was in place.

The end of life care facilitator was responsible for organising training sessions for ward and clinical staff. Managers would provide the end of life care facilitator with details of those that were due to attend. Although the training was now part of the mandatory training programme, staff only had to attend once. There was no requirement for staff to attend refresher training. This meant that over time the learning from any training could be lost.
Palliative and end of life care staff told us they had completed mandatory training including but not limited to infection prevention and control, safeguarding, Mental Capacity Act and deprivation of liberty safeguards. All 11 staff providing palliative / end of life care had completed their mandatory training. All staff were trained to level two in child and adult safeguarding.

**Safeguarding**

Staff we spoke with were aware of their responsibilities around the report of safeguarding concerns. All end of life care staff and the palliative care staff had received training in adult and child safeguarding.

During the inspection we observed a discussion amongst the multidisciplinary team who were talking about the discharge of a patient who was at the end of their life. Due to the particular circumstances there were significant safeguarding risks identified which meant that until further information had been obtained from social services, they would not be in a position to discharge the patient safely. This demonstrated that the team worked well with outside agencies to ensure that patients were safe after discharge.

**Cleanliness, infection control and hygiene**

The wards we visited where end of life care patients were cared for were visibly clean. There were sufficient sinks available for staff to wash their hands as well as hand sanitisers placed at entry and exit points.

We observed staff using personal protective equipment and cleaning their hands prior to and after patient contact. This was in line with NICE QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

Patients that were approaching the end of their life would ordinarily be placed in a side room unless they were unavailable because they were being used by patients that were infectious. Patients that were at the end of their life and were also infectious would routinely be cared for in the side rooms.

Porters we spoke with were able to describe the process for removing a deceased patient who may have been infectious. While they would be unaware if a patient was infectious at the point they got the call, they were able to tell us that as soon as they arrived on the ward, ward staff would tell them that the patient was infectious. At this point the porters would put on personal protective equipment which was readily available on the ward to move the patient to the trolley. At the point they left the ward they were required to remove the personal protective equipment and dispose of it. Personal protective equipment could not be used outside of the clinical area in order to prevent the potential spread of infection.

**Environment and equipment**

We were told by mortuary staff that capacity within the mortuary was a concern. The trust had increased their capacity of freezer spaces in response to Human Tissue Authority guidance in relation to long term storage. There were five freezer spaces at the Queen Elizabeth the Queen Mother Hospital and an additional 10 freezer spaces at William Harvey Hospital. In addition, there were 78 fridge spaces at the Queen Elizabeth the Queen Mother hospital, and one bariatric space. At the time of the inspection the bariatric fridge was out of use and had been so for approximately 10 days. An engineer was expected to attend to fix it the same week but in the meantime any bariatric patients that died could be transferred to the William Harvey Hospital. There were 63 fridge spaces at the William Harvey Hospital including three bariatric and ten semi-bariatric with an additional 30 spaces at Kent and Canterbury Hospital.

We were told that over the winter months temporary storage had been increased by 100 spaces across the trust. However, despite the availability of temporary storage staff told us that they had exceeded capacity over the winter, despite arrangements to transfer the deceased between sites.
As a consequence, we were told that the deceased were ‘doubled up’ in storage spaces designed for one. Staff told us they had discussed this with the Human Tissue Authority, however this practice was not in line with Human Tissue Authority guidance as stated on their website; ‘Please note that placing more than one body on fridge trays or storing bodies in unrefrigerated areas, are not considered suitable practices’.

The mortuary at the Queen Elizabeth the Queen Mother hospital was based at the rear of the building in a corner of the building near to the pharmacy. Access was gained by ringing a buzzer which also had a camera that mortuary staff could use to establish who was at the door. There was a viewing room that was designed to be used if the police needed to use a room for a deceased person to be identified. However, at the time of the inspection this room was being used to accommodate an eight space, temporary storage unit. There was a public viewing room where family members wanting to visit their loved ones could go.

The main part of the mortuary building was small with trolleys stored adjacent to the refrigeration units as there was nowhere else for them to be stored. There were ceiling hoists in place parallel to the refrigeration units to assist mortuary staff with manual handling. There were two small offices within the mortuary for staff to work in. Both of these were worn with old pieces of office furniture and other furniture in them. Between the two offices was an area that could be used for viewing post mortem examinations that took place in the mortuary. There was also a store room where supplies were kept. This room was clean and well ordered.

At the rear of the mortuary there was a secure door where funeral directors could reverse up to, to collect the deceased. This area was cramped and had a disused medical gases storage building close to the rear door. Around the corner from the rear door was a pathway that passed where the funeral directors would park to allow them to collect a body. This meant that a member of the public, who had been to the pharmacy, could unknowingly walk past when a body was being removed from the mortuary. It also meant that a member of the public could access the mortuary when the doors were open and a transfer was taking place. It had been suggested by the mortuary team that the area should have been fenced off. However, the suggestion had not been taken forward and was not on the risk register.

Fridge temperatures in the mortuary were monitored remotely through a system that could be accessed wherever there was access to the internet. A mobile phone app that linked to this system was available to the mortuary manager. This meant that temperatures could be monitored 24 hours a day, seven days a week remotely. The app was also able to show graphical data of any fluctuations in the temperatures. This meant that staff were assured that the bodies were stored at the correct temperature.

In the mortuary office there was a mortuary board that gave details of the deceased that were stored there, the deceased were entered on to a register. The staff used a different colour pen each week to ensure that it could be identified when the body was first passed to them. Details on the board included the date of death, flags indicating if there was a person with a similar name, whether there was the danger of infection, if there was an implant device such as a pacemaker and a red, amber, green ranking for manual handling purposes. This helped to ensure staff were kept safe from injury during any manual handling procedures.

Mortuary staff told us that there were frequently difficulties in getting authorisation for small quantities of stock. This was because ordering small amounts would mean that they would not qualify for bulk buying discounts. This meant that they would have to travel between the trust’s sites to collect certain items of equipment.

Staff we spoke with on the wards did not report any difficulties obtaining the equipment they needed to care for patients at the end of life. For example, syringe drivers could be easily obtained through the equipment library.

**Assessing and responding to patient risk**
Staff involved in the provision of end of life care were asked whether or not they believed that all end of life care patients were being identified on the wards. They told us that they did not. However, they were much more confident that they were identifying the majority of them. The increased number of patients being identified through the patient time line provided evidence that this was the case.

Due to the introduction of the link nurses that had received specific training in end of life care, there was much greater awareness of the importance of the provision of care in a patient’s last days or hours of life.

Identification of end of life care patients was largely dependent on the ward staff indicating on the electronic patient tracking system that this was the case. When a patient was identified as being at the end of life the end of life care facilitator would visit or call the ward to review the patient care. They would ensure that the correct end of life conversations had taken place and the documentation had been completed correctly, providing support to ward staff and ensuring they felt confident in the delivery of care.

Link nurses we spoke with were better able to identify and care for patients that were approaching the end of life as a result of the specific end of life training they had received.

Patients at the end of life were risk assessed in accordance with their needs and condition. Areas such as the risk of falls and pressure damage were routinely assessed and the outcomes were recorded in the records we reviewed.

**Nurse staffing**

The end of life care team and the palliative care teams were fully staffed. The specialist palliative care team was largely formed of nursing staff. This included a nurse consultant who worked across all sites. In addition, there were two whole time equivalent palliative care nurse specialists based at the Queen Elizabeth the Queen Mother Hospital and an end of life care facilitator.

There were no vacancies among the end of life or palliative care teams

**Turnover rates**

In the period of time between the last CQC inspection in September 2016 and this inspection in May 2018, there had been no turnover of staff in the end of life / palliative care teams.

**Sickness rates**

We requested sickness rates for staff that worked in end of life / palliative care but the trust did not provide this information.

**Bank and agency staff usage**

The trust did not employ any bank or locum staff in the specialist end of life and palliative care roles positions.

**Medical staffing**

Consultant in palliative medicine cover was provided by the hospice for two clinical sessions a week at each hospital site including the Queen Elizabeth the Queen Mother Hospital. In addition, consultants attended the specialist palliative care multi-disciplinary weekly meetings and provided strategic input.

At our previous inspections in July 2015 and September 2016 there was no formally adopted service level agreement (SLA) for palliative care medical input. At our last inspection in September 2016 we were told that an SLA had been drafted and was with the procurement team.
We were also told that the trust would use the agreement with the hospice as a baseline and then work out the gaps in the service. However, at this inspection we were told that the SLA was still with the procurement team and had not progressed since our last inspection. This meant that there was no contractual framework for the provision of medical cover. This presented an area of risk for the trust, although the nurse consultant told us they believed that the risk was small as the informal arrangement had been in place for a number of years. The provision of medical cover was below the Royal College of Physicians (RCP) guidance of one whole time equivalent consultant per 250 beds.

**Vacancy rates**

As the medical cover for palliative care was provided by the hospice vacancy data was not collected by the trust.

**Turnover rates**

As the medical cover for palliative care was provided by the hospice vacancy data was not collected by the trust.

**Sickness rates**

As the medical cover for palliative care was provided by the hospice vacancy data was not collected by the trust.

**Bank and locum staff usage**

The trust did not employ any bank or locum staff in the specialist end of life and palliative care roles positions.

**Records**

The palliative care team used a patient tracking list (PTL) for patients identified as being at the end of life. This alerted the end of life care facilitator when a patient was commenced on the ‘care of the dying patient and their family’ care plan. The patient tracking list stored information that included the patient’s preferred place of care at the end of life, spiritual support needs and ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) decisions.

We reviewed a total of six sets of patient records. They were all completed well with clear documentation showing that patients were at the end of their life, evidence of the involvement of the chaplain and involvement of the palliative care team.

A review of six ‘do not attempt cardio pulmonary resuscitation orders’ showed that in all cases the form was kept in the front of the records with clearly documented reasoning why it was in place and relevant clinical information about the patient. In the three records we reviewed where it was recorded that the patients did not have mental capacity to be involved in the discussion about the ‘do not attempt cardio pulmonary resuscitation’ order, there was documented evidence that a best interest discussion had taken place with the next of kin. There were no occasions where there was a need for an Independent Mental Capacity Advocate to be involved. Discussion with the patients and the next of kin were clearly recorded in the patient’s notes. The names and designation of the person completing the form was recorded and signed in all six records. On each occasion the decision had been approved by a senior clinician.

Every set of records we reviewed had a ‘care of the dying patient and their families’ form on them where the patient had been identified as being at the end of life. We also reviewed one set of records where although the patient had been identified on the ward board as being at the end of
life, this had been reversed and the ‘care of the dying patient and their family’ care plan removed from the record. The ward board was soon amended to show that the end of life status had been reversed.

In all the records we reviewed we saw that the end of life care facilitator had either visited or called the ward to discuss the patient within 24 hours of them being assessed to be end of life.

The hospital had read-only access to the hospice records and the hospice had read-only access to the hospital records. This meant that any advice that was being given by the hospice staff was given by consultants that had a clear picture of the patient’s condition.

Information that was recorded on the end of life care record on the wards was sent to the facilitator via the patient tracking list. This contained various information, including; the patient’s preferred place of death, whether spiritual support had been discussed, whether there was a ‘do not attempt cardio pulmonary resuscitation’ order in place, the patient’s nutrition and hydration needs, clinical observations, symptom management and whether the compassion symbol was being displayed. The compassion symbol signified that a patient was at the end of life and could be recognised as such by staff on the wards.

End of life care patients that were being discharged to their preferred place of care or preferred place of death had a copy of the electronic discharge note sent by email to their general practitioner. A copy of the document that detailed the end of life discussion was also sent to the general practitioner at the time of discharge.

Each patient that was at the end of life had what was described as a ‘rounding tool’ at the end of their bed. Nursing and care staff carried out regular ‘bed rounds’ to review patients every two to four hours. This was recorded on the ‘rounding tool’ to reflect the close monitoring of the patient and helped them to identify any changing needs which they could then respond to. We observed that all staff were aware of the need to complete the form. Although there had been audits to check how often the forms had been completed, a programme of audit to check the quality of the form’s completion was scheduled to begin at the end of May 2018.

The service completed a trust wide end of life care plan documentation audit. The most recent of these was completed in April 2018. The objective was to see if the end of life care plan was being used to facilitate and support quality end of life care. It also looked to identify the quality of documentation of end of life care in the integrated care pathway and to monitor the use and completion of the record of end of life conversation. It also looked at the documented discussions and consent in relation to the use of the compassion symbol.

The outcome of the audit was predominantly done at trust level rather than site specific. However, in relation to Standard 1, 30 records from the Queen Elizabeth the Queen Mother Hospital were reviewed. Of the 30 sets of records audited, 27 (90%) had an East Kent University Hospitals care plan used. This meant that the majority of patients had had a care plan used for them and consequently information about that patient was easy to access.

There were five end of life care clinical quality indicators that the trust measured in the end of life care plan documentation audit. The first indicator was: Is there documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days. In the four-monthly audit between December 2017 and March 2018 this was done in 99% of cases. This is similar to the audit carried out between August and November 2017 (100%) and similar to the quarterly audit carried out between January and March 2017 (100%).

The second indicator asked if there was documented evidence within the last episode of care that the health professional recognised that the patient would probably die in the coming hours or days and that this had been discussed with a nominated person important to the patient. In the audit from December 2017 to March 2018 this was done in 96% of cases. This was similar to the previous four monthly audit between August and November 2017 (97%) but better than the quarterly audit carried out between January and March 2017 (92%).
The third indicator asked if there was documented evidence that the patient was given an opportunity to have concerns listened to. In the four monthly audit between December 2017 and March 2018 this was completed in 78% of cases. This was better than the four monthly audit between August and November 2017 (59%) and better than the quarterly audit carried out between January and March 2017 (50%).

The fourth quality indicator asked if there was documented evidence that the needs of the person important to the patient were asked about. In the four monthly audit between December 2017 and March 2018 this was done in 45% of cases. This was worse than the four monthly audit between August and November 2017 (51%) and worse than the quarterly audit between January 2017 and March 2017.

The fifth quality indicator asked if there was documented evidence that in the last 24 hours of life an holistic assessment of the patient's needs regarding an individual plan of care. In the four monthly audit between December 2017 and March 2018 this was completed in 54% of cases. This was worse than the four monthly audit between August 2017 and November 2017 (60%) and worse than the quarterly audit between January and March 2017 (96%).

The trust acknowledged that the audits showed some slight improvements and that the end of life care plan was used in the majority of cases. However, it was also acknowledged that more work was required to make sure the quality of the information contained within it needed to improve.

As a result of the audit, an action plan had been formulated to share the audit findings with the rest of the trust, increase the awareness and use of the end of life care plan including the care of the dying leaflets and continue the support, formal and informal training around improving the documentation within the care plan. The education programme would involve the whole multidisciplinary team. Each part of the plan had the person or group responsible for taking action clearly identified. All aspects had a target date for completion of May 2018.

The internal audit undertaken by the trust showed improvement in all five clinical indicators since the 2016 audit.

The trust carried out a ‘do not attempt cardiopulmonary resuscitation’ audit between November and December 2017. Eight wards at the Queen Elizabeth the Queen Mother Hospital were audited with a total of 15 sets of records audited. The audit looked at and considered the following:

1. Full patient details should be recorded on the DNA CPR form. At the Queen Elizabeth the Queen Mother hospital, this had been completed in 93.3% of the records. This was the same as the audit carried out in 2016.

2. Section 1 of the DNA CPR (relating to the patient’s capacity to make and communicate decisions about CPR) should be fully completed. This had been completed in 80% of the records.

3. Section 2 of the DNA CPR form (which summarises the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interest) should be completed. This had been completed in 100% of the records.

4. Section 3 of the DNA CPR form is completed (which summarises the communication with the patient or Lasting Power of Attorney for Health & Welfare or "IMCA), or if the decision has not been discussed, the reason why is documented. This had been completed in 73% of the records.

5. Section 4 of the DNA CPR form (which summarises communication with the patient’s relatives or friends) is completed, if no discussion has taken place then the reason why should be documented. This had been completed in 87% of the records.
6. **Section 5** of the DNA CPR form (providing the names of the members of the multidisciplinary team contributing to this decision) is completed. This had been completed in 73% of the records.

7. The health care practitioner completing the DNA CPR order should sign, record their job title, and record the date and time, (**section 6**). The health care practitioner completing the DNACPR had signed the records in 100% of the cases, the date and time had been recorded in 87% of the cases.

We viewed a DNACPR audit report dated February 2018 where it had been identified that improvements following regular audits had not been made. As a result, wards and divisions had been tasked with identifying action to make improvements. However, the action plan attached to the audit was blank. This meant that we were unable to identify specific action taken to ensure improvements.

**Medicines**

During a visit to one ward we observed that the drug trolley was not secured to a wall when not in use. The drug trolley itself was unlocked. This meant that anyone on the ward could have accessed the drugs on that trolley. When this was raised with a member of staff they had difficulty finding where the key was as the person with the key had gone for a break. The matter was dealt with once the key had been located.

Syringe drivers could be obtained from the medical equipment library. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin. They are used to help control pain, sickness and agitation. Each one was tagged which meant that they could be tracked and there was an audit trail of their use.

When a syringe driver was used for a patient that was being discharged the team would ensure that the patient had enough medication to last them 48 hours. Arrangements would be made that community teams would then be able to provide the patient with enough medication to last a minimum of 12 hours.

We saw evidence of anticipatory prescribing taking place. This was regularly done for patients that were at the end of life in anticipation of symptoms commonly experienced at the end of life. Recording of anticipatory prescribing was clear and in line with trust policy.
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 March 2017 to February 2018, the trust reported no incidents classified as never events within end of life care.

Staff we spoke with were aware of the duty of candour (the duty of candour requires that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress). There had been no incidents reported that required them to exercise the duty of candour.

We were told that incidents were reported using the electronic incident reporting system. The end of life care staff told us that incidents relating to the service were collated and reported to the end of life care board although these were minimal. However, while we saw evidence of complaints being collated and reported we did not see this in relation to incidents. In addition, there was no standing ‘agenda’ item on the end of life care board meeting agenda to discuss incidents as they occur. The palliative care nurse consultant told us that end of life care incidents were minimal and when we requested data of incidents relating to end of life care this was not provided. We could therefore not be sure, in the absence of incidents being reported, that any learning or understanding of themes and trends was being taken.

During the inspection we became aware that a practice of placing two deceased patients in a fridge space designed for one had been happening during particularly busy periods. Although a risk assessment had been carried out and the matter had been escalated, it had never been reported as an incident. This meant that a formal, electronic, trust wide record of each occurrence was not available.

The trust mortuary service had a mass fatality plan in place. This had been produced in conjunction with the local emergency services. This showed that in the event of a major incident where 10 or more people had died, they would be required to deal with the bodies. A decision would be made as to where, across the three acute hospital sites the bodies could be kept. If there was no capacity across the trust sites, a temporary mortuary could be set up by the local police force.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from March 2017 to February 2018.

Is the service effective?

Evidence-based care and treatment

End of life care was managed across the trust in line with National Institute for Health and Care Excellence (NICE) guidance. For example, there was evidence that the trust had developed services in line with NICE guidance NG31 Care of dying adults in the last days of life. This included aspects of end of life care such as the identification of people at the end of life; assessment, care planning and review; care in the last days of life; and, anticipatory prescribing.
In addition, the trust’s ‘care of the dying patient and their family’ care plan was in line with NICE quality standard QS144 Care of dying adults in the last days of life. This included; assessing signs and symptoms; individualised care; anticipatory prescribing; and, hydration.

Patients that had been identified as approaching the end of their life were visited by the end of life care facilitator to ensure that the relevant action had been taken and that the patients’ symptoms were being controlled.

Each ward had end of life care file that reflected what was available on the end of life care intranet page. Although the majority of the documents held on the wards were the same, there was no standardised format.

Nutrition and hydration

The ‘care of the dying patient and their family’ plan of care included guidance on the assessment of nutrition and hydration with reference and a link to General Medical Council (GMC) end of life care guidance that included the ethical considerations of clinically assisted hydration. In addition, four hourly comfort measures that were recorded in the daily delivery of care record included a prompt for staff to offer fluids and nutrition.

An ‘end of life care plan’ documentation audit carried out between December 2017 and March 2018 included analysis of the records relating to the assessment and care delivery regarding nutrition and hydration in the last days of life. This audit involved a review of 68 records of patients where the ‘end of life care plan’ had been used and 20 records where it had not been used. This audit was trust wide rather than site specific. In cases where the patient was being cared for using the ‘end of life care plan’ 59% had been assessed in relation to their ability to drink in the last 24 hours of life compared with 55% of patients where the ‘end of life care plan’ was not used. Nutrition assessments had been recorded 57% of the time for patients on the ‘end of life care plan’ compared with 60% of patient where the ‘end of life care plan’ was not used.

Discussions about hydration with patients were recorded in 19% of cases compared with 5% where the end of life care plan was not in use. Of those where it was not discussed 69% had a record as to why compared with 71% where the end of life care plan was not in use. Discussions with the nominated person important to the patient were recorded 40% of the time compared with 47% of the time where the end of life care plan was not in use. Discussions about nutrition with patients were recorded in 13% of the time compared with 45% where the end of life care plan was not in use. Discussions with the nominated person important to the patient were recorded 29% of the time compared with 40% where the ‘end of life care plan’ was not in use. This meant that patients at the end of life were not always having their nutrition or hydration assessed irrespective of whether the ‘end of life care plan’ was in place or not.

An action plan relating to the audit included action to disseminate results across the organisation through raising awareness at end of life care education initiatives and through the work of the end of life care link nurses on the wards. However, the action plan did not include details of how this would be done.

The end of life care plan documentation audit showed that 84% of the patients had had their nutrition and hydration needs recorded on the plan. Records we reviewed showed that patients were having their nutrition and hydration needs identified and met.

Pain relief

If a patient on a ward was symptomatic and required pain relief, ward staff could seek guidance from the clinical nurse specialist, Monday to Friday. If the need was urgent, the clinical nurse specialist could attend to see the patient on the same day.

Guidance was also available on the end of life care intranet page. There was a link to the Kent and Medway symptom control guidelines (Symptom Control and Care of the Dying Patient: Palliative
Care Guidelines, 5th Edition) which generalist staff could follow. This also provided guidance on anticipatory prescribing for those patients nearing the end of their life. Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms, and is based on the premise that although each patient is an individual with individual needs many acute events during the palliative period can be predicted and management measures put in place in advance. This guidance was in line with NICE clinical guideline CG140: opioids in palliative care. Medical and nursing staff on the wards were familiar with the guidance and knew how to access it.

We were provided with guidance, in the form of a flow chart for patients in the last hours or days of life. This had a specific flow chart for patients whose pain was controlled as well as guidance for those patients that were experiencing pain.

Records we reviewed showed that pain and other symptoms such as nausea were consistently being managed.

**Patient outcomes**

**End of life care Audit: Dying in Hospital 2016**

The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed worse than the England average for all of the five clinical indicators. The trust scored particularly poorly for the measure, “Is there documented evidence that the needs of the person(s) important to the patient were asked about?”

The trust answered yes to six of the eight organisational indicators. The two organisational indicators they had not answered yes to included communication skills training in the last days or hours of life for allied health professionals and a lack of end of life care facilitators. In addition, the organisational indicator for the provision of a seven day face-to-face specialist palliative care service was recorded on the audit in the affirmative. However, the trust specialist palliative care service did not operate over the weekends or bank holidays when support from the hospice was provided by telephone.

Since the national audit in 2016 the trust had further developed their ‘care of the dying patient and their family’ plan to include records of end of life care conversations, a holistic assessment plan, on-going daily review, a communication diary and care after death. Quarterly audits of the documentation evidenced improvements since the 2016 national audit. For example, following the most recent audit in March 2018, 99% of records showed that in the last episode of care it had been recognised that the patient would probably die in the coming hours or days. This was an improvement of 19% since the 2016 audit. In addition, in March 2018 there was documented evidence 96% of the time that there had been a discussion with the nominated person important to the patient that the patient would probably die in the coming hours or days. This was an improvement of 20% since the 2016 audit. The internal audit undertaken by the trust showed improvement in all five clinical indicators since the 2016 audit.

The trust had started the process to gather information for their next submission to the national care of the dying audit. This involved collecting 80 sets of notes from each hospital site as well as sending questionnaires to the families of those that had died. The submission was scheduled to be made in October 2018 and a timeline had been prepared for each stage to be completed to ensure the information was ready in time.

**Referrals to the Specialist Palliative Care Team**

Referrals to the palliative care team at the Queen Elizabeth the Queen Mother Hospital for the last 12 months were for a variety of reasons. Most commonly, referrals were due to rapid decline and symptom control.
<table>
<thead>
<tr>
<th>Reason</th>
<th>Cancer</th>
<th>Cancer &amp; Non-Cancer</th>
<th>Non-Cancer</th>
<th>Grand Total</th>
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</thead>
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<td>5</td>
<td>109</td>
<td>190</td>
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<tr>
<td>SYMP CONTROL</td>
<td>103</td>
<td>4</td>
<td>44</td>
<td>151</td>
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<tr>
<td>OTHER</td>
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<td>6</td>
<td>18</td>
<td>47</td>
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<td>19</td>
<td>9</td>
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<tr>
<td>INFORMATION</td>
<td>9</td>
<td></td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>PSYCH SUPPORT</td>
<td>3</td>
<td></td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>259</td>
<td>32</td>
<td>205</td>
<td>496</td>
</tr>
</tbody>
</table>

During the calendar year of 2017, there were 555 patients referred to the specialist palliative care team at the Queen Elizabeth the Queen Mother Hospital. Of these 526 were new patients, 16 were continuing patients and 13 were re-referred patients.

Of the 555 patients referred to the specialist palliative care team, 326 had a cancer diagnosis and 229 (41.2%) had a non-cancer diagnosis.

**Competent staff**

There were 41 end of life care ‘link workers’ across the hospital. It was the intention to always have two of these on each ward for each shift although this wasn’t always possible. These staff were often referred to as link nurses but they did not have to be qualified nurses and the role was sometimes filled by a healthcare assistant.

There were two mandatory training elements to the role of link worker, the first of which was Integrating Learning: Critical Situations; “Dying in Acute Hospitals”. At the time of the inspection, 28 of the 41 link workers had attended this training. The second mandatory training, Symptom Management: Last Days of Life, Part i, ii, iii, iv, v. At the time of the inspection, two of the 41 link workers had completed all five parts of the training with five link workers having complete between one and four parts of the training. This meant that 34 (83%) of the link workers had not completed any of this part of the mandatory training. At the time of the inspection there were no formal plans to increase to the training rates.

Staff on two wards we visited were able to show us a training matrix which was held at ward level to monitor staff compliance with the end of life care mandatory training. This demonstrated which staff had received the mandatory training in end of life care and which staff were booked to attend the training. It also demonstrated which staff had received the training while they were working on another ward. On the ward where we captured the information it showed that 18 staff had completed the training, nine were booked onto the training and three had received the training while working on another ward. This meant that all staff had either received the training or had booked a time to attend.

We were also provided with a training matrix that listed all of the link workers, which ward they worked on, what training they had received and when. It also included whether they had attended the link worker meetings.

As part of the inspection we asked if the trust cold tell us who had received training in using syringe drivers. We were told that each individual unit was responsible for ensuring that they held records that demonstrated that staff had received training and were competent to use syringe drivers. Details of who had been trained to use one type of syringe driver were held in one place while staff that had been trained in the use of a different syringe driver was held elsewhere. At the time of the inspection there was no quick way to gain this information. However, the service was in the process of setting up a training and competency database pilot. When this had been rolled out to all units it would be easier answer the question. This was one of the main reasons for
developing the database. Furthermore, the trust was able to tell us how many staff per ward were
deemed competent in the use of syringe drivers for the Queen Elizabeth the Queen Mother
Hospital.

Syringe driver guidelines were available on the end of life intranet site as well as in hard copy in
the ward end of life files.

Appraisal rates

At the time of our inspection all end of life / palliative care staff at the Queen Elizabeth the Queen
Mother Hospital had had an appraisal except for one new member of staff. The other staff had
had their appraisals in either April or May 2018.

Multidisciplinary working

Weekly palliative care multidisciplinary team meetings were held at the Queen Elizabeth the Queen
Mother Hospital. These included attendance from the hospice palliative care consultant,
the palliative care clinical nurse specialists and end of life care facilitator, chaplaincy staff and
social work representation. The end of life care working groups were also multidisciplinary. The
membership included nursing staff and medical consultants from across different specialities.

End of life care patients had access to a counsellor at the Queen Elizabeth the Queen Mother
Hospital. The counsellor represented 0.8 of a whole time equivalent per week but split that time
with one of the other trust sites.

Staff also had access to a social worker to assist with any discharges of patients back to their
homes. The social worker represented 0.6 of a whole time equivalent and their time was split
across the three trust sites. Contact was ordinarily made by telephone as the social worker was
based at a different trust site.

Seven-day services

The Palliative Care and end of life care service operated Monday- Friday 9am – 5pm. There was a
24 hour a day, seven day a week advisory line available for all hospital staff out of hours from the
local hospice.

The service was led by a nurse consultant that worked Monday to Friday. The end of life care
facilitator also worked Monday to Friday. There were two full time palliative clinical nurse specialist
who also worked Monday to Friday. A palliative care consultant who worked at the local hospice
also worked Monday to Friday. This meant that there was no consultant or specialist nursing cover
out of hours or at the weekend. Hospital staff did have access, to a specialist palliative care
consultant on call rota and advice via the local hospice advice line. Staff told us that getting advice
was straightforward.

In order to cover the weekend period, the hospice consultant would complete a plan of care for the
patients on a Friday. If a hospital doctor then needed advice, they would contact the hospice
consultant. Any advice given would be noted in the patient record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

We reviewed the ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) records for patients
where a decision not to resuscitate had been made. In total we reviewed six records. In three of
the cases where the patient did not have capacity we saw evidence that there had been a best interest discussion and that next of kin had been involved. However, in one set of notes it stated that the full mental capacity assessment was with the general practitioner and in the other two records, there was no documented mental capacity assessment. In the three cases where the patient did have capacity a clear record that the patient had been involved in the discussion was present.

We requested data around the training completion rates for Mental Capacity Act and Deprivation of Liberty Safeguards for the palliative / end of life care staff. All 11 staff required to undertake this training had completed the training.

**Is the service caring?**

**Compassionate care**

During the inspection we witnessed nursing staff treating all of their patients with kindness and compassion. Staff dealing with families that had recently been bereaved were conscious of the needs of those people. We saw that staff allowed relatives as much time as they needed to be with their loved ones soon after death.

We were unable to speak directly to any of the patients that were approaching the end of their life but were able to speak with other patients that told us how well they had been looked after and how kind all of the staff were.

The communication observed between the porters and the dispatchers was always professional and respectful.

Housekeeping staff we spoke with were aware of the compassion symbol. The compassion symbol signified that a patient was at the end of life and could be recognised as such by staff on the wards, and what it meant. They also described how they felt a sense of responsibility to make the area the patient was in was as clean and comfortable as possible.

During the inspection we observed the porters being dispatched to the clinical decision unit where a patient had died. Because the message was transmitted over radio, the dispatcher and the porters were mindful of the language they used to discuss what they had to do. This involved using words that they would understand but would not cause any distress to any members of the public who may have overheard what was said on the radio. At the same time as that was being observed we also witnessed clinical staff on the clinical decision unit using the same words. This demonstrated that all staff concerned in removing a patient from the clinical setting were sensitive to those who may have suffered a loss or were receiving care at the time.

Porters we spoke with told us how they always witnessed compassionate care from the staff on the wards and that patients that had died were always treated with dignity and respect. A group of porters also described how they continue to maintain the dignity of all patients by looking after them as if they were their own relatives.

The porters told us how the ward staff would place a compassion symbol on the door of a side room of a patient that had died, or on the curtain of the bed space in a bay area to ensure that the porters knew where to go. All porters we spoke with were able to recognise the compassion symbol.

Where it was known that patients requested that their organs or human tissue be donated following their death, details would be kept on their records. In the event that this was requested, the end of life care facilitator would work closely with the trust organ and tissue donation leads to ensure their wishes were fulfilled.

During the inspection two staff told us about one patient who had been on a ward for a long period of time. As they approached the end of their life, their final request was that they could sit in the sunshine and eat an ice cream. The staff were able to move the patient into the garden area and
give them an ice cream. The staff that described the story were visibly emotional when recounting how proud they were to be able to fulfil the patients last wish.

We were also told how the teams would allow the pets of patients to come into the hospital if they were approaching the end of their lives. We also heard how ‘pets as therapy’ (PAT) dogs were brought into the hospital for the patients to pet. Capacity issues within the mortuary led to processes for storing the deceased that did not ensure that people’s dignity was respected during care after death. We were told that the practice of storing two bodies in the space meant for one had occurred during busy periods, particularly during the winter months.

Staff took practical measures to minimise the issue as much as possible by transferring the deceased between sites and keeping the time that two bodies would spend in the same space to a minimum. However, a fundamental lack of capacity meant that more than one body was stored in a fridge space meant for single occupancy.

**Emotional support**

When a patient died or was in the final moments of life in the hospital, a member of the nursing team would make a phone call to the next of kin to explain the position. We were told by all the staff we spoke with that they would take into consideration where the next of kin was and whether they were in a position to take the call. For example, they would ask if the person was driving, if they were in public and whether they would like to move to a more private place.

All staff we spoke with had received training in how to break bad news. All reported that they had to be prepared for a range of emotions, make adjustments to their approach depending on the reaction of the person and deal with them as sympathetically as possible.

During the inspection we witnessed a senior member of the nursing team breaking bad news to a family member. The call was handled with sensitivity and carefully described what had happened. The same member of nursing staff met the family member at the entrance to the ward and accompanied them to see their relative.

We also observed the support that members of the clinical team provided to a family who were present when their relative died. The family were given enough time to be with their relative with no pressure being put on them to leave. The staff were then able to carry out the care after death before the patient was moved from the ward.

Each ward had a ‘last offices’ box which had been put in place at the end of 2016. This contained various items including gowns for the patient and bows for the sleeves. It also contained various items for cleaning the deceased patient and items to address any cultural observances. However, on one ward we visited the staff were unable to find it. This meant that there could be a delay in carrying out the last offices for the patient.

**Understanding and involvement of patients and those close to them**

The staff at the hospital cared for patients using the principles as set out in the five priorities for end of life care

- The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly by doctors and nurses.
- Sensitive communication takes place between staff and the person who is dying and those important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care.
- The people important to the dying person are listened to and their needs are respected.
• Care is tailored to the individual and delivered with compassion – with an individual care plan in place.

Staff we spoke with were aware of the five priorities for end of life care.

We were also provided with a copy of the trust’s care after death guidelines. This covered what was expected of various different members of staff including, all nursing staff, porters, mortuary staff and relative support staff. The document contained specific guidelines for staff around next of kin, other family and those close to them. In particular it is stated that staff should; ‘Contact next of kin/relatives as soon as possible. If death occurs at night and the relatives have expressed a wish not to be called at night they should be contacted the next day’. ‘If a death is unexpected, the next of kin must be contacted as soon as possible. ‘Where an elderly partner/relative lives alone and has no support, it may be advisable to request that they attend the hospital as their partner/relative has taken a ‘turn for the worse’. If they ask if the patient has died they must be informed at this point. ‘Staff should advise the next of kin/relative if they wish to view the body on the ward prior to the transfer to the Mortuary that they attend the hospital within one hour. Where this is not possible, the next of kin/relative will be advised that they may discuss the viewing options during mortuary working hours with the relative support office. Chaplaincy may be offered to accompany the visit during working hours.’ The Next of kin are informed that a relative support officer will contact them on the next working day to arrange an appropriate appointment for the collection of paperwork and property. Advice will also be offered regarding funeral arrangements. ‘Offer the family the opportunity to participate in the care after death procedure. ‘Prepare them sensitively for changes to the body after death and remain aware of manual handling and infection control issues.

During the inspection we observed nursing staff and porters dealing sensitively with the deceased patient and in the case of the nursing staff, speaking on the telephone and face to face with relatives of the deceased in a kind and respectful manner. We were unable to observe any mortuary staff dealing with any family members due to the time of day we visited the mortuary.

Is the service responsive?

Service delivery to meet the needs of local people

There was no dedicated palliative care ward and patients were nursed on the general wards in the hospital. Where possible, patients at the end of life were cared for in side rooms although this was not always possible. Patients that were infectious had first priority to ensure infections were contained. We saw that patients nursed on bays within wards could have their curtains drawn around them to provide additional privacy for them and their family.

The mortuary had a viewing room where families could be with their loved one after they had died. The room was accessed through a short side corridor, away from the main part of the mortuary. The room was clean, comfortable and had ensuite toilet facilities. Viewings were booked through the relative support office. They were part of the patient advice liaison service (PALS). Viewings were generally made in the afternoon as the mortuary was used to perform post mortems in the morning. There was no possibility of arranging a viewing out of hours. Staff we spoke with advised families that they were able to view their relatives but encouraged them to visit them at the funeral directors.

Because the hospital mortuary dealt with deaths in the community as well as hospital deaths, those wishing to visit a relative that had died away from the hospital had to arrange a viewing with the Coroner’s officer.
All staff and volunteers had access to guidance leaflets to promote dignity respect and compassion at the end of life. This had been produced after the hospital had adopted the compassion symbol used by the local hospice.

**Meeting people’s individual needs**

Due to the fact that there were occasions, for brief periods of time that two bodies were stored in spaces designed for one person, it could not be evidenced that the patients’ privacy and dignity after death had been maintained. This was against the Human Tissue Authority guidance on contingency arrangements for mortuaries during busy periods, which stated; please note that placing more than one body on fridge trays or storing bodies in unrefrigerated areas, are not considered suitable practices.

Patients that had been identified as being at the end of their life were allowed to choose a side room on the ward if there was one available. During the inspection we did observe that the majority of patients that were at the end of life were being cared for in side rooms.

We were told that patients would generally be asked about their preferred place of death when the decision had been made that they were likely to be in the last days of life. This was not in line with the end of life care interagency policy that recommended an early conversation between the health care professionals, patient and carer/family to ensure that all parties were confident that the patient and family wishes have been fully explored and considered. This may explain the high numbers of patients unable to participate in the conversation and the number of patients who wanted to go to the hospice or stay in hospital. It was therefore likely that the stage of illness may have impacted on the patient’s decision making, whereas if there was more time given to planning in advance of deteriorating health then the decision making may have been different. This possibility was supported by results from a carer’s survey that showed that while only 25% of respondents stated that the patient had discussed their preferred place of death with their family, none of them had identified that place as the hospital.

The trust did not have a framework for advance care planning in place. In addition, there was no formal framework in place for identifying patients in the last year of life. The palliative care nurse consultant told us that this was being addressed as part of the three tier regional end of life care strategy in which the trust were involved. They told us that there was a focus of the strategy on identifying patients in the last year of life within primary care and sharing information across organisational boundaries to promote the involvement of patients and those close to them in making advance decisions about their treatment and care.

The specialist palliative care nurse consultant told us they were planning on implementing the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process in the near future. This process would provide a framework for recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. The process would include a best interest discussion with family members where a patient did not have mental capacity to be involved in the decision.

Staff we spoke with told us how they would be able to get access to interpreters for patients that did not speak English as a first language. Telephone interpreters were available but it was often easier to get an interpreter to attend so the patients could speak face-to-face with someone. Staff would occasionally use other staff that could speak the patient’s language if they needed to convey straightforward messages.

Although we saw some printed material for patients who were at the end of their lives, and their families, we did not see any that were printed in other languages or available in other formats. This meant that information that could be useful was not easily available to some of those the hospital cared for.

We saw that individual care plans were completed for each patient. These were thorough and contained a lot of information about the patient. We saw that patients with dementia or any sensory impairment were identified and had their care tailored for their need.
If, in the event of a death the religious beliefs or practices of a patient and their family meant that early release of the body was necessary to adhere to those beliefs, arrangements could be made by the mortuary staff to have the body released within 24 hours or, in some circumstances on the same day as the death.

Families were also able to wash the bodies of the deceased if the cultural beliefs required this to happen.

The hospital had an area called the Beresford suite where the families of patients who were at the end of their life could stay. It was situated on the main corridor and was easy to find. There was a kitchen where items could be stored in a fridge and meals could be prepared. There was a large area with sofas that could be used to sleep on. There was a wet room so those staying there could wash and a separate toilet. Supplies of towels were kept in a storage cupboard. There were two doors that led to a small patio area that could be used in good weather. If the families of patients wanted to use the Beresford suite a member of ward staff would contact the palliative care team who would be able to take them a key. The contract cleaners would remove used, and deliver clean linen as well as carry out routine cleaning on a daily basis. At the time of the inspection the Beresford suite was visibly clean.

The hospital had a chaplaincy service that was available between 9am and 5pm. The hospital Chaplain would also be available on call between 6am and 9am and between 5pm and 6pm. There was an on call chaplaincy service available 24 hours a day, seven days a week. There were also 25 lay chaplains that would visit wards Monday to Friday.

The chaplain had three main lines of contact. This would be through a direct request form a patient, through family members of a patient or through ward staff. If a patient is very unwell a note would be a put in a book on the ward and the chaplain would visit the patient if the patient wanted to be visited or if the family had requested it.

The Chaplain employed by the hospital was a Roman Catholic priest and was able to offer chaplaincy to those patients that wanted to see a Roman Catholic priest. The trust also had a Rabbi who could provide chaplaincy. At the time of the inspection work was underway to recruit a chaplain of the Muslim faith. There was also a humanist lay chaplain available if that was what a patient or their family requested. The trust also employed lay chaplains that were of no faith.

There was a chapel situated close to the main reception area of the hospital. It was open 24 hours a day, seven days a week. It was clean, tidy and welcoming. There was a range of religious books for a number of different faiths.

The chaplaincy service had also arranged for a small area in the garden to be used as an area where patients or family could go to for period of quiet reflection. It was also used for events such as the armistice day commemoration.

Access and flow

We were told by staff how fast track discharge was problematic, particularly for those being discharged to nursing homes as places were not available. It was also difficult for those patients going home due to it being difficult to get care packages in place in time.

We were also told of the difficulties that can be encountered in trying to rapidly discharge a patient out of hours or at weekends. Ward staff were able to set discharge plans in place for the weekend in the week prior to discharge, however, they were not able to make preparations for rapid discharge at the weekend due to the availability of a palliative care consultant and the palliative care clinical nurse specialist. We were also told that junior doctors could start the initial preparations for discharge at the weekend but nothing further would happen until the start of the week / Monday. This meant that some patients were not always able to be moved to their preferred place of care or death.

Staff we spoke with all told us how they would not recommend a discharge if the patient leaving the hospital was at imminent risk of dying. They described how they would not like the patient to
die on route and would only do so at the express wish of the patient’s family. This meant that the patient may not be able to die at the place of their choosing.

Of the 496 patients that died at the Queen Elizabeth the Queen Mother Hospital, 415 (84%) had not stated a preference where they wished to die. It was deemed that it was not appropriate to discuss this in the case of 16 (3%) patients. There were 16 (3%) patients that wanted to die in the hospital, 13 (3%) in a hospice, 12 (3%) in a nursing home, eight (2%) where this was not discussed and seven (2%) that had no preference.

<table>
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<tr>
<th>Preferred Place Death</th>
<th>Cancer</th>
<th>Cancer &amp; Non-Cancer</th>
<th>Non-Cancer</th>
<th>Grand Total</th>
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<td>17</td>
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<td>4</td>
<td>7</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
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<td>1</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>HOSPICE</td>
<td>11</td>
<td>1</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>NURSING HOME</td>
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<td>2</td>
<td>7</td>
<td>12</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>Grand Total</td>
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<td>32</td>
<td>205</td>
<td>496</td>
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</table>

The average length of stay for patients at the end of life being cared for at Queen Elizabeth the Queen Mother hospital was 16 days compared to 17 days at William Harvey Hospital. This compared with an average of 12 days at Kent and Canterbury Hospital.

Learning from complaints and concerns

The end of life care board discussed any complaints that had been made specifically about the end of life care provision at the Queen Elizabeth the Queen Mother. We were told that on reviewing the vast majority of complaints that concerned a patient that had died, the complaint was not specifically about the end of life care they received.

We were provided with details of the complaints that had been made about the end of life / palliative care provision. Although there were themes identified and a history of what had happened presented to the End of Life care Board, there was little detail as what had been done as result of the complaint and what learning had been taken.

Is the service well-led?

Leadership

The medical director was the lead for end of life care across the trust. Day to day leadership was provided by the palliative care nurse consultant, end of life care facilitators and clinical nurse specialists. Palliative consultant cover was provided by the hospice and included dedicated time to be involved strategically.

Staff we spoke with were aware of who the led the end of life service in the hospital as well as who the end of life facilitator at the hospital was. We were told that they were visible and accessible. Ward managers were able to identify who their end of life link nurses were and who they had on duty at any one time.

Mortuary staff we spoke with told us of the good relationship they had with the senior biomedical scientists and the pathology team. However, they felt that their concerns, particularly around mortuary capacity were not heard or taken seriously.
Vision and strategy

The trust didn’t have their own end of life care strategy. The vision was explained by one member of staff as ‘wanting patients and family to feel that they had got their care right and that they were given choices at all stages’. The aim was to achieve this by supporting and encouraging patients and their families, while at the same time educating staff. The trust had been involved in the development of an interagency strategy for end of life care. Acute care is tier three of the strategy. Tier three of the strategy states that:

- The trust will work together with Tier 1 (primary care) to identify the patient group at risk of dying in the coming year using the supportive and palliative care (SPICT) indicator tool
- The trust will ensure all these patients are identified to the primary care teams so they can be entered onto the palliative/end of life register. At this point the trust will complete the anticipatory care plan if one is not already in place.
- If the patient or those close to them are deemed high risk, the trust will refer to Specialist Palliative Care teams at the appropriate hospices after informed consent.
- End of life care is the responsibility of all staff at the trust - a principle that is fully endorsed by the End of Life Board and forms part of the philosophy to deliver safe, effective, well led care and monitoring of standards for those in their care.
- Management of an acute episode should an end of life care patient require it
- Provide planned treatments (i.e. blood transfusions, chemotherapy, radiotherapy)
- Access and follow Anticipatory/Advance care plan (AACP) via the Medical Interoperability Gateway (MIG), including access to the DNACPR
- Early identification of patients who require specialist palliative care (SPC) from the hospital SPC team, supported by the Consultants from Hospices
- That there are discussions with patients/families/carers regarding current prognosis and ceilings of care
- Update Primary Care Team to ensure AACP is updated on MIG as soon as possible
- That care needs are still met with current levels of support at home (where ever that may be) if not make appropriate referrals
- That referral for ‘fast track’ to preferred place of care takes place as per AACP
- Offer patient/carer information pack
- Register unregistered patients with a GP in patient’s area of choice
- Care after death (if death takes place in hospital)
  - Bereavement discussion with families/carers
  - Patients GP is informed within 3 days of the patients death
  - Timely verification/certification of death
- Provision of a specialist palliative care (SPC) team. This is a trust team and not to be confused with the Pilgrims Hospice SPC – Tier 2 service) in the hospital. A team of specialist nurses and medical consultants led by a nurse consultant in palliative care who will also support and advise the generalist staff regarding end of life care.
- Provision of access to counsellors, chaplaincy, allied health care (AHP) professionals, discharge co-coordinators, site specific CNSs and acute oncology matrons who through a co-ordinated approach aim to meet the needs of the palliative/ dying patients and carers in the hospital setting.
- That generalist ward doctors, nurses and AHPs are supported and guided to provide end of life care through link nurses with a specialist interest in promoting end of life care, facilitated by the SPC nursing team.
The aim of the SPC hospital team is to provide an effective specialist palliative care service for adult hospital patients who have a life limiting condition including supporting dying patients who may wish to go home or transfer to the hospice for their end of life care and to support those important to them.

There was a working group for each site to look at this provision in the hospitals. The working groups had been operating for nine months and were led by the nurse consultant at the Queen Elizabeth the Queen Mother, a renal consultant and a clinical matron from the trusts other two acute hospital sites. The meetings were minuted but there was no formal action plan. It was anticipated that more structure would be added to these meetings and a formal action plan would be formed.

Culture

Staff we spoke with showed a real desire to make the end of a patients’ life as comfortable as possible. We were frequently told that this was an important part of their work. This included medical, nursing and other staff on the wards. The introduction of the link nurses and the role of the facilitator had increased generalist staff awareness of the importance of end of life care. Staff we spoke with felt that they had the training and support necessary to deliver a good end of life care service.

Staff we spoke with on the wards, of various grades told us how they felt confident and comfortable raising any issues with senior staff. We were told that if someone believed something could be done differently, in relation to patients at the end of their life, they would be listened to.

Staff were also aware of the duty of candour and what the process would be should they need to tell family members if something had gone wrong with their relatives care.

Mortuary staff we spoke with did not feel that senior staff outside of their direct management structure, were aware of the difficulties they faced with capacity and the environment they operated in. This meant that they were regularly having difficulty maintaining the high level of service they were striving for with little recognition of the role they undertook.

Governance

The Chief Executive established the end of life care board to focus on the delivery of patient centred high quality care. The Board had no executive powers other than those specifically delegated in these Terms of reference. The purpose of the Board was to ensure that the trust delivered high quality, person-centred care for patients and carers of patients, who are dying in the trust and to act as an expert resource on issues relating to end of life care.

The objectives of the end of life care board were;

- To develop, maintain and monitor the trust’s end of life strategy
- To ensure that the trust has in place relevant, up to date guidelines and documents to enable staff to deliver end of life care and that staff are aware of their responsibilities in relation to them.
- Review new guidance relating to end of life care and provide advice on implementation.
- To discuss strategic, operational and key clinical measures in connection with the end of life care provided at East Kent Healthcare University Foundation Trust.
- To delegate work streams and individual representation to local and national groups using the group as a feedback forum
• To work collaboratively with East Kent Clinical Commissioning Groups end of life strategy work stream.

• To work collaboratively on any other national initiatives in relation to End of Life Care.

• To set realistic timescales for the delivery of End of Life objectives across the Trust

• To ensure that the Trust remains compliant with the CQC’s fundamental standards relating to End of life care.

• To provide a forum for champions and stakeholders in end of life care across EKHUFT and Community Care (Primary Care)

• To act as a regular review of core business and tabulate for discussion additional issues relating to performance or strategic direction.

The end of life care board was comprised of people from 27 different roles. These included but were not limited to the Medical Director, Head of Specialist Services, End of Life care Facilitators, the Chaplain, senior medical and surgical Matrons, palliative care Clinical Nurse Specialists, palliative care Consultant from the local hospice, a Non-Executive director, and contracted Porters. Although there was pathology representation on the end of life care board, the mortuary was not represented. The Head of Nursing, Specialist Services was the Chair and the Nurse Consultant, Palliative Care was the Deputy Chair. Each meeting would need to be attended by no less than seven members and to include one medical representative, representatives from each division and a palliative care team member. The Chair or their nominated deputy of the Committee would be expected to attend 100% of the meetings. Other Committee members would be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum. The Governor representation can represent the public. The end of life care board met every four weeks. According to the End of Life Board terms of reference, a survey would be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met. As the terms of reference were only finalised in February 2018, there had not yet been the opportunity to carry out the survey.

We reviewed three sets of minutes from the end of life board for the three months immediately prior to the inspection. There were standing agenda items that included but not limited to complaints and compliments and any associated themes, improvement plan update, certification of death report, ReSPECT (ReSPECT records a summary of decisions made about the kind of treatments and care individuals want in the case of an emergency). Although there was some detail in the minutes it was difficult to see what action had been agreed and exactly how those actions would be achieved. There were no standing items to discuss risk, or any incidents that had been reported that specifically related to end of life care. This meant that opportunities to make continuous improvements could be missed.

Site based end of life care groups had also been implemented and met on a monthly basis. This would be attended by the end of life facilitators, surgical and medical link nurses, the health care of older people consultant, clinical nurse specialist and medical consultant in palliative care, the chaplain and the mortuary manager. Key messages were then disseminated to generalist ward staff by link nurses.

We reviewed three sets of minutes from the end of life working group for the Queen Elizabeth the Queen Mother hospital. In the minutes from the meeting on 5 April 2018 it described how the previous meeting was cancelled due to poor attendance. The minutes further showed that “It had been recognised by the EOL Board that the QEQM EOL working group was poorly attended and
was in need of a fresh re-launch to take forward the important EOL work streams. The group had no link nurses attending which shouldn’t have been the case as ward managers had agreed protected time for their link nurses within their contracts. It was also noted in the minutes that since the project lead for the implementation of the compassion symbol handed the responsibility over to the end of life facilitators the wards had been less compliant with the symbols use at the Queen Elizabeth the Queen Mother hospital. It was also noted that, although there was mortuary representation on the group, the difficulties with capacity in the mortuary had not been discussed.

Management of risk, issues and performance

At the time of the inspection no decision had been made about the continued provision of the two end of life care facilitator posts that had been funded through MacMillan Cancer Support. As they came to a year in post they would have to provide an annual review of what they had done before a business case could be submitted to the trust to look at continued funding. This meant that if the funding for the posts was withdrawn, one end of life care facilitator would be responsible for all three acute sites.

The end of life care provision and the team’s performance was not part of the trust dashboard of information. We were told that there was work taking place to add this and that the issue had been discussed at the end of life care board meetings. At the time of the inspection there was no timeline for when this might happen. This meant that a significant area of the trust’s work was not formally recognised in its own performance data.

We were told that a palliative/end of life care risk register had been developed following a previous inspection and that the only risk identified had been relating to issues with fast track discharge. When we requested a copy of the risk register from the trust we were told that there were no risks identified and that previous risks had been mitigated.

The mortuary at the Queen Elizabeth the Queen Mother Hospital had been running at near full capacity since December 2017. As a result of this, the service had procured extra storage space in the form of 16 temporary refrigeration units. The units were hired for a total of six months, and were due to be returned at the end of May 2018. We were told that the cost of renting these units for this period of time would be approximately seven times the cost of purchasing one outright. It was explained that because budgets for this were determined on a monthly basis, no case had been made to purchase one unit outright.

Because the mortuary had been running near or over capacity for at least six months, and although the practice of ‘doubling up’ patients in storage spaces designed for one had been identified, risk assessed and escalated within the service there was a perception that the trust executive were unaware of how acute the situation in the mortuary had become and how frequently this practice took place.

The mortuary service had a contingency plan in place, dated October 2016, to be used if there was any disruption to the service. It covered scenarios such as the fridge / freezers failing, the failure of the temperature monitoring system, mortuary fridge space capacity, other equipment failures, sickness, loss of IT systems, utilities failure, and building damage. In the event that capacity became an issue, the contingency plan stated; ‘If there is a major equipment failure or a Mortuary is near to full capacity then it will need to be reviewed as to whether deceased need to be transferred to another site using the contracted funeral director. The affected site will need to contact the Lead/Deputy Lead Anatomical Pathology Technologist (APT) to discuss capacity levels on the other sites then decide which site would be best to accept the deceased. Only deceased that are completely clear (completed death certificate and Cremation forms or released by the Coroner’s Office) can be considered as suitable for transfer. If any funeral director is involved with any deceased being transferred they must be contacted to inform them of the pending transfer to give them the opportunity to collect the deceased themselves. The Relative Support Office and/or the Coroner’s Office must also be contacted regarding the transferred deceased. Long term deceased should only be considered for transfer if no other deceased are clear to be transferred’. The process of doubling up in fridge spaces is not mentioned in the...
contingency plan. This meant that on occasions the trust was not following its own contingency plan.

The trust did have a standard operating procedure for the mortuary which dealt with the issue of placing two bodies in storage designed for one. This stated:

During extreme circumstances where the Mortuaries are close or full to capacity, Mortuary staff can place 2 deceased to a tray to free up some space. This must only be considered as a last option after the following has been completed:

- All nominated Funeral directors contacted to enquire about collection arrangements
- The Coroner’s Office has been contacted to enquire whether any other deceased have been cleared for release
- The Relative Support Office has been contacted to enquire about the status of MCCD’s/Coroner referrals/Cremation forms
- The other Mortuaries within the Trust have been contacted to check on capacity and discuss potential transfers of deceased
- Potential availability of hiring temporary fridges from external providers

If the above steps have been carried out and no extra space has been made available, Mortuary staff must seek permission from the Lead/Deputy Lead APT to start carrying out the procedure of “Top & Tailing”. The HTA DI must also be informed of the need to carry out this procedure in the short term. When permission has been given to “top & tail” deceased the following must be considered:

- Deceased being placed together must be the same gender (male/male, female/female)
- Chosen deceased must be of a body size and shape that can be stored securely together. All limbs and body parts must be inside the tray edges and clear of contact when placing back into cold storage. This will ensure there is not tissue damage to the deceased when being placed into the fridge. This will also ensure the safety of Mortuary staff during the manual handling procedure of placing 2 deceased to a tray and using Mortuary equipment.
- Deceased must be placed into a body bag to ensure there is no leakage of bodily fluids
- Deceased are placed opposite each other with head and feet at opposite ends
- Patients must not be top & tailed with same/similar name.
- High risk deceased (Hazard Group 3 and above) are not to be considered for a “top & tail” procedure.
- It’s desirable to choose deceased that are due to be collected the following day as this will ensure they do not remain on the same tray for too long
- Mortuary staff must choose a green fridge space as allocated in the Moving & Handling colour coded system
- Placing the deceased onto the same tray must be done by using all necessary manual handling equipment
- As soon as space becomes available, deceased are transferred to these available spaces. If space becomes available at another site then transfers can be arranged using the contracted Funeral director

This demonstrated that the standard operating procedure and the contingency plans for the same issue were not aligned.

Information management

Staff had access to up to date patient information. Paper based records were used for the care of patients at the end of life with electronic systems also in use. For example, the patient tracking list provided up to date information to the palliative care team and the care of the dying facilitator as to which patients were in the last days or hours of life. This enabled close monitoring by the care of the dying facilitator in order to provide support to ward staff around patient care. However, we were told that one issue with the system was that an alert would only be created when ward staff indicated on the electronic system for assessing patient vital signs, that the patient was at the end of life.
of life. If this particular box wasn’t ticked, or the wrong box was ticked, the information would not get to the end of life facilitator.

The trust did not participate in a regional Electronic Palliative Care Co-ordination System (EPaCCS), where patient records for those at the end of life could be accessed in the hospital, community and hospice. We were told that this had been discussed by the local network of services involved in the local end of life care strategy, however was not yet in place.

Members of the specialist palliative care team recorded their notes using computers that were in their office or ward based computers that could be accessed at the time of their review of patients. This meant that they could record up to date advice and recommendations about patient care so that it was quickly accessible to staff.

**Engagement**

An end of life carer’s survey was carried out annually. Surveys were distributed by relative support officers to people attending to collect the death certificate of deceased adults. Four hundred and fifty surveys had been sent out for the 2018 survey and 84 had been completed. Questions focused on themes around such as preferred place of care, symptom control, spiritual care, emotional care, dignity and respect, bereavement, communication and care after death.

We reviewed the 2018 carer’s survey report and saw areas where there had been a reduction in satisfaction. Particular areas that had deteriorated were people’s experience of; communication; dignity and respect; emotional support they received, including at the time of death; care after death; and, the overall level of care. The deterioration in satisfaction ranged between 6% and 21%. There was one area of improvement where relatives’ perception of the patient experiencing poor relief of pain and other symptoms was less than it was in the previous survey.

In April 2018 an engagement exercise was undertaken to establish the staff’s knowledge about end of life care. In total 150 members of the multidisciplinary team was questioned, this included nurses, doctors, physiotherapists, and health care assistants (50 on each site). In all 13 questions were asked. The results showed good areas of knowledge and awareness, but when compared to the end of life care documentation audit there was a disparity. It was assumed that though the staff have knowledge they are not demonstrating this through the documentation. A six-point action plan was put in place as a result of the survey which looked at the survey findings, action to be taken, evidence of action, responsible person(s) or group and target completion date.

The hospital Chaplain described how staff from the trust, lay chaplains and staff from the local hospice had gone to the local shopping centre, hired a space and set up a stall as part of the dying matters week that was running at the same time as the inspection. There was some disappointment that the event hadn’t attracted the number of visitors it was hoped to. It was felt that the public may have been put off by the banner headline and did not want to talk about the subject. However, some members of the public did seek advice about practical steps to take in the event of a loved one dying. As a result of this, the team that held the event took the learning and were already working towards next year’s event to ensure that it would have much greater engagement.

Mortuary staff described good working relationships with their heads of service, the biomedical scientists and the pathology teams. However, they told us that they had never seen any of the trust executive and weren’t aware if they had ever visited the mortuary.

**Learning, continuous improvement and innovation**

There was a trust-wide end of life action plan that had six objectives. These were related to governance, delivery of expert advice and support to staff patients and carers, provide staff that are skilled, partnership working with carers, care plans which are person centred and individualised and environments where effective end of life care is an embedded culture. Each objective had a standard needed to be achieved, a description of what the issue was, the action
required, the progress made, the target date for completion, who was leading the project and a red, amber and green and blue rating system. Blue meant that the project had been completed; green meant that it was underway and on track, amber meant that there had been a slight variation to plan, predicted one month delayed and red which meant there had been a major variation to plan that was predicted to be delayed by more than two months. Of the 21 projects on the action plan, only two were not completed or on track. None were rated as red (delayed by over two months). The only two that were delayed were the project to sustain the end of life facilitator at all three trust sites and the project to ensure all clinicians completed their end of life care learning in line with the training needs analysis that had been carried out.

Training for the end of life care facilitators and the palliative care clinical nurse specialist was not provided by the trust but was instead provided by MacMillan Cancer Support. All training requests were made through MacMillan Cancer Support.

Staff at the hospital identified three key areas of innovation and change that they have implemented since the last CQC inspection. The first was the introduction of comfort packs for family members of patients that are at the end of their life. These include items that anyone staying at the hospital can use to clean such as shower gel, deodorant, and razor blades. The trust had also adopted the compassion symbol from the local hospice. This is a subtle symbol that can be placed on the door or bed space of the patient, with their consent that shows that the patient is at the end of their life. The symbols are also placed on the ward board so all staff can see which patients are at the end of their life. This was a joint initiative with the local hospice and was worked on for six months before going live in September 2017. The third innovation was the electronic patient tracking system that had been introduced since the last inspection. This was called the patient timeline (PTL). This allowed the end of life care facilitators to be notified about any patient, direct from the ward that had been recognised as being at the end of their life. This had helped the service have a better understanding of where their end of life care patients were and allowed them to be able to go to the ward, or call the ward to establish if all the records had been completed correctly and that the patient was receiving the best possible care.

At the time of the inspection the mortuary team were in the process of developing a mobile or computer based application (app) that would record all of the information that was at the time recorded manually, would avoid duplication and would give a real time picture of what was happening in the mortuary. The app would be able to display a range of information that included, but was not limited to what the capacity was, when funeral directors were attending, how many post mortems were taking place, how long the deceased had been in the mortuary, if it was a coroner’s case and whether the patient had been infectious. The app was in the final stages of development and a testing phase was due to start with the developers and the in house IT team towards the end of May 2018.
Urgent and emergency services are provided at William Harvey Hospital, one of three sites within the trust that provides urgent and emergency care. The William Harvey Hospital site is a Level 1 Emergency Department that provided care to approximately 80,000 patients from May 2017 to April 2018. The emergency department is also a Major Trauma Unit and includes a Minor Injury Unit Service, acute thrombolysis stroke cover (24/7) and a separate paediatric provision.

The emergency department has a waiting area with 20 seats, three adult resuscitation bays and a child resuscitation bay. The emergency department has 14 major cubicles and two side rooms, a mental health assessment room and four minor injury assessment bays with a separate waiting area. The department has a new major assessment area with three rooms and 10 allocated spaces in the corridor for patient beds in the event of an over flow of patients. There is a clinical decision unit connected to the emergency department that had 34 beds for observing patients or awaiting investigation results. A paediatric waiting area and two paediatric treatment cubicles are also available.

Urgent and emergency services were last inspected in 2016 when overall, we rated it as requires improvement. Our inspection was unannounced and we inspected all five key questions.

We spoke with 12 patients and carers, and over 40 members of staff from different disciplines, including support and administration staff, nurses, doctors, managers and ambulance staff. We observed daily practice and viewed 20 sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

The trust has three urgent and emergency departments;

- Kent & Canterbury Hospital
- Queen Elizabeth The Queen Mother Hospital
- William Harvey Hospital

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

Total number of urgent and emergency care attendances at East Kent Hospitals University NHS Foundation Trust compared to all acute trusts in England.

There were 210,305 attendances from April 2016 to March 2017 at East Kent Hospitals University NHS Foundation Trust as indicated in the chart above.  
(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 from 2015/16 to 2016/17. In 2016/17, rates were higher than the England average.  
(Source: NHS England)
Urgent and Emergency Care attendances by disposal method

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

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

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

A breakdown of compliance for mandatory courses from January 2017 to December 2017 for medical/dental staff in urgent and emergency care is shown below:

| Training Module                  | Staff Trained | Eligible Staff | Completion Rate | Target Met?
|----------------------------------|---------------|----------------|-----------------|-------------
| Health and Safety                | 20            | 29             | 69%             | No          |
| Equality and Diversity           | 18            | 29             | 62%             | No          |
| Moving and Handling Level 1      | 18            | 29             | 62%             | No          |
| Fire Safety 1 year               | 14            | 29             | 48%             | No          |
| Infection Control (Level 1)      | 13            | 29             | 45%             | No          |
| Information Governance           | 9             | 29             | 31%             | No          |

William Harvey Hospital had not hit the target for mandatory training set for medical staff.

A breakdown of compliance for mandatory courses from January 2017 to December 2017 for nursing staff is shown below:
William Harvey Hospital had not hit the target for three out of six mandatory training modules set for nursing staff.

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

The service provided training to staff in a mixture of face to face and online training modules. Training compliance was monitored and overseen by the nursing educator, however, staff told us this position was not fully operational yet.

Although staff we spoke with told us the mandatory training they received was effective, they did not feel they had time to always complete the training during work hours.

Updated data, detailed below, for William Harvey Hospital, showed that compliance with the trust target for mandatory training had improved but had still not met the target in any of the six training modules for medical staff.

William Harvey Hospital

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control (Level 1)</td>
<td>85</td>
<td>94</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>93</td>
<td>103</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>81</td>
<td>103</td>
<td>86%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>78</td>
<td>103</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>73</td>
<td>103</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>50</td>
<td>103</td>
<td>45%</td>
<td>No</td>
</tr>
</tbody>
</table>

Updated data for William Harvey Hospital, detailed below, showed that compliance with the trust target for mandatory training had improved and was meeting the target in five out of the six training modules for nursing staff. The only module to be below target was information governance training.

William Harvey Hospital

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>20</td>
<td>29</td>
<td>81%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>18</td>
<td>29</td>
<td>72%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>18</td>
<td>29</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>14</td>
<td>29</td>
<td>66%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>13</td>
<td>29</td>
<td>47%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>9</td>
<td>29</td>
<td>56%</td>
<td>No</td>
</tr>
</tbody>
</table>

On our last inspection, we found the completion figures for medical staff was worse than for nursing staff and below target in all six training modules. We found the same at this inspection.
Completion figures for medical staffing were all worse than our last inspection except one module (health and safety training) which remained similar (improvement by 1%).

Some of the paediatric nurses had attended Child and Adolescent Mental Health Services (CAMHS) training as part of the paediatric nurse training but there was no assurance other staff had up to date training in mental health issues. None of the emergency department staff, we spoke with, were aware of any specific mental health training but told us they felt they would be supported to attend training if it became available.

As part of a request, following inspection, we asked the trust to provide us with sepsis training data for each staff group within the emergency department. Although the trust told us of a number of training sessions that ran, they did not have oversight of which members of staff had or had not completed this training. The training session that ran varied, for example, the trust held mandatory training sessions in the staff room on world sepsis day.

Safeguarding

Safeguarding training completion rates

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

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

A breakdown of compliance for safeguarding training courses from January 2017 to December 2017 for medical staff is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>29</td>
<td>29</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>10</td>
<td>29</td>
<td>34%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>8</td>
<td>29</td>
<td>28%</td>
<td>No</td>
</tr>
</tbody>
</table>

William Harvey Hospital only achieved safeguarding adult level 1 training target.

A breakdown of compliance for safeguarding training courses from January 2017 to December 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>103</td>
<td>103</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>73</td>
<td>103</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>49</td>
<td>103</td>
<td>50%</td>
<td>No</td>
</tr>
</tbody>
</table>

William Harvey Hospital failed to meet the target for safeguarding for two training modules.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
The emergency department at William Harvey hospital made eight adult and 136 child safeguarding referrals.

Not all emergency department staff had level two safeguarding children training as a minimum. This was not in line with the Safeguarding Children’s Standard produced by the Royal College of Emergency Medicine’s clinical effectiveness committee or in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 42.

They had not achieved target for nursing staff compliance in safeguarding children level three and safeguarding adults level two. Medical safeguarding training compliance, at William Harvey Hospital, for adults level 2 was significantly worse (34%) than the compliance at our last inspection (74%).

Staff told us the emergency department held a weekly safeguarding meeting attended by the emergency department consultant, a paediatric nurse and the safeguarding lead. We requested minutes of these meetings so we could review how comprehensive discussions were, if there was a clear agenda and if there was learning. The trust told us there were no minutes from these meetings as discussions were recorded against the patients safeguarding records by the safeguarding team who attended the meetings. There was little assurance that learning was shared at these meetings.

We were also told the trust held a cross site safeguarding meeting each week where they discussed twenty to thirty safeguarding cases. This gave all staff an opportunity to learn from real cases and improve their ability to identify and manage people at risk of abuse. However, there were no minutes from these meetings either.

The Head of Safeguarding children told us an issue they were facing in the emergency department was the unaccompanied asylum seeker. This is when an asylum seeker, who is a child, presents to the emergency department without an adult. We asked the trust to provide us with their policy around the care, treatment and safeguarding of the unaccompanied asylum seeker. The trust directed us to their safeguarding policy and told us that young asylum seekers were usually accompanied by an adult. The information provided after inspection conflicted with information provided at inspection. This shows the trust may not have effective oversight of the issues they are facing with regards to safeguarding children.

Following inspection, we requested the trust provide us with their standard operating procedure for the treatment of unaccompanied children (under 18 years old). The trust provided us with a draft, incomplete procedure. There was no approval, creation date or review date. The draft process did make reference to Gillick competence and made appropriate reference to assessing the child’s safety and wellbeing. However, as this was in draft we had no assurance that staff knew what process to follow if a child presented to the emergency department without being accompanied by an adult.

The service used an online screening tool to assess the risk of physical abuse in children. Children could not be discharged until the screening tool was completed. Certain answers triggered an immediate notification to the safeguarding team.

The emergency department had a Child Protection Information Sharing System embedded in their screening tool. This is a national alert system to help prevent child abuse. The system holds information from local authorities about children vulnerable to abuse. As part of the screening tool, staff were prompted to search the sharing system and could not discharge the child until they had
done so. If the system alerted staff to a child vulnerable to abuse they alerted the safeguarding team who assessed the child and contacted the local authority.

Staff we spoke with, understood the process and management of Female Genital Mutilation. Female Genital Mutilation training was embedded in safeguarding training. Low safeguarding training levels meant there was little assurance that all staff had taken part in up to date Female Genital Mutilation training. The emergency department had identified ten female genital mutilation cases this year. Not all staff we spoke with identified the need to contact the police in line with Trust policy.

All staff we spoke with knew who the safeguarding lead was and understood their responsibilities to safeguarding both adults and children. All members of staff, we spoke with, could identify the differing signs of abuse and were able to give examples of when they had made a safeguarding referral. For example, a member of staff told us about a patient with learning difficulties who presented to the department. The patient’s mother spoke in a way that made the nurse concerned about potential physical abuse. The staff member alerted the trust safeguarding team. The safeguarding team was then responsible for assessing the case and alerting the local authority.

There was a team and process for the identification and management of people at risk of domestic violence. The team followed a risk assessment tool that scored the patient out of 24. A score above 14 indicated a serious risk of harm and prompted a patient referral to a multi-agency risk assessment plan.

Paediatric nurses received effective training in safeguarding children. All paediatric nurses had completed level three safeguarding children training. This is a six hour face to face training module, repeated annually.

The psychiatric liaison staff could attend the emergency department, if necessary, to provide additional staffing resource as well as guidance.

**Cleanliness, infection control and hygiene**

The department did not look clean in all areas. Toilets were unkempt, and dust gathered in the corners. Staff told us it was difficult to keep toilets clean as they were shared with the rest of the hospital.

Cleaning services were subcontracted out to an external company. We saw domestic staff cleaning around beds and equipment and so dust had gathered beneath. We saw a shower room in the clinical decision unit that appeared dirty. There was a dirty, wet towel on the floor, a broken shower door and a broken shower handle resting behind the toilet. Staff immediately removed the towel and removed the broken shower door handle.

We observed the department’s cleaning check sheet but found no cleaning schedule for May 2018. There were also no cleaning check sheets in the toilets to indicate when they had last been cleaned. This was not in line with Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 2. We spoke to a domestic staff member who had been employed by the contractor for two weeks but was unsure of their role and had not received an induction.

We reviewed a comprehensive cleaning audit carried out by the contracted cleaning company for April 2018. This showed an average compliance of 98% after checking the cleanliness of 431 different areas. The areas that scored low were consistent with our findings, for example, ‘bed frames dusty’, ‘debris round floor’, and ‘low dusting required’.
Dirty utility areas were cleaned by nurses. Although these areas were visibly clean and stickered with 'I am clean' stickers. They were not dated so it was not clear when the equipment had last been cleaned.

We reviewed the service level agreement with the contractor that clearly detailed all the areas they were responsible for cleaning. We asked senior staff about the standard of cleaning, who told us the contract was ending at the end of the year and cleaning would be carried out by cleaners directly employed by the trust. Staff also highlighted that the building was old and this made it appear dirty.

Disposable curtains were used throughout the department and each had a label showing the curtain had been recently changed. This complied with Health Building Note (HBN) 00-09.

Chairs in the department had plastic seats so that they could be cleaned easily.

We saw good infection prevention control and sterile technique while cannulating a patient. Sharps management complied with Health and Safety (sharps instruments in healthcare) regulation 2013.

We reviewed five sharps boxes, all dated and not over filled.

We observed staff changing gloves and washing hands in between patients, and all staff were bare below the elbows.

Hand washing facilities were readily available. All clinical handwashing basins were compliant with the Department of Health’s Health Building Note 00-09: Infection control in the built environment. Hand sanitising gel was available throughout the department, although one was empty outside the staff hub. We notified staff and this was immediately replaced.

Environment and equipment

The design and layout of the waiting areas did not enhance patient safety. The meet and greet nurse could not always see patients sat in both of the emergency department waiting rooms. Corridors were used to keep up to 10 patients, in beds, that were overflowing from the major’s department.

The area where the meet and greet nurse met patients was opposite a door to exit the hospital, this made the area cold and uncomfortable to work in.

Staff told us there were not enough areas for staff to take breaks. There was only one staff room for the emergency department and this was small and used for meetings. Throughout our inspection we saw the room was used regularly for meetings and shared with other departments. This gave staff very little time to take their breaks. This was not in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 15, that says staff should routinely be able to take breaks. Tired staff can impact on the quality of care provided to patients.

Staff we spoke with told us there were not enough computers. Although there were a number of new computers on wheels, these were not all connected to the trust server. This meant staff could not always easily access the information they needed on patient history or previous attendances.

During the day there was a separate paediatric emergency department with a waiting area and two rooms. This area was well designed and provided audio and visual separation from the adult section, however it was too small for the number of patients they were receiving. Staff told us the capacity was for 10 patients but they could have up to 14 children in the department.

During the hours the children's area of the emergency department was closed (10pm to 7am),
children shared waiting areas with adults. Although children in the major’s area were placed in front of the nursing station there was no audio and visual separation from the adult patients. The adult area of the waiting room did not have facilities available for the distraction of distressed children in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 43.

Equipment in resuscitation trolleys, was not always accessible in a reasonable time. An adult resus trolley was mixed with both adult and paediatric resus equipment. This was because children shared the area with adults at night. However, this meant in the event of a cardiac arrest staff would not be able to respond in a timely and effective manner. We asked a member of staff to find the correct equipment in the event of a cardiac arrest, although all the equipment was present, they could not do this.

We raised this with the provider. On the second day of our inspection we found the staff had reorganised the resus trolley. While the equipment was easy to retrieve at that time, through the opening and closing of the drawers it was not possible for this to stay organised and posed a significant risk to the management of an adult or child in cardiac arrest.

Although we found a disorganised resuscitation trolley, the resuscitation unit itself was organised well. Equipment here was very well organised with colour coded drawers and clearly labelled equipment in glass fronted cabinets. The cabinets made it easy to see when a piece of equipment was missing. Equipment was colour coded in cabinets, for example, emergency airway equipment was coded red. This meant staff could quickly find the correct equipment they needed to treat a deteriorating patient.

There was also a dedicated resuscitation bay for children that was organised in the same way and had all sizes of equipment for children. We observed equipment check sheets in the resuscitation area and these were routinely carried out and completed for equipment in the resuscitation area.

The emergency department walk in area had 20 seats and the major’s area had 14 bays and two side rooms. The department also had a new major’s assessment area with three rooms and two allocated nurses. The minor’s area had a separate waiting area and four rooms. The department had a clinical decision unit, that had 34 beds and we also saw there was a separate ambulatory care unit, although this was not part of the emergency department, the staff could triage patients there.

The department had a new Rapid Assessment and Treatment (RAT) area led by a doctor to provide early assessments and decisions of patients brought in by ambulances. This had significantly improved the environment ambulance patients were waiting in. This area had five trolleys in bays and three offloading bays for ambulances.

The trust had set up an equipment library. Staff could contact the library and request equipment to be delivered to the department, for example, drip stands and blood pressure machines. All staff we spoke to found this service very effective, however it was only open until 4pm, staff told us finding equipment while the equipment library was closed became increasingly difficult.

The emergency department had been allocated their own mechanical chest compression device. This was a portable device used to deliver consistent uninterrupted chest compressions during a cardiac arrest.
Assessing and responding to patient risk

Emergency Department Survey 2016

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>6.0</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</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did you wait before</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>threatened by other patients or visitors?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

The median time from arrival to initial assessment was better than the overall England median in all of the months over the 13 month period from February 2017 to January 2018.

In January 2018 the median time to initial assessment was two minutes compared to the England average of nine minutes.

Ambulance – Time to initial assessment from February 2017 and January 2018 at East Kent Hospitals University NHS Foundation Trust

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

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

William Harvey Hospital

From March 2017 to February 2018 there was a slight decrease in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at William Harvey Hospital there is no data from June 17.
**Ambulance: Number of journeys with turnaround times over 30 minutes - William Harvey Hospital**

![Graph showing the number of journeys with turnaround times over 30 minutes from March 2017 to June 2017.](image)

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - William Harvey Hospital**

![Graph showing the percentage of journeys with turnaround times over 30 minutes from March 2017 to June 2017.](image)

(Source: National Ambulance Information Group)

**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 February 2017 to February 2018 the trust reported 2,395 “black breaches”, with December 2017 having the highest number just over 350.

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

All patients walking into the emergency department were met by the meet and greet nurse. This nurse used an emergency severity index (ESI) triaging system to stream the patients. This risk assessed patients by asking what their symptoms were, scoring them from one to five and directing them to, resus, majors or minors.
Patients were rated three if they were in severe pain or distress. A pain score of seven out of ten or above would indicate severe pain, however we spoke to six patients, five of those patients told us the meet and greet nurse did not ask their pain scores. This meant the ESI triaging system was not always being followed correctly.

Both junior and senior staff told us the meet and greet nurse did not take any vital observations because ‘the ESI system did not need observations to stream patients’. However, we saw that the system required the nurse to assess physical responses to indicate severe pain, such as a high heart rate or raised blood pressure. Both of which cannot be identified without vital observations.

The ESI system says that if the patient has symptoms that may require the intervention from more than one resource then the nurse must take the patient’s vital observations. This is to ensure patients with symptoms more difficult to diagnose, such as abdominal pain, can be suitably assessed for many serious conditions. These are the conditions that are most easily identified through the observation of physical responses.

There was a risk that staff may not have recognised or responded appropriately to signs of deteriorating health or medical emergencies. The ESI system was not being used as it was designed and so not only were patients being streamed without a thorough assessment, they were also out of sight of the meet and greet nurse and had not had any vital observations taken.

The trust could not provide us with evidence that vital observations were being recorded within 15 minutes of a patient being streamed to majors.

The receptionist, who could view one of the waiting areas, did not have any training in how to identify a deteriorating patient.

Staff told us the triaging system worked well when there was an experienced nurse covering the ‘meet and greet’ role, however with low staffing levels this was not always possible. The divisional head of nursing acknowledged the system did not work well and told us they were in the process of adding things to the system to make it more effective and safe. Following our inspection, the trust could not clearly show us what this new system was.

The approach to assessing and managing the risks to children at night was focused on clinical risks and did not take a holistic view of children’s needs. Children walking into the emergency department were directed to the paediatric unit where they would be triaged by a paediatric nurse. However, when the paediatric emergency department was closed, overnight, the meet and greet nurse triaged the children. There was no assurance that this nurse had paediatric training or could suitably identify risks to children.

We reviewed the paediatric pathway. This did not clearly specify the pathway for children through the emergency department out of hours. The pathway did direct children to be reviewed by appropriate staff out of hours, for example, children under one year between 11pm and 7am required a senior review. However, the pathway did not make it clear where children with minor injuries would be seen and cared for in the emergency department.

Staff felt the paediatric emergency care pathway needed updating. This pathway set out when the emergency department could directly refer children to the paediatric ward. Staff felt this needed to be based on the symptoms of the child rather than just their age. Staff also told us they needed the pathway to include the process to be followed at night when the paediatric area was closed.

Staff told us that seriously ill children were seen in the resuscitation unit. Children seen as a high clinical risk were placed in a major’s bed directly opposite the nursing station. Children considered low clinical risk sat in the waiting room with other adults. Staff we spoke with told us they felt the
environment was unsafe for children during these times and were unhappy working at night because of the risk it posed to children. Staff told us, where possible, they would send children to the paediatric ward to be cared for and treated, however, this was not always possible.

We reviewed an escalation plan for the paediatric emergency department when only one or no paediatric nurses were on duty. This plan detailed that ‘all stable paed majors to wait in main waiting area’. The stability of unwell children is uncertain and children decline rapidly compared with adults. This escalation plan was not fit for purpose and did not recognise the risk of children rapidly declining from stable to unstable. It was particularly unclear what the procedure was for managing a child’s care out of hours.

We asked the trust how they were assured staff had oversight of children waiting in the waiting area, they told us their staff took vital observations every hour and could see the child at all times. We did not see evidence to support this.

Patients arriving to the Emergency Department by ambulance used a dedicated ambulance-only entrance. Patients were seen in the Rapid Assessment and Treatment (RAT) area where a consultant was present to make a competent initial assessment, create a care plan and decide whether to admit the patient or not. This removed the risk around waiting to see a consultant and ensured patients were quickly risk assessed by a senior member of the medical team. The ambulance staff we spoke to felt the RAT area was a huge improvement and better assessed the risks of the patients they were bringing into the department.

Updated data for May 2018 at William Harvey Hospital, showed that 26% of ambulance handovers were completed in under 15 minutes. Data showed that 16% of patients waited over 30 minutes to be handed over and only 1% of patients waited over an hour to be handed over.

Staff recognised and responded appropriately to changes in the risks to patients. The department was using an electronic early warning system for the monitoring of vital signs in adult patients, in majors bays, to highlight early signs of deterioration of a patient’s conditions. The electronic early warning system improves detection of a deteriorating patient by regularly reviewing six physiological findings and one observation that prompted staff to take further action. We looked at 12 adult patient records. We saw all the early warning score charts were fully completed and scores calculated correctly and action taken when required.

Patients needing immediate treatment were taken to the resuscitation area where staff could continuously monitor them and manage any risks associated with the injury or illness promptly.

We saw that paediatric early warning scores (PEWS) were used when needed. We looked at six child patient records, all showed children attending the department were being assessed using the national warning score tool so that any deterioration in their condition would be rapidly detected.

The department was working to increase the appropriate management of sepsis. Sepsis was well identified and responded to within the paediatric emergency department with audits showing 100% screening for the last five months.

The electronic system prompted staff to fill out a sepsis checklist for any patients with an EWS or PEWS score above four. The last audit in February 2018 showed the percentage of patients screened for sepsis with an early warning score above four was above target at 94%.

There was an escalation plan for the critically ill patient. This was present on the back of all observation charts. This was clearly laid out with an easy to follow process to prompt action and, where necessary, escalate concerns. For example, the process prompts staff to contact the emergency medical team if there is rapid deterioration of their patient.
There was an escalation policy for patients with presumed or confirmed sepsis who needed immediate review. Staff were prompted to complete this if the patient had an early warning system score of four or above. The plan follows a step by step, tick box process to identify sepsis. If sepsis is present without red flags the escalation plan prompts staff to reassess the patient every hour. If sepsis is present with red flags then this is categorised as a critical condition and directed the staff member to begin sepsis treatment. This escalation plan also notes that action must be taken within 60 minutes of patient arrival.

There were several checklists in place to follow local safety standards for invasive procedures. For example, we saw a chest drain procedure checklist and a sedation standard operating procedure.

All checklists, we reviewed, for invasive procedures were clear and easy to follow, this reduced the risk of human error. For example, the checklist for rapid sequence intubation followed three simple stages; prepare team and patient, prepare equipment and prepare for difficulty.

At the time of our inspection, the department was creating prompt cards for the management of different injuries and illnesses. These cards were to be laminated for use in the department so staff could easily see correct medicine doses and timings. Each prompt card was tailored to William Harvey Hospital and included up to date national guidance. In a meeting we saw the medical team decide to review the cards in three months to ensure they were being used effectively and fit for purpose.

The trust had local arrangements to provide a place of safety for mental health patients. Patients can be transported by ambulance with police escort from the ED.

**Nurse staffing**

The trust reported their registered nursing staff numbers as below as of December 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Harvey Hospital</td>
<td>94</td>
<td>104</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>94</strong></td>
<td><strong>104</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.

From January 2017 to December 2017, the trust reported a vacancy rate of 15% in urgent and emergency care;

- William Harvey Hospital: 11%

This is in comparison to the trust target vacancy rate of 10% or less.

(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.
From January 2017 to December 2017, the trust reported a turnover rate of 17% in urgent and emergency care;

- William Harvey Hospital: 16%

This is in comparison to the trust target turnover rate of 13% or less.

(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.

From January 2017 to December 2017 reported an overall sickness rate of 4% in urgent and emergency care. A breakdown by site for nursing staff is as below;

- William Harvey Hospital: 5%

(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.

From February 2017 to January 2018, the trust reported a bank and agency usage rate of 73% in this core service;

- William Harvey Hospital: 72%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

A team of 104 nurses, supported by a team of healthcare assistants (HCAs), led nursing care in the William Harvey Hospital emergency department, including the clinical decision unit and the paediatric unit. The whole time equivalent for nursing staff was 94. This was larger than at the time of our previous inspection where William Harvey hospital had 80 whole time equivalent nursing staff.

There were periods of understaffing in the paediatric emergency department that were not addressed well enough. Staffing levels in the paediatric emergency department were not sufficient to keep the paediatric emergency department open 24 hours a day.

We reviewed the staffing levels, in the paediatric unit, for the week of our inspection where we found five days were not fully covered between 4pm and 2am. Staff told us, this meant the paediatric emergency department would close by 10pm and children would be seen in the adult unit of the emergency department.

Senior staff told us that agency, bank and locum staff made up a high percentage (72%) of the nursing staff, this resulted in a large gap in skill mix as the day to day nursing care varied significantly. Staff we spoke with felt the department needed better nursing protocols and procedures for agency nursing staff to follow.

At the time of our inspection, the department was well staffed. However, the rapid assessment and treatment (RAT) and major assessment areas appeared to be difficult to manage. The number of
staff assigned to these areas made it difficult for staff to manage triaging patients, administering medicines and providing care. Staff told us they felt overwhelmed with the work load and this was partly down to the large number of bank nursing staff who were not familiar with the day to day running of the department.

The department placed agency staff in low risk areas and permanent nursing staff in higher risk areas. This ensured staff who were familiar with the departments protocols and procedures were in areas where key decision making took place, but this also meant permanent staff were under increased pressure.

All staff we spoke with knew who the paediatric lead for the department was and felt able to contact this lead for support. Nursing staff told us they could access support from the paediatric registrar from the paediatric ward.

The divisional head of nursing had submitted a business case to request increased funding of paediatric nursing staff so that the service could keep the paediatric area in the emergency department open 24/7. Human Resources had provided data to show that an additional 5.49 staff were needed to fully staff paediatrics in ED for 24 hours a day and 7 days a week.

The trust was taking positive action to recruit nursing staff and looking at different ways to attract nurses to the department. The trust reported that a new nurse was starting in June and three new nurses were due to start in September 2018 and a number of student paediatric nurses from the local university had taken up placements in the department.

Following the concerns we raised with low paediatric nursing staff, the trust assured us that the paediatric emergency department would have 24hr cover with paediatric registered nurses from 23 July 2018.

**Medical staffing**

The trust reported their staffing numbers for medical staffing as of December 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Harvey Hospital</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>29</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.

From January 2017 to December 2017, the trust reported a vacancy rate of 38% in urgent and emergency care;

- William Harvey Hospital: 46%

This is in comparison to the trust target vacancy rate of 10% or less.

(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.

From January 2017 to December 2017, the trust reported a turnover rate of 12% in urgent and emergency care;

- William Harvey Hospital: 12%

This is in comparison to the trust target turnover rate of 13% or less.

(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.

From January 2017 to December 2017 reported an overall sickness rate of 4% in urgent and emergency care. A breakdown by site for medical staff is as below;

- William Harvey Hospital: 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 February 2017 to January 2018, the trust reported a bank and locum usage rate of 43% in this core service.

- William Harvey Hospital: 64%

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

**Staffing skill mix**

As of December 2017 the proportion of consultant staff reported to be working at the trust was about the same the England average and the proportion of junior (foundation year 1-2) staff was lower.
Staffing skill mix for the 46 whole time equivalent staff working in Urgent and Emergency Care at East Kent Hospitals University NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>34%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

At the last inspection, the emergency department was not meeting the Royal College of Emergency Medicine (RCEM) recommendations, that A&E consultants should provide 16 hours of cover per day, seven days per week. At this inspection, there was a dedicated emergency department medical rota that provided consultant cover for 14 hours, from 8am till 10pm. The consultant cover at weekends had increased since our last inspection from eight hours to 14 hours. The trust was still not meeting the Royal College of Emergency Medicine (RCEM) recommendation.

The whole time equivalent for medical staff was 28. This was larger than at the time of our previous inspection where the department had 25.5 whole time equivalent medical staff. Although there were no middle grade vacancies, the lead consultant for the department felt that an additional seven whole time equivalent middle grade doctors would be needed to manage the workload more effectively.

The emergency department heavily relied on locum doctors. On day two of our inspection the rota showed that 11 out of 23 (48%) doctors were locums. The weekend following our inspection, 15 out of 32 (47%) doctors were locums.

The medical team had a system for handovers. Handovers took place at 8am and 3pm. We observed one of these meetings where medical staff discussed key safety areas such us, deaths, infections and staffing.

The paediatric doctor and emergency department registrar saw children under six months during the day and the emergency department registrar saw children under 12 months during the night.

Following inspection, we asked the trust to tell us if there was any time the emergency
department at William Harvey Hospital did not have a paediatric lead on site. The trust told us they could not have a paediatric lead on site for every shift. Although staff had access to an on-call emergency department consultant, they did not have immediate access to a paediatric lead in the department, to offer advice and support, at all times.

Since our last inspection a doctor had been allocated to the paediatric area and the department had a consultant with a sub specialty in children. It is recommended by the Royal College of Paediatrics and Child Health, *Standards for children and young people in Emergency Care Settings* (2012) that emergency departments seeing more than 16,000 children per year should have at least one consultant with sub-specialist training in paediatric emergency medicine. William Harvey hospital saw 15,356 from May 2017 to April 2018. Although attendance was not above 16,000 the department was still meeting this standard.

**Records**

Patients’ individual care records were written and managed in a way that kept people safe. We looked at a total of 20 patient records. All records were filed away tidily with no loose paperwork. The records were easy to read and clearly signed and dated.

The service made sure there was appropriate and timely availability of records for staff. In the major’s assessment area, patient notes were stored in trays and clearly labelled according to where the patient was in the emergency department pathway. In the major’s area, notes were filed by the nurses’ station in drawers clearly labelled to match the patients bed number.

Records contained clear details of patients’ needs. We saw symbols on records that indicated if a patient had additional needs, for example, epilepsy or sepsis. This made it easier for staff to identify and respond to the needs of their patients.

Patient records held on going care plans for patients who had previously attended one of the trust’s hospitals. This meant patients could transition seamlessly between services because there was advance planning and information sharing between teams. For example, a staff member told us about a child taken into the emergency department by his mother. When the child was booked in, the system alerted the team that the child was autistic and suffered with significant anxiety in the hospital environment. This meant staff could plan services to suit the child. This child was given a private room and sedation was arranged so the child could be treated without causing distress.

Electronic records were designed to give staff up to date and accurate information on a patient’s history as well as real-time information across services. We saw a consultant track a patient’s journey through the emergency department, with up to date results and waiting times. We also saw that staff had access to previous diagnostic results and treatments.

When patients moved between services, all the information for their ongoing care was shared promptly and appropriately. For example, when patients were discharged, the system automatically populated a discharge summary that was immediately sent to the patient’s GP.

The emergency department used a different record system to the psychiatric liaison service. The two systems did not communicate with each other. This meant the staff in the emergency department did not have the full psychiatric history of patients attending at the emergency department.
Medicines

The arrangements for storing medicines did not always keep people safe. During our inspection we saw several opportunities for unauthorised people to access a variety of medicines throughout the emergency department. This meant safe medicines management was not fully embedded or monitored. We found that three medicines cupboards were left unlocked and open with easy access to people walking past.

Medicines within resuscitation trolleys were not always locked away. We found two out of the four resuscitation trolleys we inspected were not tamper proof. This meant people had access to emergency medicines kept within. We also found one resuscitation trolley that had an unsealed case of paediatric emergency medicines resting on top of the trolley, in full view and reach of the public.

We found eight patient group directives had gone past their review date. A patient group directive is signed by a doctor and agreed by a pharmacist. A patient group directive can act as a direction to a nurse to supply and/or administer prescription-only medicines to patients using the nurses’ own assessment, without necessarily referring to a doctor for a prescription. Without regular reviews the trust could not be sure that medications listed on patient group directives had not changed, the situation the medicine was used in was the same or if the staff named to use the direction was still correct.

Although the department had a large medicines store room for staff to prepare medicines and allocated work top areas, this area was easily accessible to the public as it was a large room that no longer had the doors attached.

Medicines were kept in locked cupboards that required a combination code that all nursing and medical staff had access to. However, there was no plan to renew or update the code to the cupboards.

We reviewed the last three months of medicine fridge temperature records, March to May 2018. We found the maximum temperatures were out of range for two days in a row in March but remained within parameters for the remaining months. Temperatures were recorded clearly and neatly but we found three dates had been missed. We asked the trust what action had been taken when fridge temperatures had gone out of range. The trust told us the fridge temperatures had not gone out of range during the three-month period. This means that no action was taken for the two days that the fridge temperature had gone above the maximum temperature. This meant the trust could not be assured the quality and stability of the medicines stored in the fridge at these times had been maintained.

Staff kept accurate records of medicines. We reviewed seven different medicines, all were in date and the quantities matched the corresponding records.

Controlled drugs were stored and managed appropriately in all areas. One key accessed each cupboard, and this was held by the senior nurse on shift. We reviewed the controlled drugs register for May where all data was complete and accurate.

We reviewed the March 2018 medication safety report for the trust. This identified themes and trends related to medicine incidents. We also saw that key messages were highlighted to share learning from incidents across the trust. For example, staff were reminded that medicine
administration should not be missed out of hours, and that staff should contact on call doctor or pharmacist.

A trolley containing medicines in the clinical decision unit was stored securely and remained locked when not in use.

Incidents

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 March 2017 to February 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported 5 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from March 2017 to February 2018.

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

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (40% of total incidents)
- Treatment delay meeting SI criteria with two (40% of total incidents)
- Medication incident meeting SI criteria with one (20% of total incidents)

(Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018))

Three of the five serious incidents related to urgent and emergency care.

In the 12 months prior to our inspection, the department reported 3218 incidents. Of these incidents the most commonly reported incident (1140 incidents) related to tissue viability of pressure ulcers, the second most reported incident (642) related to patient falls and the third most commonly reported incident (313) related to care / treatment.
Staff understood their responsibilities to raise concerns and report incidents and near misses. The trust used an electronic incident reporting system. We spoke to 12 members of both nursing and medical staff of different grades about incidents. All 12 staff members confidently explained how they used the system to report incidents and near misses.

Three of the five reported serious incidents related to William Harvey Hospital. Two serious incidents were categorised under ‘treatment delay’ and the third a ‘diagnostic incident including a delay’. We reviewed the investigation reports for all three of these serious incidents. We found that each incident was thoroughly investigated, questions from the patient were answered and the trust identified recommendations and actions out of all three incidents.

For example, one incident referred to a female patient with abdominal pain who had been discharged home without having a pregnancy test. The patient later had surgery for an ectopic pregnancy that was missed in the Emergency Department. An ectopic pregnancy is when a fertilised egg begins to grow outside of the womb and can be life threatening if undiagnosed. The learning from this incident was to ensure all staff were aware of the signs and symptoms of an ectopic pregnancy. We also saw a shared learning document that was circulated to all staff.

Staff told us they had watched a seven-minute training video in major incident awareness. The most recent data from the Trust showed that 85 out of 133 (64%) of the Emergency Department staff at William Harvey Hospital had completed face to face major incident training. Not all staff we spoke with knew where the hard copy of the major incident policy was kept but they knew they could access the policy on the trust intranet.

Staff we spoke with did not always understand the term ‘duty of candour’ but, with prompts, they did understand the principle and application of duty of candour, Regulation 20 of the Health and Social Care Act 2008. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of “certain notifiable safety incidents” and provide them with reasonable support.

We saw that duty of candour was applied in all three serious incidents. The trust gave the patient or their family member a verbal apology, explanation of the process and contact details so they had one point of contact throughout the investigation. The trust then spoke to the patient or family member to see if they had any questions they wanted answering during the investigating process. Support was offered and a written summary of the investigation was shared. This showed that the trust apologised, involved the patient in the investigation and kept them informed of the findings.

Staff communicated incidents and lessons throughout staff groups, departments and hospitals. Staff discussed incidents at team days and cross site team days to look at incidents, learning and objectives together. There were monthly meetings for medical staff to discuss incidents, attended by consultants, middle grade doctors and locums. There were also patient safety meetings held every Thursday open to both nursing and medical staff. We saw minutes of these meetings; they showed thorough discussions of incidents and learning was identified to cascade down to staff.

Learning from incidents led to improvements in patient safety. Staff told us about an incident where a trauma patient was not correctly referred to another hospital. This led to the creation of a new trauma protocol to ensure the correct and timely transfer of trauma patients.
The trust had arrangements for reviewing and investigating incidents. We reviewed a governance newsletter from December 2017, this detailed the importance behind investigating incidents. The newsletter stated that an investigation into an incident ‘aims to reduce the risk of a similar incident occurring again in similar circumstances by eliminating root causes, not just the immediately apparent symptoms, and sharing this learning’.

**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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, six falls with harm and eight new urinary tract infections with a catheter from February 2017 to February 2018 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Kent Hospitals University NHS Foundation Trust**

![Graph showing prevalence rate of pressure ulcers]

Insert commentary on any trends.

(Source: Safety thermometer - Safety Thermometer)

The trust used an effective risk assessment to manage falls. The risk assessment detailed that all patients over the age of 65 should receive a daily falls risk assessment and care plan. We also saw risk assessments associated with bed rail need, mouth care, pressure ulcers, and skin integrity.
Is the service effective?

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

Staff had access to professional policies and procedures using the trust intranet. Policies and procedures referred to the Royal College of Emergency Medicine (RCEM), and other guidelines. We reviewed eight guidelines in the emergency guideline handbook, for example guidelines in anaphylaxis, upper GI bleed and end of life care all were in date, checked and clearly specified a review date.

We reviewed the emergency department audit programme which included many national audits. Such as, the Royal College of Emergency Medicine asthma audit and airway management audits. We also saw the Trust had participated in the most recent Royal College of Emergency Medicine (RCEM) 2017/18 audits.

We saw pathways created to promote early treatment and improved patient outcomes in line with best practice guidance. For example, there had been several patients in the department whose testicles were twisted but not identified in the department quickly. The department created a torsion pathway that used a scrotal pain assessment tool to quickly identify a child or young man who needed to be seen by a consultant within 15 minutes. This pathway was displayed on the wall in the major’s area and staff told us they felt more confident they would be able to identify the patients at risk of torsions.

We asked the Trust for data to show that this pathway, based on evidence based guidance, had improved assessment times. Data showed that the time from streaming to a clinician assessment had remained under 15 minutes since mid April 2018.

The department had several checklists to make sure procedures were carried out correctly. We saw the rapid sequence intubation (RSI) checklist had been recently updated to reflect changes to the Difficult Airway Society (DAS) guidelines. Rapid sequence intubation is a procedure used to quickly manage a patient’s air way. We also saw that the pleural procedure checklist had been adapted from the World Health organisation surgical checklist.

The emergency department held a variety of meetings where they discussed evidence based guidance. For example, we reviewed the meeting minutes for the trauma board meeting, held twice a month. Here they discussed policies, guidelines and risks. Meeting minutes showed a discussion around ‘patients who fall in hospital’ and a review of the risk register.

Sepsis guidelines had not been updated to reflect the separate assessment by age group. Although staff told us this was in progress, we did not see any documents to evidence this.

Nutrition and hydration

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 about the same as than other trusts.

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

Staff we spoke with understood the importance of patients receiving sufficient nutrition and hydration. Patient nutrition and hydration was supported by dietitians within the hospital clinical
decision unit. Patients could be referred if there were concerns about their weight and calorie intake.

There was a kitchen area that patients could use to make hot and cold drinks.

Patients in the waiting area did not have access vending machines for snacks while they were waiting.

The trust offered a variety of menus for patients to choose from to meet their nutritional needs.

A Malnutrition Universal Screening Tool (MUST) was used to assess patient’s nutritional needs. MUST assessments were included in patient records and had been completed for elderly or frail patients.

**Pain relief**

In the CQC Emergency Department Survey, the trust scored 5.5 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was about the same as other trusts.

The trust scored 7.3 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

We were not assured that a patient in severe pain would have timely access to appropriate pain medicines in line with RCEM: Emergency Department Care (2017) Quality Statement 24. We asked six patients, in pain in the waiting area, if they were offered pain relief. Five out of the six patients said they had not been offered pain relief or pain scored. The sixth patient said they were pain scored and offered pain relief. The patient waiting the longest time was one hour, the patient waiting the shortest time was 25 minutes.

Following our inspection, we asked the trust to provide us with their most recent pain audit results. We did not receive a response that enabled us to review data and have assurance that pain in adults was effectively audited.

Staff regularly assessed pain within the majors area. The National Early Warning Score (NEWS) chart had a pain assessment section where staff could easily monitor pain over time. We saw 12 sets of adult patient records; all 12 showed staff had recorded pain scores at every set of routine observations. This was in line with the Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine, 2015) 6.4 Standard 3.
Staff effectively monitored and managed pain. Staff assessed pain for patients using the numeric rating scale (NRS-11). The NRS-11 is an 11-point scale used for adults and children, aged 10 and above, to self-report their pain. Patients were asked to rate their pain out of 10, 10 being the worst pain and zero being no pain. We saw evidence that staff used and managed these ratings.

There were processes to make sure pain relief medicines were effective for patients. Out of 12 records, four showed a pain score above three, all four patients received prompt pain relief medicine and their pain score was assessed after to ensure the pain medicines worked.

Staff told us that they had a pain escalation plan if the standard pain relief medicine was not effective. A consultant would reassess the patient and prescribe as needed pain relief medicine. As needed pain relief medicine was usually a stronger pain relief medicine for staff to administer when the patient’s pain was unmanageable.

We saw systems to make sure pain was well managed for children. When triaging children, the system would not allow staff to close the records without entering a pain score. This ensured staff were prompted to assess children’s pain and offer pain relief as soon as possible, in line with RCEM: Emergency Department care (2017) Quality Statement 44.

Staff used the Wong Baker scale for young children. This scale helped staff to assess a child’s pain from their facial expressions, for example, a smiley face indicated no pain and a crying face meant extreme pain.

Staff told us they felt pleased with how pain medicines had progressed in the department for children, for example, the use of intranasal morphine that had improved management of severe pain in children. Intranasal morphine is a strong pain relieving drug, inhaled through the nose, that is easily given to children for rapid pain relief.

**Patient outcomes**

In the 2016/17 Moderate and Acute Severe Asthma report, William Harvey Hospital failed to meet any of the standards.

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

- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). Hospital: 47.4%; UK: 19%.

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

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

  Hospital: 34%; UK: 52%.
The hospital's results for the remaining five metrics were all between the upper and lower UK quartiles.

- **Standard 1a (fundamental):** O2 should be given on arrival to maintain sats 94-98%.  
  Hospital: 28.9%; UK: 19%.
- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Hospital: 36.1%; UK: 26%.
- **Standard 3 (fundamental):** High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Hospital: 21.7%; UK: 25%.
- **Standard 4 (fundamental):** Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Hospital: 75.7%; UK: 77%.
- **Standard 5:** If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV

  **Standard 5b (fundamental):** within 4 hours (moderate). Hospital: 41.9%; UK: 28%.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Consultant sign-off audit, William Harvey Hospital failed to meet any of the standards.

The hospital was in the lower UK quartile for three standards:

- **Standard 1 (developmental):** Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Hospital: 3.5%; UK: 11%.
- **Standard 2 (developmental):** Consultant reviewed – fever in children under 1 year of age. Hospital: 0%; UK: 8%.
- **Standard 4 (developmental):** Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 0%; UK: 10%.

The hospital's result for the remaining one standard was between the upper and lower UK quartiles:

- **Standard 3 (fundamental):** Consultant reviewed – patients making an unscheduled return to the ed with the same condition within 72 hours of discharge. Hospital: 10%; UK: 12%.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Severe sepsis and septic shock audit, William Harvey Hospital was in the upper UK quartile for five standards:

- **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. Hospital: 92.2%; UK: 69.1%.
- **Standard 4:** Serum lactate measured within one hour of arrival. Hospital: 80.4%; UK: 60%.
- **Standard 6:** Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 66.7%; UK: 43.2%.
• Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 60.8%; UK: 44.4%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Hospital: 31.4%; UK: 18.4%.

The hospital's results for the remaining three metrics were all between the upper and lower UK quartiles.

• 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. Hospital: 74.5%; UK: 64.6%.

• Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 37.3%; UK: 30.4%.

• Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 43.1%; UK: 44.9%.

(Source: Royal College of Emergency Medicine)

In the 2015/16 Vital signs in children audit, William Harvey Hospital failed to meet any of the standards.

The hospital was in the lower England quartile for one fundamental standard and two developmental standards:

• Standard 1. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
  o Standard 1a (fundamental). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Hospital: 16%; England: 37.6%.
  o Standard 1b (developmental). Capillary refill time. Hospital: 2%; England: 22.5%.

• Standard 2 (developmental). 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. Hospital: 0%; England: 4.4%.

The hospital's results for the remaining two metrics were all between the upper and lower England quartiles.

• Standard 3 (developmental). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Hospital: 80%; England: 69.7%.

• Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital: 80%; England: 73.2%.

Standard 5 (developmental) was not applicable on this occasion.

(Source: Royal College of Emergency Medicine)

In the 2015/16 Procedural sedation in adults audit, William Harvey Hospital failed to meet any of the audit standards (which were all 100%).

The hospital was in the lower England quartile for two fundamental standards:
• Standard 3 (fundamental): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Hospital: 54.8%; England: 90%.

• Standard 4 (fundamental): Procedural sedation requires the presence of all of the below:
  o Standard 4a. A doctor as sedationist
  o Standard 4b. A second doctor, ENP or ANP as procedurist
  o Standard 4c. A nurse
    Hospital: 11.9%; England: 40.8%.

The hospital’s results for the remaining five metrics were all between the upper and lower England quartiles.

• Standard 1 (fundamental): Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:
  o Standard 1a. ASA grading
  o Standard 1b. Prediction of difficulty in airway management
  o Standard 1c. Pre-procedural fasting status
    Hospital: 31%; England: 7.6%.

• Standard 2 (developmental): There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. Hospital: 41.5%; England: 51.8%.

• Standard 5 (fundamental): Monitoring during procedural sedation must be documented to have included all of the below:
  o Standard 5a. Non-invasive blood pressure
  o Standard 5b. Pulse oximetry
  o Standard 5c. Capnography
  o Standard 5d. ECG
    Hospital: 40.5%; England: 23.9%.

• Standard 6 (developmental): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Hospital: 33.3%; England: 41%.

• Standard 7 (fundamental): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
  o Standard 7a. (fundamental): Return to baseline level of consciousness.
  o Standard 7b. (fundamental): Vital signs within normal limits for the patient. X%.
  o Standard 7d. (fundamental): Absence of significant pain and discomfort.
  o Standard 7e. (developmental): Written advice on discharge for all patients.
    Hospital: 4.2%; England: 2.6%.

(Source: Royal College of Emergency Medicine)

In the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit, William Harvey Hospital failed to meet any of the audit standards (which were both 100%). The hospital was in the lower England quartile for both of the two standards:

• Standard 1 (fundamental): If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment. Hospital: 0%; England: 100%.
- Standard 2 (developmental): 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. Hospital: 0%; England: 2%.

(Source: Royal College of Emergency Medicine)

From February 2017 and September 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally better than the national standard of 5% and generally better than the England average. From October 2017 to January 2018 the rate was worse than the national standard and England average.

In January 2018, trust performance was 9.4% compared to an England average of 7.6%.

**Unplanned re-attendance rate within 7 days - East Kent Hospitals University NHS Foundation Trust**

![Graph showing the unplanned re-attendance rate within 7 days from January 2017 to December 2017. The graph compares the rate for the trust and the England average.]

(Source: NHS Digital - A&E quality)

The department made changes but did not re audit their effect. For example, in response to the RCEM audit that stated William Harvey Hospital failed to meet all standards in the RCEM Consultant sign off 2015/16. The department developed a new electronic tab in patient records that could be checked to see if there had been a consultant review. We saw, in handover meetings, junior doctors were reminded to ensure their patients received a consultant review. Although the hospital made changes we were not provided with any updated internal audit results and the trust did not appear to audit this indicator at a local level outside of the national RCEM audits to confirm these changes were effective.

The department carried out a Commissioning for Quality and Innovation National (CQUIN) sepsis audit that showed sepsis screening was improving. Data from January 2018 to March 2018, showed that 93% of adults and 100% of children, who met the sepsis criteria, were screened for sepsis. However, of the adult patients who presented to the emergency department with severe sepsis, from January 2018 to March 2018, 20% were not administered antibiotics within one hour. The longer it takes to administer antibiotics the higher the risk to patient mortality and morbidity.
We asked the trust to provide us with their triage time audit results for children entering the department. The trust told us they did not hold this information. They did tell us that in the previous 12 months, 95% of children were triaged in under 15 minutes when arriving by ambulance. We were not supplied data to show how long it took to triage children who did not arrive by ambulance.

We requested the trust provide us with their most recent audit results of eligible patients receiving a consultant review before they were discharged. The trust provided us with a 2016/2017 RCEM audit report. We were not provided with any up to date results and the trust did not appear to audit this indicator at a local level outside of the national RCEM audits.

Updated data for William Harvey Hospital, supplied by the trust, showed that 9% of patients reattended the emergency department within 7 days from January 2018 to April 2018. This rate remained worse than the England average and national standard (5%). A higher reattendance rate suggests that a higher number of patients did not have an effective or positive outcome when they first visited the department.

We requested the trust provide us with their most recent audit results on mental health in the Emergency Department. The trust provided us with a 2014/2015 RCEM audit report. We were not provided with any up to date results and the trust did not appear to audit this indicator at a local level outside of the national RCEM audits. We requested and action plan to improve the results of this audit. The trust did not provide us with an action plan.

Actions from audit results were routinely delayed and slow to complete. For example, an action out of the Trust’s vital signs in majors local audit showed one member of staff being chased for information to create a poster from June through till September. The poster took six months to create and circulate. This shows a slow response to audit results. We saw this consistent slow response in the majority of the actions to audits we reviewed.

We requested action plans that had been created to improve the Royal College of Emergency Medicine audit results. We were provided with plans that were incomplete. The action plans did not always evidence that they had been shared at a consultants meeting, sisters meeting, departmental meetings, divisional board, quality assurance board or the patient safety board. For example, the consultant sign off action plan.

The plans did not always show that they had had a divisional sign off, for example the moderate and acute severe asthma action plan. Although most actions had a completion date, it was unclear if these actions had been completed within target. Many of the action plans were brief and limited. We did not see evidence that any of the actions were reaudited or effective.

Following the 2015/16 Venous thrombo-embolism (VTE) RCEM audit the department introduced a mandatory electronic form with RCEM criteria. The two audits since the introduction of this new form showed 100% of patients had a venous thromboembolism assessment completed.

The trust carried out local audits to address both standards in the 2015/16 Venous thrombo-embolism (VTE) risk in lower limb immobilisation in plaster cast audit. This showed the department had improved in both standards. Audits from May to September 2017 showed Standard 1 had improved from 0% to 54%, although still below the England average. Data showed William Harvey Hospital had improved Standard 2 from 0% to 6%, now above the England average.

We requested data to show that if a need for thromboprophylaxis was indicated, there was written evidence of the patient receiving or being referred for treatment. The Trust did provide us with
The trust had participated in national audits such as those identified by the Royal College of Emergency Medicine (RCEM). The results were used to benchmark and compare with other trusts nationally. There was a clinical audit lead in place for the department and they led on audit completion and compliance. However, we saw little evidence of re audit in the areas the department performed poorly.

The trust took part in the most recent Royal College of Emergency Medicine (RCEM) 2017/18 national clinical audits. These audits were ‘pain in children’, ‘procedural sedation’ and ‘fractured neck of femur’.

**Competent staff**

From April 2017 to December 2017, 72% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 85%.

William Harvey Hospital had a 64% appraisal completion rate.

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

There were gaps in management and support arrangements for staff. The appraisal rate for William Harvey hospital (64%) was below the Trust target (85%), although this had improved since our last inspection (55%).

We reviewed the most recent staff survey that showed poor response from staff regarding the effectiveness of their appraisals. Staff were asked 12 questions relating to their personal development. Five out of twelve questions scored below the benchmark average, five remained about the same and one scored higher than the benchmark average.

The department did not have a paediatric resuscitation team at all times. The trust told us that a doctor with European Paediatric Life Support training was not always present in the department out of hours but would be available on the hospital site. This was not in line with Resuscitation Council guidelines that states ‘organisations should have a separate paediatric resuscitation team. At least one member of a resuscitation team that may be expected to resuscitate children must have completed a national paediatric resuscitation course (EPLS/APLS) successfully’. Having access to a doctor with EPLS training somewhere on the hospital is not a paediatric resuscitation team.

The provider supported staff to maintain and further develop their professional skills and experience. For example, nursing staff from the emergency department were given one week placements in intensive care and at the time of our inspection the interim matron was studying toward a Master of Science degree in leadership. All Band six nurses had completed European Paediatric Life Support training.

The hospital supported staff to build relationships with other hospitals to improve their skills. The department promoted staff competency in managing the trauma patient. Staff attended a trauma simulation training day at a major trauma centre in London and attended study days at a local hospital. Staff also had access to a number of in house training sessions.

The provider identified the learning needs of staff and implemented training to meet these learning needs. The trust offered an in-house trauma immediate life support course that had been tailored to the needs of the department.
New locums had been through inductions before starting in the emergency department. We reviewed their induction packs that were sent by email to new locums. These included pathways and protocols used in the department as well as videos and guidelines on ambulatory care.

The department held monthly training days for teams within the department. The training days included training, learning and gave the team an opportunity to identify their learning needs.

Agency staff were also provided with an induction pack and where possible they were assigned a buddy. Although, the high number of agency staff compared with permanent staff made this difficult.

Not all staff had the right skills, knowledge and experience to care for children at night. Staff told us they felt worried about caring for children and lacked confidence in their ability. The service had recognised that adult nurses lacked confidence in treating children and so a scheme was set up for adult nurses to work in the paediatric emergency department for two weeks to build up their knowledge, skills and confidence. We did not speak to any staff who had taken part in this placement.

Health care assistants were not always supported to participate in training and development. We spoke with three health care assistants, all three felt they had not been given opportunity to develop, they felt they had been recruited with false promise and held back in their careers.

**Multidisciplinary working**

The hospital shared important information with relevant healthcare professionals so patients could have good continuation of care after discharge. Following the completion of a safeguarding assessment, concerns were sent immediately to the child’s own health visitor or school nurse. We also saw that GPs were electronically sent admission details for patients.

There were pathways for referral to NHS hospitals both in an emergency and routine situation. The department had improved their referral of the trauma patient to other hospitals so their handover of care was clear, accurate and ensured the receiving hospital had the right information to prepare for patients’ needs.

Staff worked together to understand and meet the range and complexity of patient needs. Staff told us they had good relationships with other specialties such as the domestic violence team.

We also saw joined up care and support from one team to another. For example, the emergency department could request support from paediatric nurses on the paediatric ward. The service used to have a paediatric liaison service but funding for this ceased in September 2016. At the time of our inspection the department was redeveloping a link nurse role between the emergency department and paediatric ward.

Staff delivered care in a coordinated way when different teams were involved. The General Practitioner and physiotherapy teams were available within minors to provide support to the emergency department. We also saw that simulation training was set up to support multidisciplinary working.
The psychiatric liaison team had well established links with the local community mental health team and the local police liaison.

The trust had improved joint working with the local NHS ambulance trust. The trust set up weekly meetings with the ambulance trust and had seen improved handovers since the Rapid Assessment and Treatment (RAT) area had been introduced. We spoke with ambulance crews who spoke positively about staff in the emergency department and felt they had a good relationship with nurses they saw regularly.

There were effective handovers and shift changes to ensure that staff could manage risks to people who used services. Board rounds were completed by medical staff every two hours. We listened in on a patient safety meeting where each patient in the department was discussed. Each consultant gave a patient history, any tests and results carried out and plans going forward. The team all gave their input and effectively raised questions around risk.

The ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment; this would ensure a team was waiting for them on arrival. However, we saw poor joined up care between staff in the resuscitation unit and an ambulance crew. Patients considered severely injured or seriously ill by an ambulance crew, were taken straight into the resuscitation unit for assessment and treatment by an experienced consultant. A thorough handover from the ambulance crew is essential to ensure risks are identified before treatment, such as, allergies, significant medical history or patient deterioration information.

We observed a crew who brought a patient into the resuscitation unit. A consultant who began treating the patient dismissed the paramedic without any member of staff taking a handover. The paramedic insisted on a handover so that important patient history could be shared before treatment began. For example, we heard the consultant announce that the patient was not a trauma patient before the paramedic intervened to inform the team that the patient had suffered significant trauma to the head. This information had a significant bearing on treatment plans and decisions and could have been missed. This handover was not in line with handover best practice as outlined in the British Medical Association guidance ‘Safe handover: Safe patients’ (2017), that states the need for ‘efficient transfer of high quality clinical information at times of transition of responsibility for patients’ because ‘poor handover can lead to fragmentation and inconsistency of care’.

**Seven-day services**

The emergency department GP was available 8am till 8.30pm seven days a week, there was also an additional out of hours GP service available for the department to refer to.

The safeguarding team was based at a sister site, Buckland Hospital. The safeguarding team were available Monday to Friday 8am till 5pm and support or advice could be requested by telephone. Outside of these hours staff contacted social services for support and advice. The safeguarding team attended the hospital every Wednesday to support the department and review safeguarding cases.

The pharmacy was open from 9am till 5.30pm Monday to Friday and 9am till 12pm on a Saturday. Staff has access to an on call pharmacist during out of hours. Patients could access a pharmacy telephone helpline to answer any questions about medicines prescribed by the hospital. This helpline was available Monday to Friday, 10am till 4pm.
The department were considering the development of a 24/7 paediatric pathway. They had requested funding to recruit more paediatric nurses to keep the paediatric unit of the emergency department open 24 hours a day.

The psychiatric liaison team was staffed 15 hours a day between 8pm and 11pm. Outside of this time there was a phone number to call for the crisis team who covered Canterbury. Staff told us there was usually a backlog of mental health patients after 11pm.

We asked the Trust to provide us with data to support the NHS Services, Seven Days a Week, Priority Clinical Standard 2 ‘Time to first consultant review’, which says this should be as soon as possible and within 14 hours. The trust was unable to provide us with data to assure us of this standard because their systems did not hold this information.

**Health promotion**

National priorities to improve the population’s health were supported. We did not see any leaflets specifically relating to smoking cessation and weight loss but we did see health promotion such as support for patients with alcohol related problems.

People using services were supported to manage their own health. We saw information available on how to manage a variety of different injuries at home, such as sprains and strains, swallowed items and head injury.

We also saw information for patients on how to find emotional support and guidance. For example, we saw leaflets on how to access confidential support and guidance for any person finding it difficult to cope and those experiencing domestic violence.

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

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. This will need to be requested during the inspection as part of standardised requests.

Once this has been received in the correct format we will be able to populate the analysis to complete this section.

*(Source: Trust Provider Information Request P14/P49)*

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff we spoke to could describe their responsibilities to ensure patients consented when they had the capacity to do so.

Staff identified the emotional needs of mental health patients. For example, there was a morning hub meeting between all the services in the hospital and the psychiatric liaison team attended any discussions around mental health patients. Any identified emotional needs of patients were discussed so that staff could provide appropriate care. We observed discussions during handovers that clearly identified the emotional needs of the patient’s treatment.

Patients who were suspected to be experiencing depression were referred for a mental health assessment.

There were no patients detained under the Mental Health Act at the time of the inspection however staff were aware of the links with the psychiatric liaison team and how to access support. There
was also a procedure that clearly identified the responsibilities of the psychiatric liaison to arrange a mental health assessment.

The nursing staff we spoke with did not have any in depth knowledge of the Mental Health Act holding power.

Although staff demonstrated they had the experience to manage patients with dementia and learning difficulties, we were not assured they had the appropriate training to do so.

The staff we spoke with were not up to date with current practices such as ‘stopping over medication of people with a learning disability’ (STOMP), communication passports or how to access easy read information for the patient with learning difficulties.

**Is the service caring?**

Our rating of caring went down. We rated it as requires improvement.

**Compassionate care**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from January 2017 to December 2017.

As of January 2017, the trust performance was 72.9% compared to the England average of 86.7%.

**A&E Friends and Family Test Performance - East Kent Hospitals University NHS Foundation Trust**

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

(Source: NHS England Friends and Family Test)

The most recent Friends and Family test May 2018, showed that 73.9% of patients from the emergency department at William Harvey Hospital would recommend the trust. This scored the lowest out of the other departments and hospitals within the trust.

People’s emotional, and social needs were not always viewed as important or reflected in their care, treatment and support. During our inspection staff were very busy. We did not always see nursing staff taking time to interact with patients and those close to them in a considerate way. We saw nurses interacting with patients without introduction or without talking to them. For example,
we saw a member of staff enter a bay to turn off a patient’s machine alarm and leave without saying hello, or smiling or acknowledging the patient in any way.

Staff were not responding to patients in a timely or effective manner. We heard and saw one patient’s observation machine ringing for over ten minutes before alerting a member of staff. The staff member did not check on the patient but went to find the patients assigned nurse. While they searched, the alarm continued to ring for a further four minutes. We asked the patient if the nurse had explained why the alarm was ringing. The patient told us they had not been informed.

Staff did not always understand the need to make sure that people’s privacy and dignity was maintained. While this may not have been intentional, it resulted in patients not feeling valued or respected. We saw patients in beds in corridors for extended periods of time. Beds in corridors were not screened off from people passing through, so there was no privacy. There were no call bells for these patients which meant patients would have had to call across the corridor to nursing staff if they needed them.

While showing us around the department, the divisional head of nursing spoke to one of the patients and showed genuine care and compassion when asking how they were feeling. However, we did not see any other member of staff interact with these patients. We observed two nurses in the corridor assigned to care for the three patients in beds. We saw the nurses interacting with one another. There was no interaction with the patients. During our inspection we returned to the corridor over 12 times, at no point did we see them talk to or engage with the three elderly patients waiting in the corridor.

The friends and family test also raised concerns around privacy and dignity. One response stated ‘I was disturbed… to see at least half a dozen mostly elderly women stuck in corridors in quite degrading conditions. My young daughter was very distressed by this too. No dignity or privacy. Staff milled about as though this was normal but patients and those with someone with them looked utterly miserable and helpless’. This comment mirrored what we saw during our inspection.

Feedback left by patients on the NHS Choices website was more negative than positive about the care provided. Six patients left feedback in May, five of the six patients one gave the department five out of five star feedback but the other five patients gave one star out of five. We saw comments such as ‘Lots of staff aimlessly wandering around chatting’ and a 95 year old ‘Spent over 9 hours in the corridor’.

We did see health care assistants engaging with patients in a compassionate manner but this did not always extend to the other nursing staff. We saw very busy nurses, rushing around, unable to spend the time that patients needed for good care.

Complaint themes and trends showed a quarter of complaints related to subjects that impacted care and compassion. As part of a request for data after inspection, we asked the trust to provide us with complaints data for the previous 12 months (May 2017 – May 2018). The trust only provided data from 2017. Based on this data we saw approximately 25% (25 out of 99) of informal complaints related to staff attitude, communication, dignity and nursing staff. We also saw that approximately 25% (26 out of 98) of formal complaints related to the same categories.

We reviewed the most recent staff survey results at William Harvey Hospital emergency department. These showed that 47% of staff responded positively to ‘Care of patients/service users is organisation's top priority’ and 41% of staff responded positively to ‘If friend/relative
needed treatment would be happy with standard of care provided by organisation’, both were below the benchmark average.

We could not be assured that staff were proud of the care provided. We spoke to a number of staff who described being ‘too busy’ and a need for ‘more staff’ to be able ‘to provide better care’. The staff survey results showed that 34% of staff answered positively to ‘Able to provide the care I aspire to’. This was below the benchmark average and not in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 50

**Emotional support**

Staff did not always provide timely and appropriate support to patients and those close to them. We spoke to a parent of a young mental health patient. The parent told us that they often attended the department and this was a very distressing time for them both. We asked if they felt cared for and supported. The parent also told us ‘staff make me feel embarrassed, you know, as if we are underserving of their time’. The patient told us ‘staff are busy though, and I’m not deserving of their time’.

We were not assured that the meet and greet nurse recognised when patients needed to talk in private. The friends and family test for May 2018 raised similar concerns, one comment stated, ‘No privacy at triage or booking in – personal details could be heard by all!’.

We spoke to a family who had not attended the hospital before. They told us staff were ‘very caring and supportive’.

Staff told us they helped patients, who became distressed in an open environment. They maintained their privacy and dignity by taking them to a private room where they could voice their concerns and worries. Staff told us they would offer as much support as they could by listening to their patient’s worries or concerns.

We reviewed many ‘thank-you’ letters provided to the department. These demonstrated staff commitment to providing compassionate care. For example, ‘thank you so much … for taking the time to have a chat with me’, and ‘thank you so much for your care and attention during my sickness’.

**Understanding and involvement of patients and those close to them**

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 20 of the 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>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG trusts</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examing 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>8.7</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>6.8</td>
<td>Worse than 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>7.9</td>
<td>Worse than 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>7.1</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>8.6</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>7.4</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>8.5</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>6.5</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>5.6</td>
<td>About the same as 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>7.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.6</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>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
Q39. Did a member of staff tell you about medication side effects to watch out for?  
Trust 2016: 4.9  
2016 RAG: About the same as other trusts

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?  
Trust 2016: 5.0  
2016 RAG: About the same as other trusts

Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?  
Trust 2016: 4.9  
2016 RAG: About the same as other trusts

Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?  
Trust 2016: 5.8  
2016 RAG: About the same as other trusts

Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?  
Trust 2016: 7.4  
2016 RAG: About the same as other trusts

Q45. Overall... (please circle a number)  
Trust 2016: 7.7  
2016 RAG: About the same as other trusts

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

The nursing staff were not prioritising a caring environment. Some people were not given information or helped in other ways to be involved in their care and treatment. We spoke to a patient who had been in the hospital for a procedure but was then admitted to the emergency department because she was unwell. The patient asked us what was happening as they had been in the corridor for over three hours. We asked the nurse in the corridor what was happening. The nurse could tell us they were waiting to discharge the patient and reschedule the procedure for another day but had not shared this information with the patient. We had to request that the nurse communicated this information with the patient. This was not in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 26, ‘are patients routinely given forecasts’.

The Emergency Department survey 2016, showed only four areas that scored worse than other trusts. All four areas were themed around communication. We reviewed the friends and family test results for May 2018 where we saw a number of comments about poor communication. For example, ‘not listened to … no understanding of the pain I was in’ and ‘… no one called for 90 minutes … felt like nothing was happening’.

We spoke with 12 patients, seven of these patients were happy with the care they received describing their care as ‘spot on’ and ‘good’. One said their care was ‘ok’ and another said it was too soon to comment. The remaining three patients described their care negatively, such as ‘I don't know what is going on’, ‘they don’t have time’ and ‘rushed’.
There were some systems in place to help staff deliver care to patients in need of additional support. Staff told us there was a learning disabilities specialist nurse within the trust to provide additional support.

Medical staff made sure patients could ask questions about their care. We saw a consultant explaining test results to a patient. The consultant asked both the patient and their husband if they had any questions. The consultant listened to their questions patiently and answered them thoroughly and in a way the patient could understand.

Is the service responsive?

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The department remained under significant pressure to meet the needs of their patients. During our inspection we saw three patients who had been waiting over nine hours for a bed and the corridor used for overflow patients was in constant use throughout the two days of our inspection.

The department held a number of meetings to discuss capacity needs. Staff held two video conferences at 8am and 5pm, with other sites, to discuss capacity. The department also held a site meeting at 10am and 3pm that looked at the emergency department status and the hospital bed status. A representative from each area of the emergency department attended this meeting including a representative from the discharge planning team. At this meeting, staff discussed where bed spaces were and made efforts to free up more space. However, there was little success at these meetings as capacity within the department remained a problem due to lack of bed space throughout the rest of the hospital.

The department enabled patients to easily see waiting times in the emergency department so they could attend at a time that suited their needs. This was accessible both online and within the waiting room area.

We saw a constant monitoring of bed state by the sister in charge and the sister coordinator. Staff also had access to an ‘A&E’ application they could access on their phones. This showed the number of patients in the department, the number of breaches and waiting times. This also predicted the number of patients for the day. This meant staff could be allocated to the appropriate area of the department to improve service delivery.

During our inspection we saw there was enough seating space in the reception and waiting areas for patients. There were chairs for relatives next to patients in majors and they had access to a kitchen to help themselves to hot drinks. All areas were well lit in line with Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 6 and 1.

The signage and information throughout the department made it easy to navigate to, through and from the emergency department in line with RCEM: Emergency Department Care (2017) Quality standard 10.

The hospital had not been identified as having a large number of referrals compared to the other emergency departments so had not been identified as requiring 24-hour cover by the mental assessment teams.

We saw a small room available for patients to wait for a mental health assessment. Patients who presented to the department due to a mental health crisis were shown to this room so they had privacy and dignity at their time of distress. We saw a mental health patient in this room, they told us they felt calmer ‘away from people looking’ at them.
Meeting people’s individual needs

The trust scored “worse than” other trusts for two questions of the three Emergency Department Survey questions relevant to the responsive domain and “about the same” as other trusts for the remaining one questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>6.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

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

Staff acted to remove barriers when people found it hard to access services. Staff told us, patients had access to translation services and they knew how to access them. This was in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 35.

The emergency department met the communication needs of children. It is recommended by the Royal College of Paediatrics and Child Health, Standards for children and young people in Emergency Care Settings (2012) that Emergency departments seeing more than 16,000 children per year employ play specialists at peak times or have access to a play specialist service. William Harvey hospital saw 15,356 from May 2017 to April 2018, so did not need to employ play specialist at peak times, but they were aware that the number of children being cared for was very close to this recommendation. In response to this, the trust had given the emergency department access to play therapists from the paediatric ward that showed their commitment to best practice. Play therapy uses play to understand and communicate with children about feelings, thoughts and behaviour.

The emergency department used a frailty screening tool to identify and measure frailty as early as possible in patients over the age of 65. The screening tool was simple, quick and easy to use. The tool asked five questions of the patients, for example, ‘has the patient been admitted from a nursing or residential home’. If the answer to any one of the five questions was ‘yes’ then the patient was classed as frail. This was used to identify the patient in the electronic system so that staff were aware of frailty at every point of patient contact. Identifying frail patients enabled staff to support and direct patients and carers to supportive services and interventions.

The department had a relative’s room. This was a quiet space for relatives to go to if they needed the space.

The department had worked hard to improve the discharge of patients. The integrated discharge team worked well to support the needs of patients. There was also a new appointment of a community link worker to make discharging to the community a seamless process for patients. The community link worker could liaise with both the hospital and the appropriate community organisation to ensure patient information was shared and preparations were made for the patient.

The service considered the individual needs of patients with complex needs. We saw patients living with dementia were identified by a butterfly, and autistic patients were identified by a butterfly.
with a puzzle piece on it. Staff had access to specialist guidelines for patients with learning difficulties and complex needs. They could access records of patients with learning difficulties to prepare the area to suit. Staff told us about a time they prepared a quiet room for a child with autism and made immediate contact with the relevant teams to support the patient.

If patients with mental health needs needed extra support or supervision the department had access to additional staff to provide one to one care. The department also had support from the psychiatric liaison team who could attend the department to offer support.

The psychiatric liaisons team had a bank of information and links to local support groups and patients and carers groups. They took these when they visited the emergency departments when assessing patients.

The department had a kitchen that patients, relatives and staff could use to get hot and cold drinks. This meant people could access drinks at times to suit them. We saw healthcare assistants asked patients if they would like a tea or coffee and directed relatives to the shared kitchen area.

The trust provided menus to suit the individual needs of their patients, for example, we reviewed a kosher menu and a vegan menu. We also saw that pre – mashed, mashed and pureed menus were available for patients who were unable to eat solid food. Each menu had a variety of options for patients.

Staff told us they did not have access to a specialist link dementia nurse to provide specialist advice and support for dementia patients.

Patients had little privacy when discussing their illnesses or injuries when talking with the meet and greet nurse. Although there was a private room on request, this was not routinely offered. This was not in line with Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 4. One patient told us they felt uncomfortable talking in front of everyone but did not want to ‘rock the boat’ because ‘that just seemed to be the only option’. The meet and greet nurse was unable to meet individual needs because they did not ask patients if they needed privacy.

The department had a clinical decision unit to allow a short period of observation, investigation or treatment prior to discharge. However, most of these patients were awaiting transfer to a medical ward and so the clinical decision unit was not used for the purpose it was designed for.

Access and flow

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 did not meet the standard for ten months over the 12 month period from February 2017 to January 2018.

Performance against this standard showed improvement from October 2017. As of January 2018, the median time to treatment was 58 minutes compared to the England average of 57 minutes.

Ambulance – Time to treatment from February 2017 to January 2018 at East Kent Hospitals University NHS Foundation Trust
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 ED.

The trust did not meet the standard from February 2017 to January 2018.

The trust breached the standard 12 times from February 2017 to January 2018.

From October 2017 the trust showed signs of improvement but this declined in the winter months.

**Four hour target performance - East Kent Hospitals University NHS Foundation Trust**

From February 2017 to January 2018. East Kent Hospitals University NHS Foundation Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted started the reporting period better than the England average but has decreased since October 2017 to worse than the England average with January 2018 showing signs of improvement.
Percentage of patients waiting more than four hours from the decision to admit until being admitted - East Kent Hospitals University NHS Foundation Trust

Over the 12 months from February 2017 and January 2018, eight patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in August 2017 (two patients), December 2017 (two patients) and January 2018 (two patients)

<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>Feb-17</td>
<td>322</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>242</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>210</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>386</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>224</td>
<td>1</td>
</tr>
<tr>
<td>Jul-17</td>
<td>423</td>
<td>1</td>
</tr>
<tr>
<td>Aug-17</td>
<td>447</td>
<td>2</td>
</tr>
<tr>
<td>Sep-17</td>
<td>554</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>586</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>624</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1082</td>
<td>2</td>
</tr>
<tr>
<td>Jan-18</td>
<td>877</td>
<td>2</td>
</tr>
</tbody>
</table>

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

From February 2017 to January 2018 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average.

As of January 2018, the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 3.9%, compared to the England average which was 3.0%.
Percentage of patient that left the trust without being seen - East Kent Hospitals University NHS Foundation Trust

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

From February 2017 to January 2018, the trust’s monthly median total time in A&E for all patients was consistently similar to the England average. In January 2018, the trust’s monthly median total time in A&E for all patients was 169 minutes, which is worse than that of the England average which was 153 minutes.

Median total time in A&E per patient - East Kent Hospitals University NHS Foundation Trust

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

The emergency department was open 24/7 and patients could self-refer, be referred by their GP, the 111 service or arrive by ambulance.
People with the most urgent needs had their care and treatment prioritised. The meet and greet nurse triaged patients without observations and gave patients a card to book in. If the patient was very ill the nurse would take them straight to majors. The meet and greet nurse was responsible for all patients in the waiting room.

Potential risks were considered when planning patients' access to services. The service had a demand and capacity escalation plan 2017 to 2018 that had been recently reviewed. The plan clearly detailed an accident and emergency improvement plan. This covered admission avoidance, streaming, workforce and recruitment, improved flow and discharge.

Staff told us that the orthopaedic team were easy to refer patients to since the introduction of a trauma and orthopaedics transformation proforma however staff told is it was difficult to refer patients to gynaecology. In particular, staff told us the early pregnancy unit were not always happy to see their patients and encouraged the emergency department to discharge these patients.

A television in the waiting area displayed the estimated waiting time for minor injuries and the number of patients in the emergency department. This information could also be accessed on the Trust website so that patients could access services at a time to suit them.

Patients could self-refer to the psychiatric liaison team when they attend the emergency department.

Adults with urgent mental health needs received prompt support when referred. There was a service level agreement between the emergency department and the mental health liaison team, which agreed that patients with mental health needs would be responded to within 30 mins and assessed within two hours assessed within two hours. Staff told us patients were always assessed by the mental health liaison team within two hours. and this was sometimes quicker depending on the patient’s condition. However, Child and Adolescent Mental Health Services (CAMHS) did not have a contact available on site so these responses were slower, although staff felt they had a positive input and were better than the service provider at the time of our last inspection.

From January 2018 to April 2018, 22% (2683) of patients were in the emergency department for over six hours, 43% (5245) of patients were admitted in under four hours and 48% (2140) of patients were waiting between four and 12 hours from the decision to admit to admission. Data showed that 2% (587) of patient's left the department without being seen during these months.

Flow through the emergency department was significantly held up due to low availability of beds in other departments. When patients were waiting for inpatient beds they were often waiting in the clinical decision unit or in the over flow corridor area. Although the department could discharge to ambulatory care, the unit was often too full to do so.

The meet and greet nurse did not have a specific doctor to escalate concerns to but would have to leave the waiting area to look for one. This meant patients who entered the emergency department and required immediate assessment by a doctor did not always have timely access to one.

We asked the trust how many children they cared for at William Harvey Hospital, during the time the paediatric area of the emergency department was closed. The trust told us the paediatric area was closed between 10pm and 7am. During this time, the trust cared for approximately 324 children per month. There also was no paediatric emergency department nurse on shift, for an
average of 7.5 hours, each night, in May 2018. This meant a significant number of children could not access the area of the emergency department, tailored to children’s needs, or a paediatric nurse, at night.

**Learning from complaints and concerns**

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

The trust received 99 informal complaints and 97 formal complaints in 2017. There have been no complaints referred to the ombudsman from the emergency department at William Harvey Hospital in the last 12 months.

People knew how to give feedback or raise any concerns about their experiences and could do so in a range of ways. Patients could ask to speak to a senior member of staff to raise their concerns or they could contact the Patient Advice and Liaison Service (PALS). The Trust also displayed contact information for an advocacy service who could assist patients with raising a complaint.

The outcome of complaints was explained appropriately to the complainant. We reviewed the service’s responses to three complainants. All three responses were kindly written and details of the investigation were openly shared. The response addressed and answered all concerns raised by the complainant and offered a sincere apology.

There was little evidence of the learning applied to practice within the service from complaints. We asked eleven members of staff if they knew of any learning from a complaint. None of the eleven staff members could give us an example.

**Is the service well-led?**

Our rating of well-led stayed the same. We rated it as requires improvement.

**Leadership**

A trio led the emergency floor at William Harvey hospital made up of a site lead consultant, Interim matron and an urgent care service manager.

A trio provided site leadership for William Harvey Hospital. This was made up of the governance manager for acute and emergency medicine, the clinical lead for emergency medicine and MIU and the clinical lead for acute medicine.

A team of band seven nurses managed by the Matron, were responsible for the day-to-day running and co-ordination of the department. The band seven nurses managed band six nurses, band five nurses and health care assistants.

The emergency department did not report having any identified lead for mental health. The psychiatric Liaison team was available 15 hours a day, so there were times where there may not have always been specialist knowledge and support available to staff.

The stability of the leadership team within the department was unclear. The department had an interim matron who was also the paediatric nurse lead. The trust had struggled to find suitable candidates to fill the matron post permanently. Staff expressed concern about this and felt they needed a permanent matron as soon as possible to provide direction and stability to the department.
Senior leaders were not visible and approachable at every level. Staff we spoke with did not consistently know who their leaders were or how to gain access to them. Leaders were not confident in the support they were receiving from the senior team. Interviews with the leaders within the emergency department showed a depleted and worn out attitude where we were told ‘maybe now you [CQC] have seen it, things will change’.

We reviewed the most recent staff survey, that asked eleven questions about staff managers. For example, ‘Immediate manager values my work’, ‘Senior managers act on staff feedback’ and ‘Immediate manager supportive in personal crisis’. Ten out of eleven question scored below the benchmark average. The lowest being a 20% positive response to ‘Senior managers try to involve staff in important decisions’, and the best being an 80% positive response to ‘I know who senior managers are’, which was about the same as the benchmark average.

The nurse and doctor in charge, on each shift, were easy to identify as they wore red bands. This made it easy for staff to see who was managing the department and knew who to go to for support.

The leaders we spoke with understood the challenges to safe care, treatment and quality. The leadership team had a good knowledge of how services were provided and accepted full responsibility and ownership of the quality of care and treatment within their department. The divisional head of nursing acknowledged that staffing within the paediatric area was too low and had raised concerns about the effectiveness of the meet and greet role in identifying patient risks.

Senior leadership teams understood what the challenges were and acted to address them. For example, the trust acted quickly to secure suitable staff to care for children out of hours following concerns raised during the inspection.

Consultant leadership in the department was committed and consultants demonstrated clinical ownership of their patients. Consultants had oversight of the patients in the department and had an awareness of who was the most unwell or had the potential to deteriorate. This was in line with the RCEM: Emergency Department Care (2017) quality standard 14.

**Vision and strategy**

There was a clear statement of vision and values. The service had an emergency department standard operating procedure. This outlined the service, procedures and models of care to be used within the emergency department.

The emergency department standard operating procedure was mandatory for all staff working within the Emergency Floor to ‘become familiar with’.

The standard operating procedure stated the trust was committed ‘to provide the highest standards of safe emergency care to the local population’ and also stated that ‘all patients will be treated with the same level of care and dignity as we would expect for our own families.’

The first aim of the emergency floor was to ‘provide a safe, efficient, effective and co-ordinated service for the assessment, reception, referral and discharge of patients with acute illnesses and minor injuries’

Medical staff appeared to have a clearer vision than their nursing colleagues and could articulate a desire to ‘improve patient outcomes’ through research, learning and continuous improvement.

The trust values were;
- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect sit at the heart of everything we do
- People feel confident we are making a difference

Nursing staff we spoke with were not familiar with the trust’s vision and did not always understand how their role contributed to achieving the strategy. Staff told us they wished to provide ‘safe care to our patients’. Staff also told us they wanted to provide ‘the best care for our patients’. We asked staff if they felt they had a clear strategy to follow to achieve the vision of the department. Staff felt they were ‘firefighting’ and did not feel confident the department had a strategy to improve. Staff also felt uncertain about the future of the department at William Harvey hospital and were concerned that there were discussions to close the site.

Some concerns raised in the previous report had not been improved, for example ensuring all staff had attended mandatory training. This showed that the department may not have had an effective strategy to improve.

**Culture**

All staff we spoke with, told us they were very proud of their colleagues and felt that everyone worked together to manage the high volume of patients. We saw that although staff were busy they were engaged with one another and had time to support each other. Although staff were clearly busy, and often showed signs of feeling under pressure, there was a family feel in the department and genuine care and affection between staff. In meetings and huddles, staff communicated openly and without hesitation, and there was no hesitation to offer support to one another.

Candour, openness, honesty, transparency and challenges to poor practice were the norm. For example, when we identified an open medicine cupboard, the member of staff who had left it open did not hesitate to accept responsibility. This showed that staff felt able to admit mistakes and learn from them.

We reviewed a governance newsletter from December 2017, this had an entire page on duty of candour and described the principles.

The trust was committed to improving staff awareness and understanding to ensure they met duty of candour. For example, the trust had made commitments to improve staff understanding. The Trust told us they had a trust wide training programme due in June 2018 and 10 band seven nurses were booked onto this training between July and November 2018. Only one person within the William Harvey Hospital Emergency department had received Duty of Candour training.

There were not appropriate security arrangements to keep staff and others safe and protected from violence, particularly at weekends and out of hours. Staff told us they did not always feel safe when working, particularly at night. The most recent staff survey showed that only 19% of staff who responded had ‘not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public’ and 56% had ‘Not experienced physical violence from patients/service users, their relatives or other members of the public’
Following our inspection, we asked the provider what their security arrangements were. The trust told us they had one security guard based in the emergency department, at night, and another security guard for the rest of the hospital. The trust told us they supported each other in an emergency. This meant if there was an emergency in another area, the emergency department could be left unattended to provide support. There was also no assurance that the support for the emergency department security guard would be prompt, as this would depend on where they were both located in the hospital.

Staff felt demotivated by the high number of agency staff that were needed and this impacted team morale. Some staff we spoke with felt the high number of agency staff impacted on culture because it was ‘not unusual to be working with more people you don’t know than you do’.

Staff satisfaction was poor. Staff we spoke with said they felt unsupported and undervalued by their immediate leaders and felt senior leaders did not understand the pressures they were facing. The most recent staff survey showed that 13% of staff responded positively to ‘Organisation definitely takes positive action on health and well-being’. We also saw that only 2% of staff said they had ‘Not put [themself] under pressure to come to work when not feeling well enough’. Both responses show a significant amount of pressure on staff with a cultural feeling that the organisation had little regard for their wellbeing.

The most recent staff survey showed poor results. Staff were asked 88 questions. Two out of 88 questions scored above benchmark average. Seventeen out of 88 scored about the same as the benchmark average. However, 69 out of 88 (78%) scored below the benchmark average.

**Governance**

All levels of governance in the organisation functioned effectively and interacted with each other appropriately. Staff at all levels were clear about their roles and understood what they were accountable for. All staff we spoke with knew who to escalate concerns to and could detail meetings they attended and the purpose of them.

Governance and performance patient safety meetings were held regularly. We reviewed urgent care & long-term conditions governance & patient safety meeting minutes. These meetings were held monthly and had a standing agenda where patient safety was at the center. We saw polices were reviewed and incidents were addressed. We also saw a clear table of actions out of each meeting. Each action detailed a completion date, who was responsible for the action and detailed the status of the action.

Mortality and morbidity meetings were held weekly. Staff presented a case and the team discussed and identified learning. Identified learning was written into actions and this was shared with the wider team. We saw learning shared from the meeting in May. For example, staff were asked to consider using a specialised mattress to help treat hypothermia, and were reminded this was available on request.

There was regular engagement and communication with partners and third partner parties. The patient safety committee requested reports from a variety of different leads, such as the sepsis lead, trauma lead and governance manager.

**Management of risk, issues and performance**

There was a departmental risk register, which measured the cause and effect of the risk and documented the controls to manage that risk. There were three risks on the risk register. These
related to the age of the building, the high vacancy rate and the inability to provide 24 hours sufficient nursing cover for children within the emergency department.

All risks had been reviewed within the last six months, two risks were categorised as moderate risk and one as high risk. All risks had a delegated risk owner responsible for ensuring there were measures in place to mitigate the risk and to regularly re-assess the risk and update the risk register. For example, one risk was ‘Nursing staff deficits in ED’ that described the cause as a ‘large vacancy factor as unable to recruit to registered nursing posts’ and detailed the effects to be ‘Staff wellbeing impacted upon, patient safety compromised and reliance on temporary or agency staff’. One of the risk controls put in place was ‘On-going recruitment and continual live advertisement’ and this had been reviewed in February 2018.

There was an alignment between what staff felt were the departments biggest risks and what was on the departmental risk register.

We reviewed the trust’s standard operating procedure for acute medical care. This procedure was dated June 2017, however there was no review date, so we could not be assured that the trust would keep the procedure current and up to date.

Clinical and internal audit processes were inconsistent in their implementation and impact. The department had a programme of clinical and internal audit. We asked for the results of these audits but were only provided with national audit results. We were not assured that local audits were always taking place.

The results from audits were supposed to be reviewed monthly at patient safety meetings. However, both meeting minutes we reviewed of the patient safety meetings showed the audit lead was not present and so did not provide a report. While audit results were a standing agenda, we did not have assurance that these meetings placed the appropriate level of importance in the monitoring and reviewing of audit results, actions and learning.

We did see that monthly audit meetings were planned, however three meetings in a row had been cancelled. The meeting structure around audits was unclear. We saw that actions had been created however we could not see, from the notes provided by the trust, what those actions were. We also saw one action awaiting feedback from a member of staff, and a note saying, ‘drop this due to no response’. The notes were not detailed, and did not minute discussions, challenge, learning and most importantly the results.

Risks, issues and poor performance were not always dealt with appropriately or quickly enough. We reviewed action plans for all of the RCEM audits. These action plans were slow to implement. We found that concerns raised at previous inspections were little improved or addressed. For example, mandatory training figures.

We asked staff about audits, although the consultants and the nurse trauma lead, we spoke with, could discuss findings from the Royal College of Emergency Medicine audits, there was little awareness or understanding of local audit results, and very little awareness of audit results from other staff groups.
We were not assured that the trust always actioned and learnt from audit results. The trust provided us with audit results of their patient safety checklist. The results and actions were not detailed and so we were unable to establish what areas of the audit related to which area of the safety checklist. For example. There were three occasions in March that audits found ‘some data missing’, there was no further comment about what data was missing. There was also no learning or action associated with the comments to assure us that the trust was learning from the results.

**Information management**

The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. There were a number of examples where we asked the trust to provide data to evidence effective working. The trust were repeatedly unable to provide data or did not provide relevant or reliable information. For example, we asked the trust to provide us with data to show that patients had vital observations taken within 15 minutes of arrival in majors, the trust told us this happened but did not provide us with the data to clearly show it.

Leaders and staff did not always receive information to enable them to challenge and improve performance. We were not assured that the trust had effective oversight of the number of children that were being cared for across the trust’s emergency departments. The senior leadership team had been provided incorrect information that told them the emergency departments across the trust saw 270 children out of hours per year, this figure was actually 4,698.

Staff could access patient information using an electronic system and paper records.

The department used an electronic system to track patients on their journey through the emergency department. This gave staff a visual overview of how many patients were in the department, how long they had been waiting, what tests they had received and the results. The system also provided reports to track any patients approaching a breach which helped inform handovers. This information gave staff good oversight of the patient journey and meant they could provide care that was well informed.

The systems improved staff access to information about patients’ mental health. Information was noted in all electronic patient records. This prompted and enabled staff to discuss the needs of their patients during handover.

**Engagement**

Staff knew their role within the team and how this contributed to the cohesive organisation of the service.

We saw the clinical decision unit had created a newsletter called ‘summer smiles’. This included a section ‘Hello’s and Farewell’s’ that congratulated staff going on to new posts and welcomed new staff to the department.

Staff had access to wellbeing links, these members of staff helped to provide support to staff who had any concerns regarding their health and wellbeing.

Staff told us the department was implementing a programme on the theories of management, stress training and crew resource management. Crew resource management is a procedure used to train staff to manage in environments where human error can have devastating effects. Crew resource management is a system to enhance communication, leadership and decision-making.

The staff survey for 2017 was completed by 50% of staff. This was an increase compared to previous years and showed the trust was improving the way they engaged with staff.
There were many ways patients and visitors could provide feedback. The trust website clearly displayed a number of ways to share patient views. They had a ‘talk to us’ section of the website that made it easy for patients to complain, comment, compliment or raise a concern. Patients could contact the trust by phone, email, in person or using a web based form.

We saw that staff could complete the Friends and Family Test survey both in the hospital and by text directly to their mobile phones. This convenient and interactive way of engaging with patients meant they could complete the friends and family test using which ever method was most convenient. This was in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 11.

Results of Friends and Family Tests were displayed in the waiting areas and on the website. We also saw a section on the website titled 'you said, we did'. This told patients what the trust were doing to respond to some of their concerns. For example, patients said ‘The nurses are too busy to give total patient care and to give refreshments’, the trust ‘Invested in nursing budget to give 24/7 Health Care Assistant provision in the major treatment area’. During our inspection, we saw that health care assistants were more available to give care to patients than other staff groups.

The trust interacted on social media via a variety of social media networks. We saw a social media page used by William Harvey Hospital doctors. This page was used to engage and socialise with medical staff. For example, we saw the promotion of a William Harvey hospital summer ball carnival and regular social events arranged outside of work. these was a good example of positive and effective staff engagement.

Effective utilisation of social media can engage patients and was another way patients effectively communicated with the trust. This demonstrated that the trust was committed to communication and listening to feedback from social media users.

Staff wore ID badges that showed what their role was in the hospital for example, nurse or doctor. This meant members of the public and patients could easily identify staff roles.

Staff told us they received a governance newsletter every two months. We asked the trust to send us the most recent governance newsletter. The trust sent us a governance newsletter that was six months old. This would suggest that the trust was not routinely engaging and sharing governance information.

**Learning, continuous improvement and innovation**

The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they started to be addressed. Staff raised concerns with us regarding safe staffing for paediatrics, it was not until we raised this as a concern that there was a control measure put in place for the risk to children.

Where changes were made, the impact on the quality and sustainability of care was not monitored. For example, in response to the consultant review Royal College of Emergency Medicine audit, the department added a new check to the system to prompt junior doctors to request a consultant review before closing a patient’s record. The impact of these changes were not monitored.

The trust had not made sufficient improvement since the last inspection. The trust had failed to ensure mandatory training and national safeguarding training requirements were fulfilled. Safeguarding training levels had stayed well below target for the previous three inspections. This showed that the department may not have had an effective strategy to improve.
Senior staff told us safeguarding training compliance had not improved since the last inspection because they had been unsure which levels of safeguarding training each staff group was supposed to complete. This showed the trust did not have effective oversight or understanding of national safeguarding training requirements.

Although the department was involved in a variety of audits to monitor patient outcomes, staff were not always involved in these audits. Many staff told us they were not involved in audits but would like to be. Locum staff were not involved despite being long term locums.

The department held weekly teaching sessions that all staff were welcome to attend. We observed one of these sessions and saw that staff of all grades attended to learn and contribute to the improvement and development of the department. For example, the nurse trauma lead introduced a number of emergency prompt cards for teams to use. Such as their major bleed protocol and acute asthma management.

The department had an improvement project in place, this covered a variety of themes such as mental health and ambulance flow. Each theme had an assigned project lead and they held a weekly site focus meeting called ‘turnaround Tuesday’ to discuss progress. For example, the improvement of ambulance triage due to the rapid assessment and treatment area.

We reviewed the trust’s emergency care improvement project review and development of improvement plan. This clearly identified areas for improvement at William Harvey Hospital such as care standards within the emergency department, ambulance triage and the triage model.

The trust had a set a date for a ‘work plan’ and another for a ‘focus on plans’ for William Harvey Hospital. The trust showed the early stages of positive steps to moving in the direction of monitoring, learning and improving. The date for their improvement project launch was then end of May 2018.
East Kent Hospitals University NHS Foundation Trust (EKUFT) manages five hospitals including the William Harvey in Ashford. With over 1,000 beds spread across three main hospital sites, the trust provides a range of core and specialist healthcare services to a population of around 750,000 across east Kent.

The trust receives over 200,000 emergency attendances, 100,000 inpatient spells and 750,000 outpatient attendances annually. EKUFT had 53,563 surgical admissions from November 2016 and October 2017. Emergency admissions accounted for 15,456 (29%), 29,881 (56%) were day case, and the remaining 8,266 (15%) were elective. (Source: Hospital Episode Statistics)

The William Harvey (WHH) is an acute hospital providing emergency and elective services in addition to maternity, trauma, orthopaedic and paediatric and neonatal intensive care. In addition, the site includes a specialist cardiology unit and a regional centre for maxillofacial services incorporating head and neck cancer surgery, along with a postgraduate teaching centre and staff accommodation.

Surgical services at the hospital included an eight-theatre operating complex and seven wards, offering 159 beds. The theatre suite facilities included anaesthetic rooms and recovery areas along with storage for sterile instruments and consumables, plus administrative and staff rest facilities. One theatre (number eight) was equipped with laminar flow air filtration for use in orthopaedic or other cases where airborne germs was a risk. A separate recovery area was provided for children.

Apart from the operating theatres, the service at WHH comprised of:

- Surgical Admission Unit (SAU), which accepted and prepared elective cases for theatre (predominately orthopaedic, general and head and neck surgery). The unit, located on the same ‘surgical floor’ as the Kings’ wards, also admitted non-elective cases for emergency surgery.
- Kings A2, a 20-bedded general surgical ward split between three bays of six beds and two side rooms
- Kings B, a 27-bedded general surgical ward split between four bays of six and three individual side rooms
- Kings C1, a 27-bedded hip fracture unit of the same configuration as Kings B
- Kings C2, a 24-bedded elective orthopaedic ward split between three bays of eight beds
- Kings D male, a 25-bedded general trauma ward split into four bays of six and one side room
- Kings D female, an 18-bedded trauma ward split into two bays of six beds; one bay of three and two individual side rooms
- Rotary ward, an 18-bedded head and neck unit admitting ear, nose and throat surgery along with ophthalmic and maxillofacial surgery cases. The ward offered single and double-bedded rooms.
- A Surgical Emergency Assessment Unit (SEAU) was located near the main entrance to the hospital. This recently constricted facility contained six trolleys and was designed to take patients directly from GP admission or emergency surgical referrals from the emergency
department. The unit operated weekdays between 0830 and 2000 hours and accepted patients up until 1800.

- A trauma and orthopaedic unit adjoined the SEAU. Although it formed part of the outpatients' department, the facility offered five clinic rooms and a purpose-built bariatric room used by the surgical division. Facilities included a plaster room and space for the on-call orthopaedic team which enabled them to conduct a ‘virtual fracture clinic’.

During our inspection, we visited the theatre complex and each ward or unit. We also viewed the hospital facilities for medical gases, clinical waste and emergency power. We talked to clinical and operational managers, doctors, nurses, therapists and support staff including administrative, facilities and housekeepers (30 in all). We spoke with five patients, one relative and reviewed five sets of patient records. In addition, we examined a variety of policy and procedure documents, performance data, meeting minutes and staff competency records.

Is the service safe?

By safe, we mean people are protected from abuse and avoidable harm. Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The division provided mandatory training in key skills to all staff. Compliance was recorded and monitored using a computerised system maintained by the trust. Staff and managers 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 included child and adult safeguarding, information governance, infection prevention and control, fire safety, health and safety and equality and diversity. Some training topics were offered ‘on-line’ through an internet-based learning management system, which could be accessed by staff from any computer connected to the internet. This meant staff could complete training after hours or at home if desired. Other subjects required attendance at a classroom session. For example, we saw health and safety training sessions underway while we were based in the post-graduate education centre.

Clinical and therapeutic staff described additional role specific mandatory training which included more advanced safeguarding training, responding to deteriorating patients, record keeping and detailed infection prevention and control training. Training in the care of deteriorating patients included sepsis management and the use of specially designed screening tools. 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.

Staff we interviewed said they received sufficient training to ensure they had the skills to do their jobs. Staff reported having adequate time allowed to completed training and attend trust courses.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses from January 2017 and December 2017 for medical/dental and nursing/midwifery staff in surgery is shown below:
### Mandatory Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>111</td>
<td>127</td>
<td>86%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>104</td>
<td>127</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>105</td>
<td>127</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>100</td>
<td>127</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>88</td>
<td>127</td>
<td>65%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>74</td>
<td>127</td>
<td>61%</td>
<td>No</td>
</tr>
</tbody>
</table>

### Mandatory Training Completion by module – Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control (Level 1)</td>
<td>181</td>
<td>190</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>182</td>
<td>190</td>
<td>96%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>177</td>
<td>190</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>172</td>
<td>190</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>172</td>
<td>190</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>152</td>
<td>190</td>
<td>77%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

According to data provided, in 2017 mandatory training compliance among medical and dental staff failed to reach trust targets in any of the three surgical departments.

Nursing and midwifery compliance rates were better and exceeded the target in all but one topic. When we inspected, we were shown the latest figures and saw that compliance had improved. Nursing members of the division were now compliant in all topics. However, medical staff had not met the target training figures for any of the mandatory training modules. The figures provided by the trust reflected that 67% of medical staff had completed mandatory training. This represented a decline since our last inspection, when we also found variation in compliance.

**Safeguarding**

Staff understood how to protect patients from abuse and the division worked well with other agencies to do so. The trust had clear systems and processes to help staff identify and report concerns to protect their patients. The trust had a safeguarding children team within the child health division and an adult safeguarding team. The teams received safeguarding support from the local authority.

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. Patients and relatives said they felt safe on the wards and were always treated respectfully by staff.

Staff clearly described how they identified 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 knew who the safeguarding lead was to obtain support and advice. This indicated that staff identified the risks of abuse and were actively reporting it through correct channels.

Female genital mutilation and sex exploitation awareness was incorporated into safeguarding training, which was delivered as part of the mandatory training programme as well as during
induction courses for new clinical staff. The trust’s safeguarding policy included guidance to staff on a range of safeguarding issues, including Female Genital Mutilation (FGM).

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding courses from January 2017 and December 2017 for medical/dental and nursing/midwifery staff in surgery is shown below:

### Safeguarding Training Completion by module – Medical and Dental Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>127</td>
<td>127</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>76</td>
<td>127</td>
<td>58%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 3)</td>
<td>66</td>
<td>127</td>
<td>47%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P18)

### Cleanliness, infection control and hygiene

William Harvey Hospital controlled infection risks well. Staff kept themselves, equipment and the premises clean and overall, had reached a good standard of cleanliness and hygiene. The hospital areas we inspected were visibly clean, tidy and free from clutter. In the theatre complex and wards we visited, we saw that beds, trolleys and medical equipment were clean and stored correctly. Our observations were supported by local audit scores and the 2017 patient-led assessment of the care environment survey. This showed the trust scored 99%, for cleanliness, which was better than the England average of 98%.

However, in theatre, we noted some clinical consumables placed on the floor in a storeroom, which reduced the effectiveness of routine cleaning and therefore increased the risk of bacterial contamination. When we pointed this out to managers, the boxes were immediately relocated to shelving.

In three locations we checked, the disposable curtains did not have dates written on the labels. This meant it was not possible for staff or visitors to easily identify when the curtains were due for replacement. Staff explained that the cleaning contract and the service had just been brought back ‘in house’, and said this error had occurred during the transition. We saw the curtains being checked and replaced before we finished the inspection.

Some use was made of ‘I am clean’ stickers, although not in all areas we visited. Stickers are a useful indication of the date and time the article was cleaned along with the name of the person who cleaned it. More consistent use of these stickers would help staff to identify items that were cleaned ready for use and assist managers in detecting any shortfalls in equipment hygiene.
We saw that inpatients were routinely screened for methicillin-resistant staphylococcus aureus (MRSA) and MSSA in compliance with infection control policy. MRSA is a type of bacterial infection which is resistant to many antibiotics and can cause harm to patients. A care plan was implemented if a positive result was obtained and we saw examples documented in the patient plans we reviewed.

There were adequate numbers of side rooms on each ward 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 red ‘stop 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.

All staff we observed during the inspection were ‘bare below the elbows’ and dressed in accordance with trust policy. We saw ample supplies of personal protective equipment such as aprons and gloves in dispensers on walls and we saw these items being used. Gloves, in the full range of sizes, were readily available in wall-mounted storage racks. This meant staff had convenient access to correctly fitting gloves, which consequently reduced the chance of accidental tearing. Body fluid spillage kits were also available.

The trust’s hand decontamination policy was ‘in date’ and described when staff should wash their hands. We saw staff following the policy and adhering to the World Health Organisation’s “Five moments for hand hygiene”. Antimicrobial hand-rub dispensers were mounted on the walls at strategic points throughout the hospital as well as outside each room or bay. These contained gel and we observed staff using the product as they moved around the premises.

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.

In the surgical emergency assessment complex, we saw a selection of children’s toys in a separate waiting area. We noted these were ‘easy clean’ items and unit staff used a cleaning log to record routine cleaning to reduce the risk of toys becoming contaminated with germs.

Managers said there was daily housekeeping support provided to each area and we saw housekeepers working throughout the day. Housekeepers had routine cleaning schedules to follow and kept account of their progress by completing regular cleaning audits and quality monitoring. We saw records of these and observed staff changing the colour-coded mops and cloths to suit the cleaning task.

The hospital 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 locate 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. In all areas we visited, we saw staff segregated clinical and non-clinical waste into different coloured bins. Staff followed correct waste segregation which helped to prevent bacterial contamination or unsafe disposal of clinical waste, in line with the Department of Health’s Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.

Clinical waste bulk containers were correctly labelled to provide an audit trail and we saw checklists used to help audit safe transfer to the contractor for disposal. Containers were locked and held in a fenced compound. This showed the hospital had taken effective measures to prevent unauthorised access to potentially contaminated waste.
Environment and equipment

The service had suitable premises and equipment and the areas we observed supported the safe delivery of care.

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

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

The wards and units we visited were kept in good decorative order, and we noted that King D ward utilised a dementia-friendly contrast colour scheme and was fitted with easy-read clocks. Direction signs were clear throughout.

There was access to emergency equipment in the theatres and other clinical areas, 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 maintained by staff and indicated staff had active focus on ensuring these items were ready for immediate use should an emergency occur.

Beds, furniture and electrical 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.

We saw fire safety equipment available throughout the hospital along with labels that showed fire equipment safety checks had been completed by an external specialist contractor.

Our observations were supported by the results of the 2017 patient-led assessment of the care environment survey, which showed the trust scored 98%, for condition, appearance and maintenance. This was better than England average of 94%.

Assessing and responding to patient risk

Patients were risk assessed in key safety areas using nationally recognised tools. The patient records we checked were completed legibly and accurately and showed nursing staff escalated any concerns about deteriorating health and those decisions about changes to care or treatment plans were made by staff that were competent to do so.

We saw comprehensive risk assessments 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. We reviewed five sets patient notes and saw that risk assessments were reviewed and repeated within suitable and recommended timescales.

The service used the American Society of Anaesthesiologists (ASA) grading system to pre-assess patients’ level of risk for general anaesthesia. There were five grades within the ASA system. Grade one patients were normal healthy patients and grade five patients were patients not expected to survive more than 24 hours with or without surgery. The hospital had level two and three critical care facilities for critically ill patients to recover in following surgery. This allowed them to treat patients of all ASA grades safely.
The trust had provided electronic systems to help clinical staff identify and manage patients suffering from bacterial contamination of the blood. Senior clinical staff stated that there were two daily nursing handovers and five multidisciplinary meetings a week where each patient was risk assessed.

We observed one multidisciplinary meeting on King D ward and saw effective risk-based discussions and decisions that supported what we had been told. The medical team used computer generated care summary labels, that clearly indicated the clinical decisions being made. These were signed and placed in the respective patient notes.

The trust used a national early warning system along with a track and trigger flowchart. It was 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 increasingly unwell and provide them with increased support. In the notes we reviewed we found that the national early warning system scores had been calculated consistently and accurately.

Nursing staff told us they had good support from the doctors and the outreach support team whenever a patient’s deterioration was observed. We saw members of the outreach team working with ward staff during our visit.

We noted separate children’s play facilities in the surgical emergency assessment unit and a separate recovery bay used for children in the theatre suite. The trust had an ‘in date’ policy and guidelines for “Age of admission to acute paediatric services”, which was in line with the Royal College of Nursing’s core standards for services providing health care for children and young people.

The service used the American Society of Anaesthesiologists (ASA) grading system to pre-assess patients’ level of risk for general anaesthesia. There were five grades within the ASA system. Grade one patients were normal healthy patients and grade five patients were patients not expected to survive more than 24 hours with or without surgery. The hospital had level two and three critical care facilities for critically ill patients to recover in following surgery. This allowed them to treat patients of all ASA grades safely.

We observed theatre staff carrying out the World Health Organisation (WHO) Surgical Safety Checklist. The WHO checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre) and debrief.

For all procedures we saw, staff fully completed all the required checks. We reviewed World Health Organisation Surgical Safety checklist audit results, which showed a high level of staff compliance with the checklist. Results showed theatre staff across the trust achieved between 97.9% and 100% between March 2017 and April 2018.

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.

Patients’ acuity levels fed into the hospital’s electronic “safer staffing” tool, which staff completed daily. Staff described how the safer staffing tool flagged up in real-time if the ward needed additional staff. The hospital augmented this information with another web-based application that could be securely accessed by any smartphone, tablet or desktop platform. Senior managers had been issued iPhones and used the “App”, which showed real-time colour coded symbols indicating
bed capacity and any delays in the referral system. This app linked to another piece of software that showed more information about individual patients.

The surgery matron and ward managers used this information to anticipate admissions and outliers, which meant they could predict peaks in demand. This meant they could deploy available resources from one area to another to help manage the overall risk. This data was the same as used in the daily ‘bed state’ meetings. This data was also available to on-call managers and directors, even while off-site.

**Nurse staffing**

The division 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. We saw that actual staff on duty matched staffing templates used and this information was clearly displayed on performance boards in each ward.

Recruiting and retention of nursing staff was a concern raised by staff and managers alike, and was included on the divisional and corporate risk registers. The trust had acted to address the shortfall in staffing such as recruiting overseas nurses.

Managers explained that planned staffing was generally met, although bank and agency staff were often required. Bank use was encouraged as permanent staff taking on extra work were familiar with the ward processes and environment. Where outside agency staff were used, we were told that shifts were block booked whenever possible. 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.

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

Ward managers explained that they escalated any staffing shortages to the matron and staff reported staffing shortages as incidents.

In theatres, we saw the service met the Association for Perioperative Practice (AfPP) guidelines on staffing for patients in the perioperative setting. The guidelines suggested a minimum of two scrub practitioners, one circulating staff member, one anaesthetic assistant practitioner and one recovery practitioner for each operating list.

The trust has reported their nurse staffing numbers below as of December 2017

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Harvey Hospital</td>
<td>176</td>
<td>195</td>
</tr>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>107</td>
<td>121</td>
</tr>
<tr>
<td>Kent and Canterbury Hospital</td>
<td>107</td>
<td>119</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>390</strong></td>
<td><strong>435</strong></td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From January 2017 to December 2017, the trust reported a vacancy rate of 20% in surgery.
• Kent and Canterbury Hospital: 20%
• Queen Elizabeth The Queen Mother Hospital: 30%
• William Harvey Hospital: 17%

This is in comparison to the trust target vacancy rate of 10% or less.

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

Turnover rates

From January 2017 to December 2017, the trust reported a turnover rate of 12% in surgery.

• Kent and Canterbury Hospital: 10%
• Queen Elizabeth The Queen Mother Hospital: 17%
• William Harvey Hospital: 11%

This is in comparison to the trust turnover target rate of 13% or less.

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

Sickness rates

From January 2017 to December 2017, the trust reported an overall sickness rate of 5% in surgery. A breakdown of nursing staff sickness rates by site is as below:

• William Harvey Hospital: 3%
• Queen Elizabeth The Queen Mother Hospital: 7%
• Kent and Canterbury Hospital: 6%

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

Bank and agency staff usage (nursing staffing)

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

From February 2017 to January 2018, the trust reported a bank and agency usage rate of 59% in this core service;

• Kent & Canterbury Hospital: 52%
• Queen Elizabeth The Queen Mother Hospital: 61%
• William Harvey Hospital: 62%

(Source: Routine Provider Information Request (RPIR) - Nursing bank 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 the appropriate specialism 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.
Staff stated that inpatients received a daily medical review, including on weekends. We reviewed five patient records, which confirmed evidence of daily medical review. Nursing staff told us doctors promptly attended to review patients when they escalated any immediate concerns.

After hours (on-call) arrangements included one consultant, one registrar and one senior house officer for each speciality. On-call consultants were contacted via mobile through the hospital switchboard service. Middle grade and junior doctors remained on site when on-call.

Anaesthetic cover was available Monday to Friday from 0800 to 1900 hrs and on weekends from 0800 - 1400. Outside these hours cover was provided by a resident anaesthetic registrar.

Nurses in the SEAU told us registrars attended promptly to review patients.

The trust has reported their medical staffing numbers below as of December 2017

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Harvey Hospital</td>
<td>127</td>
<td>131</td>
</tr>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>95</td>
<td>97</td>
</tr>
<tr>
<td>Kent and Canterbury Hospital</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>290</strong></td>
<td><strong>296</strong></td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From January 2017 to December 2017, the trust reported a vacancy rate of 10% in surgery;

- Kent and Canterbury Hospital: 13%
- Queen Elizabeth The Queen Mother Hospital: 10%
- William Harvey Hospital: 10%

This is in comparison to the trust target vacancy rate of 10% or less.

(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.

From January 2017 to December 2017, the trust reported a turnover rate of 6% in surgery.

- Kent and Canterbury Hospital: 10%
- Queen Elizabeth The Queen Mother Hospital: 4%
- William Harvey Hospital: 6%

This is in comparison to the trust turnover target rate of 13% or less.

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

**Sickness rates**

From January 2017 to December 2017, the trust reported an overall sickness rate of 5% in
surgery. A breakdown of medical staff sickness rates by site is as below:

- William Harvey Hospital: 1%
- Queen Elizabeth The Queen Mother Hospital: 1%
- Kent and Canterbury Hospital: 1%

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

Bank and locum staff usage (medical staffing)

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

From February 2017 to January 2018, the trust reported a bank and locum usage rate of 43% in this core service.

- Kent & Canterbury Hospital: 54%
- Queen Elizabeth The Queen Mother Hospital: 43%
- William Harvey Hospital: 37%

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

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

Staffing skill mix for the whole time equivalent staff working at East Kent Hospitals University NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date and available to all those responsible for providing care.

We saw integrated records which were shared by doctors, nurses and other healthcare professionals. 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 when not in use 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. When we asked, managers told us it was trust policy to record surnames only. The boards 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 safely. 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.

Medicines were stored securely. Records indicated that medicines requiring refrigeration were kept within their recommended temperatures. Staff told us they monitored, but did not record room temperatures. Pharmacy provided a weekly stock top-up service.

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.

A clinical pharmacy risk assessment had been undertaken. A clinical pharmacy service was provided to most of the wards Monday to Friday. However, Rotary, King A2 and King C2 did not receive a clinical pharmacy service. The risk assessment, also indicated that back fill for leave cover was not available for the surgical wards. Nurses on King C2 were concerned about the lack of a clinical pharmacy service. They explained that, medicines could not be administered to patients when their medicines charts were in pharmacy. The clinical pharmacy team used an app on a hand-held device to identify newly admitted patients awaiting medicines reconciliation and electronic discharge notes requiring screening by a pharmacist.
The surgical wards monitored the proportion of patients who had missed doses and missed doses of critical medicines. The most recent data provided by the trust indicated a patient missed dose rate of 29% and 16% for critical medicines. Staff were aware of this data and working to reduce these figures.

In-patients on admission would receive a leaflet “Your hospital stay, planning for discharge”. On discharge details of a medicines telephone help line was given to all patients receiving medicines. The pharmacy service monitored calls to this helpline via a customer satisfaction survey. Those who answered the survey were highly complementary of the help line and the information provided.

We examined three prescription charts and found these were legally valid and contained information about people’s allergies. Charts had been clinically screened by a member of the pharmacy team.

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

Emergency medicines were available on emergency trolleys which were secure, sealed and checked regularly.

Medicine related alerts and recalls were communicated via email to the nurse in charge of the ward. The pharmacy staff also delivered a paper copy and these were cascaded to all staff.

**Incidents**

The service managed patient safety incidents well. Staff recognised what constituted 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 reviewed two recent investigation reports and saw evidence of learning from that was shared across the trust through email alerts, announcements on the trust intranet and at local level during team and divisional meetings.

In addition to a trust-wide monthly newsletter, the division had introduced an “Outcomes With Learning” monthly bulletin (OWL) that focussed on clinical and medication incidents relevant to surgery. In addition, the surgical matron at WHH had produced a monthly “OWLett” newsletter which focussed on more local safety issues and learning. We saw examples of the bulletins on staff notice boards and wards managers stated that copies were also emailed to staff.

Senior managers explained that these bulletins were deliberately kept separate from more general trust and divisional information, which was covered in another monthly publication called ‘Cutting Edge News’. This indicated that trust and divisional leaders had considered more effective ways to communicate important messages to staff.

On the wards we saw team communication folders containing the newsletters and bulletins along
with minutes of team and divisional meetings that also detailed actions taken. Wards had control mechanisms in place to record the names of staff reading the announcements.

**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 March 2017 to February 2018, the trust reported one incident classified as a never event for surgery. This was a surgical/invasive procedure incident meeting SI criteria.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from March 2017 to February 2018.

Of these, the most common types of incident reported were

- Treatment delay meeting SI criteria with five (36% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with three (21% of total incidents).
- Pressure ulcer meeting SI criteria with two (14% of total incidents).
- Medication incident meeting SI criteria with two (14% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (7% of total incidents).
- All other categories with one (7% of total incidents).

*(Source: Strategic Executive Information System (STEIS))*

**Safety thermometer**

We observed ‘green cross’ charts displayed on notice boards in each ward or unit 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 24 new pressure ulcers, five falls with harm and 18 new urinary tract infections in patients with a catheter from February 2017 to February 2018 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and new urinary tract infections in patients with a catheter at East Kent Hospitals University NHS Foundation Trust**

![Graphs showing prevalence rates](image)

(Source: NHS Digital)

**Is the service effective?**

**Evidence-based care and treatment**

Both divisions 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 could 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, we saw patients with a fractured neck of femur (fractured hip) followed a pathway based on NICE clinical guideline CG124 - Hip fracture: management. 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. The service audited staff compliance with trust policies and national guidance, for example, World Health Organisation Surgical Safety Checklist audits. Audits provided assurances around staff compliance and helped identify areas for improvement.

**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 adjusted 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. 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.

The service followed the Royal College of Anaesthetists’ guidance on fasting before surgery. This included advising patients on an afternoon operating list to have a light breakfast up until 7.30am on the day of surgery, and clear fluids up until two hours before their operation. The trust provided patients with written and verbal instructions regarding fasting before surgery.

Staff offered patients three main meals and snacks were available if needed. There was a choice of food available and the hospital could 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 ‘pictograms’ signs 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 individual rooms. These provided visiting staff and therapists with a visual reminder that the patient had a special requirement or need.

Our observations were consistent with the 2017 patient-led assessment of the care environment survey, which showed the trust scored 90%, for food and hydration. This was better than the England average of 89%.

**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.

During routine observations, staff used a standardised pain assessment tool and asked patients to rate their pain between one and 10. One meant no pain and 10 represented extreme pain. Patient charts included space for recording patients’ perception of pain and we saw visual pain charts.
stocked on the wards. These were designed to help patients who could not speak indicate their level of pain or discomfort.

Patients confirmed to us that if needed, pain relief medication was promptly brought by staff. There were different methods of managing patient’s pain. Pain relief was given by mouth (oral), injection, suppositories, epidural and patient controlled analgesia (PCA). Patients had access to an outreach pain team for acute pain. There was a separate chronic pain team.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From November 2016 to October 2017, all patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Trauma & orthopaedics patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

All patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- General surgery patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & orthopaedics patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph](image)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*
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 (November 2016 – October 2017))

William Harvey Hospital (Ashford)

From November 2016 to October 2017, all patients at William Harvey Hospital (Ashford) had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Trauma & orthopaedics patients at William Harvey Hospital (Ashford) had a higher than expected risk of readmission for elective admissions when compared to the England average.
- ENT patients at William Harvey Hospital (Ashford) had a higher than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at William Harvey Hospital (Ashford) had a higher than expected risk of readmission for elective admissions when compared to the England average.

All patients at William Harvey Hospital (Ashford) had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at William Harvey Hospital (Ashford) had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & orthopaedics patients at William Harvey Hospital (Ashford) had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- ENT patients at William Harvey Hospital (Ashford) had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - William Harvey Hospital (Ashford)

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.
Non-Elective Admissions - *William Harvey Hospital (Ashford)*

![Bar chart showing readmission rates for different specialties at William Harvey Hospital (Ashford).](image)

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

(Source: Hospital Episode Statistics)

**National Hip Fracture Database**

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate for William Harvey Hospital (Ashford) was 10.2% which was worse than expected. The 2016 figure was 9.2%.

- The proportion of patients having surgery on the day of or day after admission was 74.1%, which was worse than the national standard of 85%. The 2016 figure was 74.2%.
- The perioperative medical assessment rate was 97.8%, which failed to meet the national standard of 100%. The 2016 figure was 97.1%.
- The proportion of patients not developing pressure ulcers was 99.1%, which falls in the top 25% of trusts. The 2016 figure was 99.8%.
- The length of stay was 22.1 days, which falls in the middle 50% of trusts. The 2016 figure was 15.1 days.

(Source: National Hip Fracture Database 2017)

**National Bowel Cancer Audit**

In the 2017 National Bowel Cancer Audit for East Kent Hospitals University NHS Foundation Trust, 60.2% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate of 69.5%. The 2016 figure was 51.4%.

- The risk-adjusted 90-day post-operative mortality rate was 3.7% which was as expected. The 2016 figure was 3.5%.
- The risk-adjusted 2-year post-operative mortality rate was 20.0% which was as expected. The 2016 figure was 18.5%.
- The risk-adjusted 30-day unplanned readmission rate was 7.7% which was as expected. The 2016 figure was not reported.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 76.0% which was a negative outlier. The 2016 figure was 75.6%.

(Source: National Bowel Cancer Audit 2017)

**National Vascular Registry**

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.0% for Abdominal Aortic Aneurysms, indicating that the trust was as expected. The 2016 figure was 1.6%.
Within Carotid Endarterectomy, the median time from symptom to surgery was seven days, which was better than the national standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was as expected at 1.5%. The 2016 figure was 0.5%.

(Source: National Vascular Registry 2017)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer National Audit (NOGCCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 3.6%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure had poor quality data.

The trust was not eligible for the 90-day post-operative mortality rate metric in either 2015 or 2016.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 40.0%, which was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

In the 2017 National Emergency Laparotomy Audit (NELA), William Harvey Hospital (Ashford) achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 202 cases.

- The William Harvey Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 166 cases.
- The William Harvey 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 119 cases.
- The William Harvey Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 76 cases.
- The risk-adjusted 30-day mortality for the William Harvey Hospital was within expectations, based on 202 cases.

Green ratings show a positive outlier (below 99.8% control limit), whereas red ratings show a negative outlier (above 99.8% control limit).

(Source: National Emergency Laparotomy Audit 2017)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:
- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was about the same as the England average. For hip replacements, performance was about the same as the England average. For Knee replacements, performance was better than the England average.

(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Line managers appraised their teams individual 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. 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 or carers during our inspection.

A wide range of specialist nurses supported the nurses on the ward. For example, outreach team, dementia care team, palliative care team, safeguarding leads, diabetes care team and discharge co-ordinators.

**Appraisal rates**

From April 2017 to December 2017, 89% of staff within surgery at the trust had received an appraisal compared to a trust target of 85%.

William Harvey Hospital had an 86% appraisal completion rate at December and we saw data showing this had increased to over 95% when we inspected.

(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 saw clear lines of accountability that contributed to the effective planning and delivery of patient care.

We observed examples of strong and positive effective multidisciplinary working. Staff consistently praised the family feel and friendliness of the organisation and we observed effective working relations between speciality doctors, nurses, therapists, specialist nurses and GPs.

At meetings, we saw 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 also described good working relationships with staff in other directorates and we observed this when.

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 pharmacy and social services. This had an impact on the care of patients ready for discharge and reduced flexibility when arranging supported accommodation or home care packages. We observed a multidisciplinary team meeting where these aspects were addressed as early as possible.

Medical out of hours cover was 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.

**Health promotion**

Patients having elective orthopaedic surgery attended a pre-operative “joint school”. This was an information session run by physiotherapists to help patients feel fully informed about their planned surgery and the subsequent recovery period. Physiotherapists demonstrated exercises and started patients on their exercise programmes pre-operatively with the aim of helping them recover more quickly after surgery.

At the time of our visit, the trust was in the final stages of developing a smartphone application called “my journey” for orthopaedic patients. The application, which was due to be rolled out shortly after our visit, supported patients on their journey from pre- to post-operative. The application reminded patients of their medications and exercises to support them as they prepared for, and recovered from, surgery.

**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 division 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. One patient in Kings C2 ward was the subject to deprivation and we saw good examples of safe and dignified control, care and support being provided by the nursing and secure care staff. The latter individual was contracted in by the hospital; was familiar to the staff and well-regarded. We checked the record and saw where the consultant responsible for the patient’s care undertook safeguarding checks.

We also saw correctly completed examples of mental capacity assessments for those unable to consent. The trust had an assessment of capacity checklist for patients aged 16 and above for the consultant to complete.

The trust had a consent policy in, 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. When we reviewed patient records, we saw clear documentation of discussions relating to consent before any examinations or procedures were undertaken.

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

We observed clinical staff consistently wearing photo-ID name badges and we saw the widespread use of displays showing key staff on each ward. This indicated the trust actively considered ways to inform patients and relatives about who was responsible for providing their care or treatment.

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.

The wards we visited had 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.

Staff understood and respected the personal, cultural, social and religious needs of patients; we saw these being discussed in relation to their care needs during handovers and multidisciplinary meetings.

People’s privacy and dignity needs were consistently understood and respected. We observed physical and intimate care interactions between staff and patients where procedures were explained and consent asked.

Our observations were consistent with the 2017 patient-led assessment of the care environment survey, which showed the trust scored 84.5% for ‘privacy, dignity and wellbeing’. This was better than the England average of 83%.

**Friends and Family test performance**

From December 2016 to November 2017 the Friends and Family Test response rate for surgery at William Harvey Hospital (Ashford) was 43% which was better than the England average of 29%.

SEAU ward had the highest response rate with 121% and the day surgery centre had the lowest response rate with 26%.

A breakdown of the friends and family test performance by ward for medical wards at the trust with total responses over 100 is below. The monthly and annual performance figures represent recommendation percentages.

**Friends and family test response rate at William Harvey Hospital (Ashford), by ward**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Ann. Perf.</th>
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<tbody>
<tr>
<td>DAY SURGERY CENTRE</td>
<td>2319</td>
<td>26%</td>
<td>94%</td>
<td>94%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>90%</td>
<td>94%</td>
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<td>94%</td>
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<tr>
<td>Kings C2</td>
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<td>97%</td>
<td>100%</td>
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<td>95%</td>
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<td>95%</td>
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<tr>
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<td>98%</td>
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<td>86%</td>
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<td>95%</td>
</tr>
</tbody>
</table>

**Key**

- 100%
- 50%
- 0%
Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

**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 longer-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.

**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. Family members felt positive about the involvement they had in their relatives’ treatment and discharge processes. Patients were given time to ask questions when being told about new treatment options in line with National Institute for Health and Care Excellence, QS15 Statement 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.

Staff involved patients and those close to them in decisions about their care and treatment. Staff took into consideration peoples’ opinions and beliefs. Patients and relatives said staff communicated with them at an appropriate level and they could understand their care and treatment plans. This made patients and their relatives feel valued and engaged in episodes of care. This is in line with National Institute for Health and Care Excellence, QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

Staff established effective ways to communicate with people when their protected equality and other characteristics made this necessary. We heard examples of speech and language therapists engaging with patient-centred multidisciplinary teams to conduct assessments and education sessions regarding communication charts and assistive technology aimed at facilitating rehabilitation as well as supporting future communication needs in a community and social setting.

We saw examples of how people could find further information, including community and advocacy services, or ask questions about their care and treatment. This included readily available leaflets and posters.
Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. We saw improvements to the service since our last inspection.

For example, the new surgical emergency assessment unit operated each day to help ensure patients were seen by a specialist and admitted within two hours. This was located near the main entrance to the hospital and the facility contained six trolleys. It was designed to take patients directly from GP admission or emergency surgical referrals from the emergency department. The unit operated weekdays between 0830 and 2000 hours and accepted patients up until 1800.

Another good example was seen in the trauma and orthopaedic unit, which adjoined the surgical emergency assessment unit. The purpose-built facility offered five clinic rooms and a purpose-built bariatric room used by the surgical division. The complex included a plaster room and space for the on-call orthopaedic team which enabled them to conduct a ‘virtual fracture clinic’. This was designed to allow specialists to assess patient progress following stabilisation of their fracture in a cast. Using the patient’s own smartphone, the specialist could observe and discuss progress with the patient without the need for the patient to attend the hospital.

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

We also saw positive examples of contingency service planning during our visit, such as the uninterruptable power supply arrangement for the hospital.

Average length of stay

Trust Level – elective patients

From December 2016 to November 2017, the average length of stay for all elective patients at the trust was 3.0 days, which is lower compared to the England average of 3.9 days.

- For trauma & orthopaedics elective patients at the trust was 3.8 days, which is as expected compared to the England average of 3.9 days.
- For urology elective patients at the trust was 1.7 days, which is lower compared to the England average of 2.5 days.
- For general surgery elective patients at the trust was 2.6 days, which is lower compared to the England average of 3.9 days.

Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.
Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 4.6 days, which is as expected compared to the England average of 5.0 days.

- The average length of stay for general surgery non-elective patients at the trust was 4.0 days, which is as expected compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at the trust was 9.1 days, which is as expected compared to the England average of 8.8 days.
- The average length of stay for urology non-elective patients at the trust was 1.2 days, which is lower compared to the England average of 2.9 days.

Non-Elective Average Length of Stay – Trust Level

![Chart showing average length of stay for different specialties at the trust and England comparison.]

Note: Top three specialties for specific trust based on count of activity.

William Harvey Hospital (Ashford) - elective patients

From December 2016 to November 2017 the average length of stay for all elective patients at William Harvey Hospital (Ashford) was 3.2 days, which is as expected compared to the England average of 3.9 days.

- The average length of stay for trauma & orthopaedics elective patients at William Harvey Hospital (Ashford) was 3.5 days, which is as expected compared to the England average of 3.9 days.
- The average length of stay for ENT elective patients at William Harvey Hospital (Ashford) was 1.9 days, which is as expected compared to the England average of 2.0 days.
- The average length of stay for general surgery elective patients at William Harvey Hospital (Ashford) was 2.6 days, which is lower compared to the England average of 3.9 days.

Elective Average Length of Stay - William Harvey Hospital (Ashford)

![Chart showing average length of stay for different specialties at William Harvey Hospital (Ashford) and England comparison.]

Note: Top three specialties for specific trust based on count of activity.

William Harvey Hospital (Ashford) - non-elective patients

The average length of stay for all non-elective patients at William Harvey Hospital (Ashford) was 5.3 days, which is as expected compared to the England average of 5.0 days.
• The average length of stay for general surgery non-elective patients at William Harvey Hospital (Ashford) was 3.7 days, which is expected compared to the England average of 3.8 days.
• The average length of stay for trauma & orthopaedics non-elective patients at William Harvey Hospital (Ashford) was 9.3 days, which is as expected compared to the England average of 8.8 days.
• The average length of stay for ENT non-elective patients at William Harvey Hospital (Ashford) was 2.2 days, which is as expected compared to the England average of 2.2 days.

Non-Elective Average Length of Stay - William Harvey Hospital (Ashford)

![Graph showing average length of stay for different specialties at William Harvey Hospital (Ashford) compared to England average.]

Note: Top three specialties for specific trust based on count of activity.

(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 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 86% for dementia care, which was significantly better than the England average of 76% and 91% 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 help 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 could 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 often admitted with medical complaints 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 eight outlier patients receiving care in areas outside of their speciality.

Hospital managers acknowledged the issue and worked towards minimising outliers almost in an hourly basis. In addition to the performance information made available to all managers on their mobile phones, we observed an operational meeting where demand and capacity was analysed using the real-time data. We saw the managers identify and move to close any gaps in bed capacity, flow of patients, staff resources and resolve outliers.

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

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery. This was generally below the England average and was shown to be stable during the reporting period.

As of December 2017, 57% of this group of patients were treated within 18 weeks versus the England average of 72%.
Referral to treatment (percentage within 18 weeks)

Admitted

By specialty (just for admitted)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>64.2%</td>
<td>77.0%</td>
<td>Cardiothoracic Surgery</td>
<td>0%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>47.5%</td>
<td>61.1%</td>
<td>Oral Surgery</td>
<td>45.8%</td>
<td>62.2%</td>
</tr>
<tr>
<td>Neurosurgery</td>
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<td>70.9%</td>
<td>ENT</td>
<td>34.7%</td>
<td>63.6%</td>
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<tr>
<td>Plastic Surgery</td>
<td>0%</td>
<td>82.0%</td>
<td>General Surgery</td>
<td>59.2%</td>
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</tr>
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<td>Ophthalmology</td>
<td>62.3%</td>
<td>70.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS England)

The data for referral to treatment by specialty is shown above. Of these, all the specialties were below the England average.

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 showed no noticeable trend, and was generally higher than the England average.

As of Q3 2017/18, this trust cancelled 150 surgeries. Of the 150 cancellations 5% weren't treated within 28 days.
Over the two years, the percentage of cancelled operations at the trust was lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

*(Source: NHS England)*

**Learning from complaints and concerns**

The division treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. We saw examples of incident and complaint investigations that had been communicated to staff through newsletters and bulletins as well as ward and divisional meetings.

Each ward had a file of recent team meeting minutes and used signature lists or email address lists to demonstrate that staff had read the notes. This meant the ward managers could ensure that those working shift patterns or on leave did not miss key announcements.

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.

### Is the service well-led?

#### Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. We saw improvements to the service since our last inspection.

For example, the new surgical emergency assessment unit operated each day to help ensure patients were seen by a specialist and admitted within two hours. This was located near the main entrance to the hospital and the facility contained six trolleys. It was designed to take patients directly from GP admission or emergency surgical referrals from the emergency department. The unit operated weekdays between 0830 and 2000 hours and accepted patients up until 1800.

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We also saw positive examples of contingency service planning during our visit, such as the uninterruptable power supply arrangement for the hospital.

#### Average length of stay

##### Trust Level – elective patients

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- For urology elective patients at the trust was 1.7 days, which is lower compared to the England average of 2.5 days.
- For general surgery elective patients at the trust was 2.6 days, which is lower compared to the England average of 3.9 days.
Elective Average Length of Stay – Trust Level

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>3.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>3.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Urology</td>
<td>1.7</td>
<td>2.5</td>
</tr>
<tr>
<td>General Surgery</td>
<td>2.6</td>
<td>3.9</td>
</tr>
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</table>

Note: Top three specialties for specific trust based on count of activity.

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 4.6 days, which is as expected compared to the England average of 5.0 days.

- The average length of stay for general surgery non-elective patients at the trust was 4.0 days, which is as expected compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at the trust was 9.1 days, which is as expected compared to the England average of 8.8 days.
- The average length of stay for urology non-elective patients at the trust was 1.2 days, which is lower compared to the England average of 2.9 days.

Non-Elective Average Length of Stay – Trust Level

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4.6</td>
<td>5.0</td>
</tr>
<tr>
<td>General Surgery</td>
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<td>8.8</td>
</tr>
<tr>
<td>Urology</td>
<td>2.6</td>
<td>2.9</td>
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</table>

Note: Top three specialties for specific trust based on count of activity.

William Harvey Hospital (Ashford) - elective patients

From December 2016 to November 2017 the average length of stay for all elective patients at William Harvey Hospital (Ashford) was 3.2 days, which is as expected compared to the England average of 3.9 days.

- The average length of stay for trauma & orthopaedics elective patients at William Harvey Hospital (Ashford) was 3.5 days, which is as expected compared to the England average of 3.9 days.
- The average length of stay for ENT elective patients at William Harvey Hospital (Ashford) was 1.9 days, which is as expected compared to the England average of 2.0 days.
- The average length of stay for general surgery elective patients at William Harvey Hospital (Ashford) was 2.6 days, which is lower compared to the England average of 3.9 days.
**Elective Average Length of Stay - William Harvey Hospital (Ashford)**

Note: Top three specialties for specific trust based on count of activity.

**William Harvey Hospital (Ashford) - non-elective patients**

The average length of stay for all non-elective patients at William Harvey Hospital (Ashford) was 5.3 days, which is as expected compared to the England average of 5.0 days.
- The average length of stay for general surgery non-elective patients at William Harvey Hospital (Ashford) was 3.7 days, which is expected compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at William Harvey Hospital (Ashford) was 9.3 days, which is as expected compared to the England average of 8.8 days.
- The average length of stay for ENT non-elective patients at William Harvey Hospital (Ashford) was 2.2 days, which is as expected compared to the England average of 2.2 days.

**Non-Elective Average Length of Stay - William Harvey Hospital (Ashford)**

Note: Top three specialties for specific trust based on count of activity.

(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 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 86% for dementia care, which was significantly better than the England average of 76% and 91% 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 help 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 could 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 often admitted with medical complaints 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 eight outlier patients receiving care in areas outside of their speciality.

Hospital managers acknowledged the issue and worked towards minimising outliers almost in an hourly basis. In addition to the performance information made available to all managers on their mobile phones, we observed an operational meeting where demand and capacity was analysed using the real-time data. We saw the managers identify and move to close any gaps in bed capacity, flow of patients, staff resources and resolve outliers.

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

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery. This was generally below the England average and was shown to be stable during the reporting period.

As of December 2017, 57% of this group of patients were treated within 18 weeks versus the England average of 72%.
Referral to treatment (percentage within 18 weeks)

### Admitted

<table>
<thead>
<tr>
<th>Specialty Grouping</th>
<th>Result</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>64.2%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>47.5%</td>
<td>61.1%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0%</td>
<td>70.9%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>62.3%</td>
<td>70.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

The data for referral to treatment by specialty is shown above. Of these, all the specialties were below the England average.

### 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 showed no noticeable trend, and was generally higher than the England average.

As of Q3 2017/18, this trust cancelled 150 surgeries. Of the 150 cancellations 5% weren’t treated within 28 days.
Over the two years, the percentage of cancelled operations at the trust was lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

The division treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. We saw examples of incident and complaint investigations that had been communicated to staff through newsletters and bulletins as well as ward and divisional meetings.

Each ward had a file of recent team meeting minutes and used signature lists or email address lists to demonstrate that staff had read the notes. This meant the ward managers could ensure that those working shift patterns or on leave did not miss key announcements.

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.

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.

The senior leadership team consisting of a divisional head of nursing, a divisional director and a divisional medical director, who led the trust’s surgical services across the three main hospital sites.

Surgical and theatre matrons were responsible for nursing staff. The matrons reported to one of the three senior surgical matrons, who reported to the divisional head of nursing. Each branch of surgery had a consultant clinical lead. The clinical lead for each surgical specialty reported to the divisional medical director. There were five general managers covering different surgical specialties, who each reported to the divisional director for surgery. Operations managers, who were responsible for non-clinical staff, reported to the relevant general manager.

We observed photograph displays of key staff in each ward or unit we visited. When we checked, the displays were accurate and up-to-date. These helped relatives and visitors to the hospital understand who was responsible for the provision of care in that area.

All ward managers we spoke with knew what their wards were doing well and could articulate the challenges and risks their team faced in delivering good care. Staff told us they felt well supported, valued and that that their opinions counted.

Staff generally spoke in positive terms about the visibility and approachability of the senior management team. They said they felt free to raise any issues with them direct or through their line manager. They described the new chief executive in positive terms and spoke about monthly meetings and listening events they had attended. Most junior staff we asked had not seen the executive team in their clinical areas. However, they could identify the executives from publicity material and many had read the chief executive’s weekly blog.

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.

We learned from staff and managers about how staff had contributed to the strategy through a series of ‘listening events’.
Staff we spoke with understood what the vision, values and strategy for the division was and how their work contributed to achieving the vision.

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 that despite the challenges, spoke in positive terms about how they felt appreciated, supported and enjoyed their work.

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 meant the trust provided staff with a route to raising concerns anonymously if they needed to do so, and openly advertised this service to staff.

Governance

The trust operated a divisional governance model, which helped to provide a forum for clinicians and managers to be involved in the planning of hospital activities.

We reviewed the terms of reference and minutes of meetings (the last dated April 2018), 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.

All divisions completed a monthly Quality report which detailed performance against safety metrics. This report was shared at the divisional governance meetings and at monthly quality, performance and patient experience committees.

The divisional governance team was led by a matron and a clinical lead for governance, patient safety and quality. The matron and clinical lead for governance reported to the divisional director.

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.

We reviewed the surgical divisional risk register and saw senior staff regularly reviewed and updated risks. We saw items on the register matched the things senior staff told us about, such as bed capacity and outliers from other specialities.

We saw the hospital’s surgical quality dashboard. This measured and monitored the service’s monthly performance in key areas against trust targets. This included monitoring of harm-free care, readmissions, infection rates, referral to treatment times, incidents, complaints, staff turnover and vacancy rates. The dashboard had a red, amber, green (RAG) rating system to allow staff to see whether the service was meeting its targets. We saw that the service compared performance to the previous month to identify trends. This meant managers could identify emerging concerns, and obtain assurances they were performing well or improving.

The service’s internal audit programme helped provide assurances around staff performance and compliance with policies and drive continuous improvement. This included regular audits on the
World Health Organisation Surgical Safety Checklist and sepsis screening audits. Audits provided assurances around staff compliance and helped identify areas for improvement. Staff told us they received feedback on audit results to help drive continuous improvement.

**Information management**

The trust collected, analysed, managed and used information very well to support all its activities, using secure electronic systems.

We saw divisional governance reports and quality dashboards that contained information to help managers effectively monitor quality across the service. The service collated and submitted data to a range of national audits and benchmarked with other trusts in the region. This allowed the comparison of data against national averages and standards to help facilitate continuous improvement.

The trust’s website provided safety and quality performance reports and links to other web sites such as NHS Choices. This gave patients and members of the public a 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. Senior clinicians described examples of dementia care projects in the community and other forums such as the Kent & Medway NHS Emergency Planning Group. Managers explained that the trust was also a member of the Kent Resilience Forum, which brought 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 and complaints.

The management team told us that any good ideas put forward by staff were discussed at ‘hub’ 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.

The service used the NHS Friends and Family test as a means of capturing patient feedback. Results for the period December 2016 to November 2017 showed most patients would recommend the service to their family and friends.

**Learning, continuous improvement and innovation**

We found evidence the division was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

The way the trust supported and encouraged innovation through the “hub” program was a real strength. We saw good examples across the division and our observations were consistent with positive feedback we received from staff individually and at the focus groups.

The service had a positive focus on developing its own staff. Managers explained this was a deliberate strategy to help recruit and retain medical and nursing staff. The service had recently
introduced an “improvement journey” programme to support nurses recently promoted from band five staff nurses to band six junior sisters/charge nurses. We saw a copy of the improvement journey booklet to provide a record of newly-promoted band six nurses’ development in their new role. The booklet was comprehensive and provided links to further guidance and support, as well as a record of training, development and reflective practice to support appraisal and revalidation. New and longstanding staff shared examples of courses they had attended that had been funded by the trust.

Maternity

Facts and data about this service

East Kent University Hospitals NHS Foundation Trust has 50 maternity beds across two sites; Queen Elizabeth The Queen Mother Hospital in Folkstone and William Harvey Hospital in Ashford.

The Queen Mother Hospital has eight labour rooms, three induction rooms and 22 beds on the maternity ward. The midwifery led birth unit has four beds.

William Harvey Hospital has 11 labour beds, three induction of labour rooms and 28 beds on the maternity ward that is used for postnatal & antenatal (before and after birth) women. The site has one bereavement suite and a six bedded midwifery led birth unit.

(Source: Trust Provider Information Request – Acute sites)

From October 2016 to September 2017 there were 6,645 deliveries at the trust.

A comparison from the number of births at the trust and the national totals over the most recent twelve months is shown below:

Number of babies delivered at East Kent Hospitals University NHS Foundation Trust – Comparison with other trusts in England.
A profile of all deliveries from October 2016 to September 2017 can be viewed below:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>East Kent Hospitals University NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>1,946</td>
<td>29.3%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>690</td>
<td>10.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>3,997</td>
<td>60.2%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>12</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>6,645</td>
<td>100%</td>
</tr>
</tbody>
</table>

\(^1\)Includes elective and emergency caesareans  
\(^2\)Includes forceps and ventouse (vacuum) deliveries  
\(^3\)Includes breech and normal (non-assisted) deliveries  

Notes: To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with *** (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below:

Number of deliveries at East Kent Hospitals University NHS Foundation Trust by quarter.

(Source: HES - Deliveries (October 2016 - September 2017)
The number of deliveries per quarter during this reporting period has remained about the same with no trends of increase or decrease.

Is the service safe?

Mandatory training

The majority of staff was provided with training. This meant they were able to provide care that met patients’ needs.

The trust set a target of 85% for completion of mandatory training. Compliance for the clinical staff, which included midwives and support workers, was reported as 84% which was just worse than the target. The leadership team were able to provide additional evidence that this rate would be improved in the forthcoming months. Nursing and midwifery staff told us they received the right amount of training to be able to do their jobs and to meet patients’ clinical needs.

However, training compliance for medical staff was far worse the trust target of 85%. Training compliance range between 54% and 79% for the various modules. This meant that not all medical staff received the mandatory training required to undertake their rolls.

A breakdown of compliance for mandatory courses, at the William Harvey site from January 2017 to December 2017, for nursing/midwifery and medical staff is shown below:

### William Harvey Medical Staff group

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>28</td>
<td>19</td>
<td>68</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>28</td>
<td>22</td>
<td>79</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>28</td>
<td>21</td>
<td>75</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>28</td>
<td>15</td>
<td>54</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>28</td>
<td>18</td>
<td>64</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>28</td>
<td>22</td>
<td>79</td>
<td>No</td>
</tr>
</tbody>
</table>

### William Harvey Hospital Nursing and midwifery staff group

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>97</td>
<td>101</td>
<td>98%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>95</td>
<td>101</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>85</td>
<td>101</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>86</td>
<td>101</td>
<td>84%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>72</td>
<td>101</td>
<td>84%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>80</td>
<td>101</td>
<td>84%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Additional data request)

The department used an electronic tool to monitor and record mandatory training and this was held centrally in the Human Resources department. The senior leadership team had local
oversight of the training records and could easily identify when staff had not completed the required modules. Staff received an email reminder when their training was about to expire. Staff training needs were discussed regularly and they were able to request additional training if required.

The department provided a range of training resources to staff. This includes online and self-directed training, as well as face to face teaching sessions. Senior staff told us that there was going to be more of a focus on face to face teaching in the coming year as a result of staff feedback.

**Safeguarding**

Mothers and babies were mostly protected from the risk of abuse. Staff were able to demonstrate knowledge of safeguarding systems, processes and identify the signs of abuse. However, safeguarding training amongst the medical staff was worse than the trust’s own target of 85%.

The department had a dedicated safeguarding lead midwife in post. However, this formed 0.5 of a Whole Time Equivalent (WTE) post which appeared insufficient to manage the work load. Staff were aware of how to contact this staff member for additional support with safeguarding issues.

The trust had a safeguarding adult policy and a child abduction procedure, which linked into the children’s safeguarding policy. The trust’s safeguarding adults at risk policy identified female genital mutilation (FGM) in relation to the mandatory process of both reporting and recording newly identified cases of FGM. The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. It is mandatory for all acute trusts to report to the Department of Health, on the number of patients who have a family history, or had FGM.

During our visit we reviewed safeguarding plans on the electronic records system. The notes were robust in the information recorded and showed good multidisciplinary working.

Access to the delivery suite and wards was via a keypad entry system. There was additional closed circuit television outside the entry points of each area. However, this posed a “tailgating” security risk. The door was a long way from the main reception and if there was an unauthorised entry it would be very difficult to identify. This security concern was risk assessed in November 2016, and was recorded on the risk register. We were told that there was a plan to upgrade the entry system to address the risk. However, we were not provided with an expected end date for this work to be completed.

We also noted the abduction policy had been in draft form since September 2016. The unit did not undertake child abduction exercises which meant it may be missing an opportunity to ensure all staff know their roles and responsibilities and would act in line with trust policy if abduction were to occur.

The trust set a target of 85% for completion of safeguarding training. Data we received from the trust showed medical staff safeguarding training compliance for adults and children was worse than the trusts own target. Of the 28 medical staff eligible for level two training, 15 had attended training. Of the 28 medical staff required to attend level 3 training, 18 had attended the training. This was a compliance rate of 64%. Training compliance in the nursing and midwifery staff group was better than the trust target of 85%.

The department followed the threshold criteria set down by the Kent Safeguarding Children Board. This meant that any pregnant young person under the age of thirteen would automatically be referred to Social Services as an offence under the Sexual Offences Act 2003. In addition, any young person already known to the Local Authority, including Looked after Children were also
automatically referred. Concealed pregnancies and any identified cases of Female Genital Mutilation in this age group would also be automatically referred.

Between the ages of 13-18 years old, each case was assessed on a case by case basis, dependent on the age, vulnerable indicators (for example schooling), family support, age of partner and stage at which they accessed maternity care.

The trust provided evidence of its involvement in Serious Case Reviews and the learning actions from these. This meant the department was engaging with external providers and using the learning from these to improve the way it protected vulnerable adults and children.

A breakdown of compliance for safeguarding courses from January 2017 to December 2017 for nursing/midwifery staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>101</td>
<td>101</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>87</td>
<td>101</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>74</td>
<td>101</td>
<td>81%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request: Training)

**Cleanliness, infection control and hygiene**

Generally, patients were protected from the risk of health acquired infections during their admissions. Staff used control measures to prevent the spread of infection and were observed following the World Health Organisation five moments of hand hygiene. We observed staff following the trust infection control policy of being bare below the elbows. This national incentive was introduced to control the spread of infection by ensuring sleeves must be short or rolled securely up to the elbow, in order to allow access to the wrist for good hand wash technique. This was in line with trust policy and national guidance.

Side rooms were available for women that needed isolation, or protection from infections. This meant that patients were protected from the risk of health acquired infections during their admissions.

Staff were observed washing their hands and wearing Personal Protective Equipment when attending to personal care in line with National Institute for Health and Care Excellence guidance, QS61 statement 3: ‘People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care’.

Clinical waste was separated and stored in the appropriate colour coded bags in line with best practice guidelines. The department was using the National Colour Coding System for hospital cleaning equipment and materials. Sharps bins were assembled and labelled in line with trust policy with the exception of one bin in the labour ward that was not assembled as per guidance.

National Specification of Cleanliness audit data demonstrated the clinical areas were meeting the national set target of 95% for high risk areas. Six months’ worth of data for the delivery suite, Folkestone ward and Singleton ward showed an average compliance rate of between 96% and 98%. The data showed high levels of cleanliness were maintained. However, during our inspection...
we identified areas that were dusty. For example we saw dust on the skirting boards in the delivery unit.

A recent change in the housekeeping contract saw an external provider take over the provision of the service. Folkestone ward had a dedicated housekeeper which meant there was a consistent standard of cleanliness. The staff felt proud of the level of the house keeping support and the level of cleanliness achieved in this area.

We observed all cleaners wearing disposable aprons and following the correct procedures for preventing the unnecessary spread of germs.

Data provided by the trust showed zero *Clostridium difficile* or *Methicillin-resistant Staphylococcus aureus* bacteraemia cases at the William Harvey maternity unit for the reporting period April 2017-April 2018.

Equipment was readily available and marked with an ‘I am clean’ sticker. This sticker indicated that the device had been cleaned and was ready for use.

**Environment and equipment**

Staff had access to the equipment needed to meet peoples individual health needs. However, two fridges on Folkestone ward had been condemned just before the inspection. This meant that medication requiring cold storage had to be moved to another clinical area to ensure they were stored in line with manufactures guidelines. This meant that staff had to leave their clinical areas to access the medication, rather than have immediate access to it on their allocated wards.

The second fridge was used for the storage of breast milk. During the inspection, there was no facility to store breast milk. This meant any mother wishing to store milk was unable to do so.

We carried out random checks of the emergency equipment across the department and found checks were being undertaken in line with trust policy and best practice guidelines.

The maternity unit environment appeared cramped, lacked suitable storage facilities and in need of modernisation. This observation extended to the entire department. The timeliness and responsiveness to many of the facilities projects required to improve the general environment was a major concern.

For example the bathroom facilities in Folkestone ward were in poor condition and did not support best practice infection control and prevention guidelines. Staff had reported their concerns about these facilities several times and no action had been taken. We were informed during our inspection that the trust had allocated funding to ensure these areas were renovated as a matter of urgency. The floor in side room four on the maternity led unit was also in need of repair. Staff told they felt ‘it was like fighting a losing battle with estates’.

During the inspection staff told us they had access to the necessary equipment to be able to undertake their rolls. However, we noted Folkestone ward did not have a hoist and only 16% of staff at this site felt they had adequate materials, supplies and equipment to do their work. This meant the department was not able to meet the needs of patients that required a hoist.

**Assessing and responding to patient risk**

Staff ensured that patient's individual care needs were risk assessed and managed effectively in line with trust policy.

The department used a standardised Modified Early Obstetric Warning Score (MEOWS) to measure individual clinical risk. This tool helped staff recognise signs of physical deterioration in women by monitoring their physiological parameters such as blood pressure, heart rate,
respiratory rate and temperature. The sample of records we viewed showed that the warling score was being used in line with trust policy to ensure patients risk was escalated appropriately.

Staff undertook a wide range of individual risk assessments upon admission to identify additional health risks. We saw these risk assessments in the medical records we reviewed during the inspection. Examples were not limited to, but included, past medical history, foetal and maternal condition and progress of labour. We saw patients had their Venous Thrombosis risk assessed upon admission. However, the unit was achieving a 92% compliance with this, slightly worse than the national standard of 95%. The department was moving toward electronic and automatic Venous Thrombosis risk assessments in the coming months. Evidence of risk assessments being undertaken was gathered from our conversations with patients, staff, and the medical records we reviewed.

The service followed the ‘Five Steps to Safer Surgery’ World Health Organisation (WHO) checklist, which included a sign in, time out and sign out checks. Patients also had a copy of the ‘Five Steps to Safer Surgery’ (WHO) checklist in their notes. We were told that compliance was audited regularly. Data supplied by the trust showed performance was audited. It also showed poor compliance rates of 57%. In our additional data request for WHO audits, we asked for any associated action plans implemented as a result of poor scores. We did not receive any evidence indicating that poor performance had been addressed. This meant that this safety standard was not being applied in practice to safeguarding patients from essential practices known to reduce preventable maternal and new-born deaths around the time of childbirth. When shortfalls were identified, the service did not evidence the necessary actions taken to improve.

Patients who were identified as ‘high risk’ were routinely attended by consultant obstetricians during birth to ensure the safety of mother and baby. This meant that patients received care in line with numerous National Institute for Health and Care excellence and the Royal College of obstetricians.

Daily safety huddles were in operation. This meant there was an opportunity for staff to raise concerns about any patient that may require additional oversight or clinical input.

Patients could present at the early pregnancy unit (EPU) if they had bleeding and or were experiencing pain. The EPU helped women identify the cause of symptoms and offered advice, support and any treatment which may be needed.

Staff also received an in house simulation programme which was delivered in two streams depending on the clinician’s main place of work – ‘In hospital’ and ‘Out of hospital.’ This provided staff with an opportunity to learn and develop and improve performance in emergency situations.

The service had sourced sponsorship from a baby wrap company who provided the unit with wraps for all mothers who undergo a caesarean section. Mothers wore the wrap to theatre and their baby was placed in the wrap immediately after birth. This meant that babies born by caesarean section were less likely to have a sudden drop in temperature and provided an immediate and invaluable skin to skin contact to aid bonding.

There was also a criterion for paediatricians attending births. This meant there was clear guidance to ensure specialist staff were available to attend complex births.

The department took part in annual emergency pool evacuation exercises. This included staff entering the water and role play. Emergency pool evacuation was also covered in mandatory practical moving and handling teaching which is undertaken by all staff yearly. This meant that staff had the necessary training and skills to manage an emergency pool evacuation.
There was an appropriate exclusion criterion for water births. Whilst the service aimed to support mothers to have the birth of their choice, it also had to ensure the choices were safe for patients and new-borns. Staff were able to tell inspectors about the exclusion criteria. This meant staff were able to undertake individual risk assessment appropriately and provide consistency of advice for women when considering the relative risk associated with where they wish to give birth.

No live simulation transfers were conducted on the Singleton Unit. The trust told us in the event of a real transfer the extra member of staff pre-called the lift and opens the door in order for a smoother and quicker transfer. However, during the inspection we noted the staff did not have a key to lock the lift or expedite its descent to the ground floor. Staff we talked with said that they never had a problem with the lift during an emergency transfer. We were not aware of any risk assessment that had been undertaken to assess the risks of unforeseen delays and the clinical impact a delay may have.

The trust was aware that their third degree tear rate has increased in the six month period before the inspection. The leadership team were aware of this and were in the process of undertaking an audit to ensure these rates returned to rates similar to the England average.

**Midwifery and nurse staffing**

The trust reported their staffing numbers below for the period March 2017 to December 2017.
- Maternity had a staffing rate of 79% across both acute sites.
- William Harvey Hospital had a staffing rate of 77%, indicating that the unit had to function with 24 less whole time equivalent (WTE) nursing staff in post than what was planned for.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Harvey Hospital</td>
<td>105</td>
<td>81</td>
</tr>
</tbody>
</table>

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

Shift co-coordinators were counted in the daily staffing numbers. This meant their ability to provide leadership support, deploy resources, and oversee the quality of care in the department may be affected.

There was only one consultant midwife on the William Harvey site. We asked the trust to provide an overview of the role and responsibilities for this position. The response we received said that the consultant midwife coordinates all Public Health projects including Screening Team; Perinatal Health Midwives; Smoking Cessation Midwife Infant Feeding Team includes the Tongue Tie Service and lactation consultants. However, the consultant midwife was only employed two days a month to provide this level of oversight and co-ordination. This meant that this position was not able to provide appropriate support to the service or those who worked in it.

We noted this risk was reported on the trust risk register which identified compliance with one to one staffing in labour between 90-95% at the William Harvey Site. This meant that the trust was failing to ensure one to one care was provided to all mothers in line with best practice.

**Vacancy rates**

From January to December 2017, the trust reported a vacancy rate of 4% in maternity, better than the trust target of 10% or less.
- William Harvey Hospital: 2%

The service had a vacancy rate better than the trust target of 10% or less
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
Turnover rates

From January to December 2017, the trust reported a turnover rate of 13% in maternity; in line with the trust target of 13% or less.

- William Harvey Hospital: 11%

William Harvey Hospital had a turnover rate of 11% better than the trust target of 13%.

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

Sickness rates

From January 2017 to December 2017 reported an overall sickness rate of 7% in maternity. A breakdown by site for nursing staff is as below;

- William Harvey Hospital: 10%

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

Bank and agency staff usage

Additional evidence we received from the trust showed from March 2018 to April 2018, the agency use and shift fill rate for the midwifery led unit, labour ward and Folkestone ward. During this period, the Midwifery led unit had a bank/agency use of 11% and a shift fill rate of 88% which accounted for 214 hours of employment. Data for the labour and Folkestone ward was combined and reported a bank and agency use of 22% with a shift fill rate of 90.7% which accounted for 1,468 hours of employment. This period showed a high use of maternity care assistants and support workers. The agency/bank used was reported at 33%, with a fill rate of 82% accounting for 637 hours of employment. This meant that there was high agency use in the department between March 2018 to April 2018.

Midwife to birth ratio

The trust Provider Information Request showed as of September 2017 the trust had a ratio of one midwife to every 28 women. This is about the same as other trusts. However, during the inspection, it was identified that the ratio at the William Harvey Hospital was higher at 1:30. We were provided with assurance that mothers continued to receive one to one care during labour. We were provided with evidence of five additional staff due to join the team in next two months post inspection. This meant the ratio would return to the national average within the specified time frame.

(Source: Electronic Staff Records – EST Data Warehouse)

Medical staffing

We asked the trust to provide additional data to show the planned staffing verses the actual rates for the medical staff group. The data to show the planned staffing rates was not received.

The trust reported a total of 27.65 whole time equivalent medical staff as of April 2018.
<table>
<thead>
<tr>
<th>Grade</th>
<th>Actual Current Staff WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Specialist</td>
<td>1.00</td>
</tr>
<tr>
<td>Consultant</td>
<td>9.65</td>
</tr>
<tr>
<td>F2</td>
<td>1.00</td>
</tr>
<tr>
<td>Specialty Doctor</td>
<td>2.00</td>
</tr>
<tr>
<td>Specialty Registrar</td>
<td>14.00</td>
</tr>
<tr>
<td>Total</td>
<td>27.65</td>
</tr>
</tbody>
</table>

Consultant cover was provided the department between 08:00 – 18:00 daily, after this time, consultants provided on call cover. We reviewed the rotas and found sufficient cover. A specialist’s registrar provided medical cover between 18:00 and 08:00. The trust demonstrated sufficient anaesthetic consultant cover for the department.

**Sickness rates**

We were provided with the following data in our additional data requests. It shows the sickness and absence rates for the department between April 2017 – April 2018. The highest absence rates were in the nursing and midwifery group which was 9.7%, and the additional clinical services group which was 8%. We discussed the sickness rates with the leadership team during the inspection. They were aware the rates for this 12 months period was high, however, they were able to demonstrate rates were improving in the most recent months.

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Staff Group</th>
<th>Cumulative % Abs Rate (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>344 3205 Maternity Lead Unit</td>
<td>Additional Clinical Services</td>
<td>1.60%</td>
</tr>
<tr>
<td>344 3205 Maternity Lead Unit</td>
<td>Nursing and Midwifery Registered</td>
<td>1.86%</td>
</tr>
<tr>
<td>344 3210 Maternity WHH</td>
<td>Additional Clinical Services</td>
<td>7.91%</td>
</tr>
<tr>
<td>344 3210 Maternity WHH</td>
<td>Administrative and Clerical</td>
<td>0.83%</td>
</tr>
<tr>
<td>344 3210 Maternity WHH</td>
<td>Nursing and Midwifery Registered</td>
<td>9.74%</td>
</tr>
<tr>
<td>344 3201 Obs &amp; Gynae - WHH</td>
<td>Medical and Dental</td>
<td>0.56%</td>
</tr>
</tbody>
</table>

**Staffing skill mix**

In December 2017, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was also about the same.
Staffing skill mix for the 57.8 whole time equivalent staff working in maternity at East Kent Hospitals University NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>40%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>Junior*</td>
<td>7%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept appropriate electronic and paper records of patients’ care and treatment. Medical records were clear, up-to-date and available to all staff providing care. We saw records were stored securely and kept confidential.

Women held their own paper maternity records. Babies had a separate (Red book) record created after birth. Red books are used nationally to track a baby’s growth, vaccinations and development.

We reviewed four sets of records which contained completed risk assessments, past medical history and patient preferences.

The department took part in an annual records audit. Examples included recording of weights, Venous Thrombosis assessments and staff signatures. Data provided to us showed the maternity service achieved 80% with four of the eight standards. There was an action plan in place which included providing a teaching session with staff.

Medicines

Medicines were stored, handled and dispensed in line with trust policy and national guidance.

We carried out random checks of how controlled drugs were managed in the department. We found these were ordered, stored, and dispensed in a way that reflected trust policy and national guidance.

Medicines fridges were checked in line with trust policy to ensure they were stored as per manufacturers’ recommendations.

We also reviewed a selection of medication charts and found them to be complete. Medication was prescribed in line with national guidance, patients and their allergies and weights were recorded.
Staff told us they had sufficient support from the pharmacy department.

The trust provided additional evidence of the department routinely auditing medicines practice. When areas of improvement were identified, an action plan was in place to address concerns. This meant that the trust monitored medicines handling to ensure best practice was adhered to.

**Incidents**

There was an electronic incident reporting tool which could be easily accessed by staff. The department had on average 110 incidents reported each month. Midwives and support workers reported incidents, but it was widely accepted there was room for significant improvement of incident reporting, especially amongst the medical staff group. In the most recent staff survey, 93% of staff reported knowing how to report unsafe clinical practice, and 75% reported feeling secure raising concerns about unsafe clinical practice.

We reviewed evidence of root cause analysis investigation outcomes being shared with staff and changes to practice as a result. We found they contained an appropriate level of detail and sufficient learning actions. However, we noted a lack of staff with Root Cause Analysis (RCA) training. Root Cause Analysis training can be defined as a problem solving and quality improvement approach used to identify, understand, and resolve any root causes of problems or incidents.

There was some evidence that learning from lower level incidents was not always shared with the clinical teams. It was clear that the practice of providing feedback required further attention to ensure better communion and learning. Staff we talked with provided a mixed response when asked how learning from incidents was disseminated. This meant that the learning outcomes of investigations required further development to prevent future recurrence.

There was a lack of robust cross site learning during this inspection. The senior leadership team were aware that these concerns and had provided assurance that there was a plan to strengthen learning, feedback and the cross site and wider organisation learning. This meant that the service may be missing an opportunity to embed learning and prevent recurrence of incidents.

However, it was clear that the department had embraced learning from serious incidents and root cause analysis investigations. Examples of this include changes to practice for cardiotocography monitoring and safeguards against medicine overdose. The learning and practice changes were communication via the social media group, perinatal meeting minutes, Birthing Excellence Success Through Teamwork (BESTT) posters and notice boards in the clinical areas, message of the week and staff meetings.

The newly introduced maternity training programme had incorporated local and national clinical scenarios and trend and theme data into the departmental learning programme. The faculty also took the lead in ensuring there was robust learning, and changes to practice from serious incidents. For example, a recent retained swab never event, and the systems changes implemented was built into the ‘major obstetric haemorrhage’ scenario. This was seen as a way to accelerate the embedding of these system changes into practice, because staff could see in a learning environment how these changes improved safety.

The department had identified a need to train more staff to undertake Root Cause Analysis training to ensure that the quality of these investigations reports was upheld. There was an action plan in place to train a significant number of staff in the coming months.

We asked the trust to provide evidence that Duty of Candour was applied in the maternity service. Data indicated that this regulation was being met. However there was some concern of a varied approach to applying candour amongst the consultant group. Staff told us that some consultants were ‘excellent’ at being open when things went wrong and others had not fully embraced the
regulations and required regular prompting to do so. This meant there was a concern that the regulation may be inconstantly applied in the department.

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 March 2017 to February 2018, the trust reported one incident which was classified as a never event for maternity.

This was a maternity / obstetric incident meeting SI criteria: mother only.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2017 to February 2018.

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

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with six (55% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only with two (18% of total incidents).
- Screening issues meeting SI criteria with one (9% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (9% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with one (9% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Maternity unit continuously monitored the quality of care provided to patients via a maternity dashboard. The dashboard is an improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. We saw data for a six month period which
showed us that patients received 100% harm free care most months with the exception of September 2017 which scored 83.3%.

**Is the service effective?**

**Evidence-based care and treatment**

Patients received care and treatment that reflected national and best practice guidance. Service policies and procedures reflected evidence based practice. For example, the service had implemented a sepsis pathway and audited its application and patient outcomes as a result.

The National Institute for Health and Care Excellence quality standard 22 was also in place. This standard relates to the care provision for all women up to 42 weeks of pregnancy and includes antenatal care in the hospital and community setting.

Patients, who needed a caesarean section, whether planned or emergency, also received care in-line with the National Institute for Health and Care Excellence recommendations (quality standard 32. For example, Quality statement 1: Vaginal birth after a caesarean section.

The National Institute for Health and Care Excellence quality standard 37 was being met in post-natal care. All women we spoke with told us staff had provided them with breastfeeding advice and support and were discharged after the appropriate checks had been undertaken.

Patients told us they were offered a choice in terms of their preferred birthing location. This was in line with National Institute for Health and Care Excellence quality standard 190: Intrapartum care. There was specific criteria and guidance for staff to follow at times where individual choice had to be balanced with clinical risk. This meant that staff were supported to make decisions that balanced choice with clinical risk to ensure the best outcomes possible for patients and their newborns.

A smoking cessation specialist midwife provided help and support to patients in line with National Institute for Health and Care Excellence Quality Standard 43.

The department ensure that patients with diabetes in pregnancy were treated in line with National Institute for Health and Care Excellence clinical guideline 03.

The trust offered foetal anomaly screening in accordance with current UK National Screening Committee programmes. This was in line with National Institute for Health and Care Excellence quality standard 22: Antenatal care.

The maternity training programme took an active and direct role in ensuring that guidance from National Institute for Health and Care Excellence quality standard and the Royal College of Obstetricians and Gynaecologists guidelines was incorporated into all teaching and the multidisciplinary team. Staff received updates about guidance changes via social media, safety huddles and newsletters.

We were provided with a list of audits from the unit’s audit programme. There was insufficient evidence to demonstrate that clinical audit activity in the department was given the prominence required to measure outcomes and improve practice. A new clinical lead had recently been appointed and had taken responsibility for audit activity in the department. Whilst we were told by the senior team that there were plans to improve the frequency and quality of the audits in the department, at the time of the inspection, there was a lack of structure, oversight or impact from the activity. There was evidence that the department did not act quickly in response to data that showed poor standards or practice, for example the high caesarean section rates, and World
Health Organisation surgical check list. This meant that patients were exposed to care that may be harmful.

However, the faculty of multi-professional learning in maternity had identified all of concerns we noted relating to audit practice during the inspection. As a response to this, a training programme for the trust had been developed. This meant that had all training had a focus on evidence and be driven by local, regional and national evidence of best practice, national guidelines and recommendations, local audit findings, risk issues and case review. It also included a focus on local data to influence the programme which included risk, governance data, feedback from women and families and feedback from staff. The training had a focus on strong governance which was built into the staff appraisal processes, escalation processes regarding non-attendance and failure to demonstrate safe practice. This meant that there was a plan in place to not only improve audit performance in the department, but a drive to change the culture of the unit towards understanding the importance of measurement against best practice and national guidelines.

We asked the trust to provide evidence of community midwives having been advised about the use of aspirin in early pregnancy in the event of pre-eclampsia. The trust responded with the following statement: ‘This was introduced in 2014 and unable to get evidence to support the request above. Routine practice with community midwifery team’. This meant the trust also sent a copy of a letter sent to all patients with information about pre-eclampsia.

**Nutrition and hydration**

Patients and their babies had their nutritional and hydration needs met.

We saw patients had access to adequate food and drink during the inspection. The patients we talked with told us they were provided with a daily menu that offered sufficient choice. Others we talked with told us their individual dietary preferences were met by ‘very accommodating’ staff. There were ample breastfeeding information leaflets available. This included expressing techniques, contact details for local support groups and personal support. This included one to one teaching and support from lactation specialists. Patients we talked to told us they received support to breastfeed from the unit staff. However, during the inspection, we were aware that the only fridge to store breast milk had been decommissioned. This meant that patients did not have suitable storage for breast milk. There was no dedicated breast-feeding room which meant that patients had to feed their babies by their bedside in the ward area.

The unit had implemented an independent fluid monitoring system following feedback from patients. A receptacle and weighing scales was readily available to patients to do so. This meant that fluid output monitoring was undertaken regularly and accurately recorded by patients.

Women were given advice on healthy eating in their maternity notes along with risks associated with weight gain and diabetes.

The unit did not have Baby Friendly Initiative (BFI) accreditation but were keen to work towards this. The UNICEF UK Baby Friendly Initiative was launched in the United Kingdom in 1995 to work with the NHS to ensure a high standard of care for pregnant women and breastfeeding mothers and babies in hospitals and community health settings.

**Pain relief**

Patients had their individual pain needs assessed and managed in line with best practice guidance. Appropriate analgesia was prescribed and administered.
We were told by patients they were provided with the medication if and when they needed it. The medication chart we viewed had as required medication analgesia prescribed for use. This meant that medication could be dispensed to patients without delay.

A birthing pool was available to those who wished to use emersion as a form of pain relief in labour.

The National Institute for Health and Care Excellence clinical guideline 190 states patients require access to a range of pain relief. The unit provided Entonox (gas and air) and Pethidine (a morphine-based injection) for medical pain relief during labour. Epidurals were also available. Data we reviewed showed that 98% of patients who had an elective caesarean section were given an epidural/spinal pain relief and 2% had a general anaesthetic. It also showed that 86% of emergency caesarean section had an epidural/spinal pain relief and 9% of this patient group had a general anaesthetic. We were told by staff that epidurals were provided within 30 minutes of the request. We asked the trust to provide additional data to evidence this and it was not submitted. At our last inspection, we noted the trust did not monitor the average waiting times for epidurals. The Association of Anaesthetists of Great Britain & Ireland states the time from the anaesthetists being informed that a woman has requested an epidural to the time the epidural is performed should not exceed 30 minutes and should only exceed an hour in exceptional circumstances. This meant that despite indenting this at our last inspection, no action was taken to monitor the timeliness of epidural medications and therefore the department had no way of assessing if it was compliance with the standard.

**Patient outcomes**

**National Neonatal Audit Programme**

**William Harvey Hospital**

In the 2017 National Neonatal Audit, based on data for January 2016 to December 2016, William Harvey Hospital performance was as follows:

**Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 114 eligible mothers identified for inclusion in this audit measure, 87.8% of which were given a complete or incomplete course of antenatal steroids. This was within the expected range nationally and better than the national aspirational standard of 85%.

**Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

There were 36 babies identified for inclusion in this audit measure, 22.2% of which were given magnesium sulphate in the 24 hours prior to delivery. This was in the middle 50% when compared to other trusts nationally.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

**Standardised Caesarean section rates and modes of delivery**

From October 2017 to September 2017 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections were as expected and rates for emergency sections was also as expected.
Standardised caesarean section rates

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>East Kent Hospitals University NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.2%</td>
<td>787</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.5%</td>
<td>1,159</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>27.7%</td>
<td>1,946</td>
</tr>
</tbody>
</table>

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Source: Hospital Episode Statistics October 2016 to September 2017
Note: Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from October 2016 to September 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>East Kent Hospitals University NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,946</td>
<td>29.3%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>690</td>
<td>10.4%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,997</td>
<td>60.2%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>12</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>6,645</td>
<td>100%</td>
</tr>
</tbody>
</table>

¹Includes elective and emergency caesareans
²Includes forceps and ventouse (vacuum) deliveries
³Includes breech and normal (non-assisted) deliveries

Notes: To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with “***” (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, an additional number (generally the next smallest) has also been suppressed.

However, during the inspection we reviewed the most recent caesarean section rate and found
them to be 30%. This was worse than the England average. The trust provided the most recent audit and action plan which demonstrate this risk had been identified and was being managed effectively.

Normal (non-assisted) delivery rates were about the same as the England average. 

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

**Maternity active outlier alerts**

As of April 2018, the trust reported no active maternity outliers. 

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

**Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)**

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.3. This was fractionally below the comparator group.

(Source: MBRRACE UK)

**Competent staff**

Patients were cared for by staff who received training to ensure they were able to competently meet their individual care needs.

The Faculty of Multi-professional Learning had aligned the teaching programme to the service incident reporting tool, risk register and staff need. This unique approach to providing training meant that the unit was actively addressing clinical risk, preventing recurrence and ensuring all staff had the competency they needed to carry out their roles in line with national guidance and best practice guidelines.

We saw professional registrations were monitored and reviewed by the department. This meant all staff held the necessary qualification from a national body to be able to undertake their rolls.

The Faculty of Multi-professional Learning in maternity provided a five day mandatory programme for all staff. These included modules on foetal monitoring, essential life support skills in obstetrics, simulation – divided by main place of work (out of hospital or in hospital), a maternity update day and human factors. Human factors can be described as is the study of the interrelationship between humans, the tools and equipment they use in the workplace, and the environment in which they work. The training was specifically designed to have both discrete learning objectives on the individual courses, but also thematic objectives which cut across all five training days. The faculty believed that this approach helped to achieve the ambition of ‘Learning together to work better together’. There are now forty human factors trainers in the trust who are midwives, support workers, obstetricians, theatre staff, anaesthetic staff, neonatal nurses, neonatologists, emergency department and ambulance service. This is the largest number of human factor trainers from any provider in the UK.

The department had changed its approach to foetal monitoring training after some concerns were identified. Training is now provided face to face rather than via an online training tool. This approach was modelled on training used in a London trust where some of the lowest perinatal and maternal morbidity and mortality rates in the Western world international literature. This was in line
with the latest Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) report and Each Baby Counts which found that had physiological interpretation been used the outcome would have been different in 80% of cases expertly reviewed. Each Baby Counts is the Royal College of Obstetricians and Gynaecologist’s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

Essential life support (ELSO) and simulation training in obstetrics was also provided to staff. Topics included; Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE), Each baby counts, Management of major obstetric haemorrhage and maternal collapse, vaginal breech delivery, shoulder dystocia, Neonatal collapse. This training was delivered by an external international organisation (Advanced Life Support in Obstetrics). This course concluded with an assessment of each individual clinician’s competency to undertake these skills. The trust is the only maternity unit in England to have undertaken this quality assurance process.

A number of staff who had undertaken assessment had been selected independently by Advanced Life Support in Obstetrics (UK) as being outstanding. These staff were planning to undertake the instructors course to ensure the department can continue to deliver quality assured, standardised in house skills training.

The trust provided an in house simulation programme delivered in two streams depending on the clinician’s main place of work – ‘In hospital’ and ‘Out of hospital.’ In hospital training included staff from: delivery suite and midwifery led unit midwives; support workers; obstetricians; obstetric trainees; theatre staff; anaesthetic staff; neonatal nurses; neonatologists; and emergency department staff. The out of hospital simulation course had been built in collaboration with the local ambulance trust. This ensured community midwives and support workers, paramedics and ambulance technicians learnt together.

The faculty also provided a multi professional maternity update day. The focus of this day was to engage staff with changes in the service and floating topics related to activity within risk. Topics covered included diabetic care (as this was identified as significant by risk governance), stillbirth reduction, Obstetric Anal Sphincter Injury (OASIs) /PEACHES/Episcissors training, Adult and child safeguarding.

The period of preceptorship for new staff was recently increased to 18 months. This meant that new staff were supported for longer to ensure they were confident and competent to undertake their role.

We were told all temporary staff had an induction before they commenced working in the department. We were shown a blank induction record which was used to record various aspects of the induction. However, staff were not able to provide us with evidence of completed records to demonstrate staff had the induction as outlined in trust policy. This meant that we were not provided with appropriate assurance that temporary staff were provided with a suitable induction to the clinical area and trust policy and procedures prior to starting work.

**Appraisal rates**

From April 2017 to December 2017, 82% of staff within maternity at the trust had received an appraisal compared to a trust target of 85%.

*(Source: Routine Provider Information Request (RPIR) P43 Appraisals)*
The staff we talked with told us they had an annual appraisal and valued the appraisal process. However, data from the last staff survey showed only 30% of staff had the organisational values definitely discussed, 67% had their training, learning or development needs identified and only 42% reported their training, learning or development needs had been identified. We reviewed data received from the Faculty of Multi-professional Learning that showed there was a significant improvement to how training was delivered, staff uptake, and satisfaction levels.

**Multidisciplinary working**

The care and treatment delivered was the service had a multidisciplinary focus.

Patients we talked with provided examples of how their care needs were met by the multidisciplinary team. Examples included access to various specialists midwives, consultants, registrars, mental health professionals and psychologists.

Records we viewed showed a multi-disciplinary approach to patients care. Conversations we had during the inspection told us they had access to a range of professionals who helped them make informed decisions about the care they received.

We saw evidence the service was working with a local ambulance trust to ensure a holistic and more streamlined service to patients.

The electronic safeguarding database we reviewed also demonstrated a multidisciplinary approach to patient management.

**Seven-day services**

The maternity service at the William Harvey provided a service seven days a week, twenty four hours a day. The service was supported by consultant obstetricians seven days a week from 8am to 6pm. Outside of these hours, there was an on call system to ensure consultant cover.

The day care unit was open seven days a week with opening hours Monday to Friday from 8am to 8pm and 8am to 4pm on weekends. Patients were provided with contact telephone numbers for the maternity and labour ward for additional advice and support.

There was a dedicated obstetric theatre that offered 24-hour caesarean sections and a second theatre available during busy times which were supported by a consultant anaesthetists and operating department practitioners.

Foetal anomaly screening was available Monday to Friday and routine ultrasounds examinations were available on the day assessment units at all times. Out of hours this service was available on Folkstone ward.

The day care unit was open from 8am to 8pm, seven days a week. The early pregnancy unit was open from 7:30am to 2pm Monday to Friday, Saturday and Sundays.

The hospital pharmacy was open seven days a week from 8am to 5pm weekdays and 8:30am to 1pm at weekends. Outside these hours, staff contacted the hospital co-ordinator who sourced required medications. Staff advised us this was a responsive service

Obstetricians provided cover on the delivery suite seven days a week from 8am to 6pm.

**Health promotion**

Staff in the department had compiled information leaflets for patients in different languages which provided health promotion advice. For example, but not limited to, information on third or fourth
degree tears, preventing a blood clot whilst in hospital, when your waters break, babies with suspected infection, vitamin K for new born babies, induction of labour and postnatal depression.

The smart phone application which was about to be rolled out had a library of verified health promotion information, contact numbers and support services details.

Support and advice for mothers to assist them stop smoking was provided in accordance with National Institute for Health and Care Excellence clinical guideline 26, ‘smoking: stopping in pregnancy and after childbirth.

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

There were policies that reflected national guidance and provided sufficient information to staff to ensure they managed any capacity, consent and deprivation of liberty concerns.

Data provided showed us 113 out of 128 nursing and midwifery staff on had received capacity training. This was a compliance rate of 88% which was better than the trust target of 85%.

Staff we talked with showed a varied understanding of mental capacity and deprivation of liberty safeguards. This meant that not all staff were aware of their individual responsibilities. This was also identified at our last inspection. However, we were provided with one example where a staff member identified a capacity concerns and raised it immediately with the matron.

The medical record we viewed demonstrated patients who opted for a caesarean section had their consent recorded prior to the procedure.

There was a consent policy that reflected national guidance and staff applied it in practice. The patients we talked with told us staff obtained their consent before any clinical intervention. However, consent to care was not always recorded in the medical records. This meant the department was missing an opportunity to record patient consent in line with best practice and national guidance.

**Is the service caring?**

**Compassionate care**

We observed staff treat patients and their loved ones with dignity and respect. Interactions we witnessed were kind, caring and attentive to peoples’ individual preferences and care needs. We were told about one patient who went into labour and their partner was unable to attend the birth due to a lack of childcare. The lead nurse stayed with the patient and accompanied her to theatres for a caesarean section to ensure she was supported throughout the birth.

The patients we talked with during the inspection were very complimentary about the care and attention they recovered whilst using the service. Comments included “I feel very safe here and I am happy my baby is in good hands”, “They spent a lot of time explaining things to me, the care is truly individual” and ‘the midwives have been brilliant’.

We saw staff pulling curtains around the beds before providing care. This meant that staff took patients privacy and dignity into account.

We observed staff taking the time to interact with patients in a kind, professional and caring way. The patients we talked with also confirmed that this was the case.

We also reviewed the comments on NHS choices website. The majority of the comments left within the inspection time frame were positive. Examples of the comments “all the staff on the labour ward were fantastic”, “the care and support I received form the midwives and doctors was
amazing” and excellent midwives”. When a negative comment was made, the trust had taken the
time to respond to acknowledge the feedback and encourage direct contact with the department
so the concerns could be reviewed.

Friends and Family test performance

Friends and family test performance (antenatal), East Kent Hospitals University NHS
Foundation Trust

From January 2017 to January 2018, the trust’s maternity Friends and Family Test (antenatal)
performance (% recommended) was generally similar to the England average. The zero reports
in October and January will be due to not enough respondents for the survey.

Friends and family test performance (birth), East Kent Hospitals University NHS
Foundation Trust

From January 2017 to January 2018, the trust’s maternity Friends and Family Test (birth)
performance (% recommended) was similar to the England average. As of January 2018, the
trust performance for birth was 97%.

Friends and family test performance (postnatal ward), East Kent Hospitals University NHS
Foundation Trust

From January 2017 to January 2018, the trust’s maternity Friends and Family Test (postnatal
ward) performance (% recommended) was similar to the England average. The performance as
of January 2018 was 95%
From December 2016 to August 2017, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of maternity services 2015

The trust performed similar to other trusts for 14 out of 16 and worse than other trusts for two in questions in the CQC maternity survey 2017.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given</td>
<td>About the same</td>
<td>8.59</td>
</tr>
<tr>
<td></td>
<td>appropriate advice and support when you contacted a midwife or the hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position</td>
<td>About the same</td>
<td>8.44</td>
</tr>
<tr>
<td></td>
<td>that made you most comfortable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care</td>
<td>About the same</td>
<td>9.44</td>
</tr>
<tr>
<td></td>
<td>during labour and birth, were they able to be involved as much as they</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>wanted?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest</td>
<td>About the same</td>
<td>9.26</td>
</tr>
<tr>
<td></td>
<td>or tummy) with your baby shortly after the birth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff during labour and</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.09</td>
</tr>
<tr>
<td>birth</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or</td>
<td>About the same</td>
<td>7.34</td>
</tr>
<tr>
<td></td>
<td>doctors at a time when it worried you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it</td>
<td>About the same</td>
<td>7.71</td>
</tr>
<tr>
<td></td>
<td>was taken seriously?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to</td>
<td>About the same</td>
<td>9.31</td>
</tr>
<tr>
<td></td>
<td>in a way you could understand?</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>If attention was needed during labour and birth, did a member of staff</td>
<td>Worse than</td>
<td>8.2</td>
</tr>
<tr>
<td></td>
<td>helped you within a reasonable amount of time</td>
<td>other trusts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved</td>
<td>About the same</td>
<td>8.30</td>
</tr>
<tr>
<td></td>
<td>enough in decisions about your care?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with</td>
<td>About the same</td>
<td>9.12</td>
</tr>
<tr>
<td></td>
<td>respect and dignity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you?</td>
<td>About the same</td>
<td>8.56</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>7.74</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>7.12</td>
<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>Worse than other trusts</td>
<td>8.08</td>
<td></td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same</td>
<td>8.24</td>
<td></td>
</tr>
</tbody>
</table>

The trust performed worse than other trusts for the questions “Thinking about your stay in hospital, how clean was the hospital room or ward you were in?” and “If attention was needed during labour and birth, did a member of staff helped you within a reasonable amount of time?”.

(Source: CQC Survey of Women’s Experiences of Maternity Services 2015

**Emotional support**

In the first instance patients were supported emotionally by clinical staff. However, there was other specialist support available to those who needed it. For example, this included but was not restricted to, referrals to psychologists, perinatal mental health midwives and breastfeeding specialists.

The trust had bereavement midwives who provided support to mothers and their loved ones following a still birth or neonatal birth. These midwives ensured mothers were provided with all the support outlined in the Stillbirth and Neonatal Death guidelines. Chaplaincy services were available for additional pastoral support.

Patients undergoing medical termination of pregnancy were offered support and counselling before and after the procedure. A total of 31 patients had this procedure during the inspection timeframe.

The service provided a ‘birth after thoughts’ conversations to those who required additional support. This was a practice where the patients talked through their experience and reflected on what went well and required improvement. These experiences were also fed back to staff.

**Understanding and involvement of patients and those close to them**

The patients told us that they were involved and consulted when planning all aspects of their care. They felt listened to and told us they had ample time to ask questions, as well as being provided with the right level of written information.

Clinical staff took the time to introduce themselves to the patients and explain their roles and responsibilities.

Patient involvement was also evidenced in the medical record review we completed and was observed by inspectors during the inspection. Staff were able to demonstrate to inspectors how best to support patients and their loved ones to be involved in their care. This meant that patients understood the treatment they were to receive and the risks associated with this in line with National Institute of Clinical Excellence Quality Standard 15 statement 5.
Is the service responsive?

Service delivery to meet the needs of local people

We saw services were delivered in a way that focused on people’s needs and individual preferences. For example, the service provided 24 hour triage services between 8am and 8pm. Outside of these hours calls were routed to the labour ward. Women who presented to the service were reviewed and triaged on the ward.

The service had identified a high level of mothers who continued to smoke whilst pregnant. The service had a smoking cessation midwife who provided support and education to improve the outcomes for these women.

Bed Occupancy

From quarter 2 of 2016/17 to quarter 3 of 2017/18 the bed occupancy levels for maternity were generally lower than the England average, with the trust having 57% occupancy in quarter 3 2017/18 compared to the England average of 58%.

Bed occupancy rates were higher than the England average for quarter 2 and 3 2016/17. Occupancy rates were lower than the England average for the following three quarters up to quarter 2 2017/18. During quarter 3 2017/18 bed occupancy rates were slightly lower than the England average.

The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)
Meeting people’s individual needs

The service had staff with specialist roles that provided additional support and information to staff and patients who used the service. Examples of these specialists include perinatal mental health, diabetes, learning disabilities and breastfeeding.

The trust website had a series of information links and videos available for pregnant mothers called ‘The Journey- pregnancy, labour and beyond’. This footage provided important information for newly expectant mothers.

The service had secured funding to develop a smart phone Maternity Application which provided mothers with verified information throughout their pregnancy. The application (which was being supported by NHS Digital) was about to be rolled out formally in June, contained many useful features. Some of the functions included mood monitoring, electronic records, service feedback function, access to health information from reliable national sources in line with current best practice guidance and emergency contact numbers. This meant that mothers had access to their medical records at all times and was readily available to many healthcare professionals throughout pregnancy or in the event of an emergency. The development team incorporated a maternal mood check which flashed three faces for the mum to click on the one that best described their mood. Data from this function was used to identify mothers whose low mood may indicate additional support was required to keep mothers well. Mothers with a persistent low mood were referred to the perinatal mental health midwife for a review. The long term outcome for mothers with postnatal depression is heavily reliant on the provision of early intervention. The application also had a function to gather feedback from service users. This application was being considered for adaptation to the NHS digital platform and rolled out nationally.

The department provided a suitable environment for patients who had suffered a bereavement. The room had been recently re-decorated with funding raised by the unit staff. This had resulted in an appropriate space for mothers and their loved ones. Cold cots were available in line with national best practice guidance. A cold cot can be defined as a cot, which looks like a conventional Moses basket, is a cooling unit that allows families to spend extra time with their baby, by regulating its temperature. However, the location of the room was not ideal as it was on the main ward area where the bereaved mum could hear the cries of, and see other babies.

Interpreting services were available to those who required the service. It could be booked in advance of clinical appointments. The service was able to provide access to information in different languages. Multilingual staff who worked in the service were also available to provide additional support if and when needed in an emergency.

Folkestone ward had a bathroom with disabled facilities that were not fit for purpose. The shower tray was raised and the bath was inaccessible. There was no hoist in this clinical area. This meant that the service was not meeting the needs of patients who had reduced mobility.

There are two perinatal mental health midwives working trust wide across sites supporting staff and offered support to women with mental health issues during their pregnancy.

The staff had undertaken a project to ensure they could provide condition specific information in different languages for mothers where English was not their first language.
**Access and flow**

At our last inspection, delayed discharges were noted as a concern. At this inspection, the service had introduced a discharge coordinator. Each discharge had a comprehensive check list undertaken to ensure a standard approach to checks, and provision of information. This role had improved the efficiency and quality of unit discharges. The feedback we received indicated the speed of the discharges had increased and the patients had a more coordinated and standardised approach to the process.

This meant that patients were not subjected to undue delays and were provided with all the discharge information required for a successful transition between hospital and community care.

The service provided a 24 hour triage service. The Midwife led until provided the service between 8am and 8pm each day. Outside of this time, the labour ward provided the service.

Generally bed capacity was better than the England average. This meant that the service could meet the needs of patients who required a hospital birth.

**Learning from complaints and concerns**

**Summary of complaints**

The service handled complaints in line with trust policy and used feedback to improve the services delivered.

There was a trust complaints policy which reflected best practice guidelines and was readily available to staff. Staff we talked to knew how the trust complaints process worked and demonstrated the competence to assist any patients who wished to make a comment or raise a concern. It was clear from all the conversations with staff that the department put a great emphasis on the importance of local complaint resolution.

We requested the trust send us data on the number of complaints received and the timeliness of the department responses. The information was provided at Trust level.

The trust received 45 complaints regarding obstetrics from May 2017 to April 2018.

Out of the 45 complaints, five are still under investigations and 37 of the 40 complaints were completed within the trust target of 93%.

**Maternity Complaints by Sub-subject (primary) grouped by Subject (primary)**

<table>
<thead>
<tr>
<th>Subject (primary)</th>
<th>Sub-subject (primary)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attitude</strong></td>
<td>4</td>
</tr>
<tr>
<td>Problems with nurse’s attitude</td>
<td>4</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>3</td>
</tr>
<tr>
<td>Misleading or contradictory information given</td>
<td>1</td>
</tr>
<tr>
<td>Other communication issues (i.e. old literature, phones not working)</td>
<td>1</td>
</tr>
<tr>
<td>Nursing communication issues</td>
<td>1</td>
</tr>
</tbody>
</table>
At the inspection the senior leadership told us they on average received two complaints a month and this was reducing. Previous themes and trends included poor staff communication, attitude and behaviour. However, we were told that this trend had ceased which they hoped reflected a happier work force. This meant that departmental complaints were being reviewed to identify trends and themes across the service.

We saw meeting minutes which demonstrated complaints were a standing item on the governance and team meeting agenda. This meant that complaints were discussed with the teams and used to improve the patient experience and service delivered.

The trust website provided relevant information to patients should they wish to make a comment or raise concerns about the service. We saw information leaflets readily available to patients that provided key information and contact details to make a complaint. This meant that the service was providing all the necessary information to support patients to raise concerns.

Is the service well-led?

Leadership

There was a triumvirate leadership structure in the department. A triumvirate is a group of three people who share power. We noted a significant turnover of personnel from the management team since our last inspection. This had resulted in a long period of instability, poor oversight, and governance systems and processes that were not consistently applied. However, the leadership at this inspection presented themselves as a cohesive, insightful and proactive team. They showed insight into the previous failings, and told us the actions being taken to bridge the historical leadership gaps. The team were proud of the changes that had been implemented in their short time of taking post provided evidence to show the improvements made to date. For example, the changes to culture and staff wellbeing, the introduction of a discharge coordinator and the newly appointed risk midwife. The senior team provided a realistic and optimistic vision for the service over the next 12 months.

Staff described the leadership team as ‘visible’, ‘transparent and fair’. Staff told us they felt valued and trusted their new leadership team. “They will always roll their sleeves us” was a repeated
comment made by staff during the inspection. An example of this included the team providing clinical cover and working with staff during a period of high sickness or absence during winter. Staff also told us the new leadership team were approachable and had ‘transformed the feeling’ of the service.

During the inspection we held interviews with the senior leadership team. We found they had a shared vision and an enthusiastic commitment to their patients, their team and the wider trust. They felt well supported by the new Head of Midwifery and were complimentary about the support and links to the senior executive team.

The leadership team and wider department benefited enormously from the strong relationship, and evidence based, multidisciplinary approach of the Faculty of Multi-professional Learning. The education programme was at the heart of service improvement and seen as an integral driver to driving the changes needed to ensure a better service for patients. It was also seen as a key driver in the culture change, in terms of transparent, blameless and making the department a supportive work place. An example of this was a staff member being sent a letter of commendation for their candid approach to reporting an incident.

**Vision and strategy**

There was an appropriate vision and strategy for the service. Staff were committed to the department and its direction of travel. The strategy was referred to as ‘BESTT’- Birthing Excellence Success Through Teamwork. It incorporated the ‘Better Births’ report of the National Maternity Review which set a clear vision: for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where woman have access to information to enable decision making about care; where mother and baby can access support centred on individual needs and circumstances. The effectiveness and impact of these values was being monitored. However, it was too early for the inspection to comment on the progress made to date.

In May 2017 the trust launched its Maternity Transformation Programme. The focus areas for the programme were drawn directly from the Department of Health’s Safer Maternity Care action plan and then localised to address collaboratively agreed areas for improvement and innovation across the maternity services. This included a focus on leadership, learning and best practice, teams, data and innovation.

**Culture**

At out last inspection we identified several concerns relating to the culture in the department. At this inspection, we noted a significant and positive improvement.

Staff felt the many recent elements of change have been very positive and was driving a major culture shift. Examples of the contributing factors included the new ‘hands on’ and ‘approachable’ senior leadership team, work undertaken by the Faculty of Multi-professional Learning which was providing a multidisciplinary approach to education which inadvertently had a positive effect on the wider team dynamics.

Staff told us engagement had also improved. Staff were proud of the work they undertook and were loyal to the strategic direction the department was traveling in. They told us things were much better under the leadership of the current team. Staff told us the team were ‘leading by example and being ‘fair’.
Governance

The governance structure consisted of three sub-meetings (Professional Midwifery Advocate, Obstetric Guidelines Group, and the Gynaecology Guidelines group) which reported to the speciality governance meetings, i.e. the Women’s Health and Clinical Governance Group. The Women’s Health and Clinical Governance Group reported directly to the divisional Board. The Women’s Health Morbidity and Mortality, Clinical Audit, VTE, safeguarding children, CQC improvement lead, NATSIPPS and Health and Safety leads also reported directly to the divisional board. This board reported directly to the executive team.

It was clear was the new systems and processes that were being developed were much improved, but not yet fully embedded. A change in culture amongst all staff at all levels appeared to be the key to successful governance in the department. We received mixed feedback on the current confidence levels in the governance process. However, we were continuously told that the new systems and processes were much improved and would with time, prove be effective.

Changes to the way the department reviewed mortality and morbidity had improved. There was clear guidance for attendance, frequency, risk register review, learning and sharing, and cases were subject to external review to ensure quality. A structured mortality review tool had been introduced to ensure consistency. The ethos of these meetings was ‘review once, review well’.

We requested the departmental governance meeting minutes. There was a standardised agenda which was laid out in line with the CQC Key Lines of Enquiry. We reviewed these and found them they contained a sufficient level of detail to demonstrate the process and risks in the service.

Audit systems and processes were not embedded in practice and staff did not yet recognise the value of quality assurance processes. There was poor compliance with the World Health Organisation surgical check list. There was no evidence that any actions had been taken to address the concern to ensure patients were protected from the risk.

We asked the trust to provide evidence to demonstrate how key performance indicators were monitored and any actions taken to address poor performance. The trust provided evidence of a ‘clinical dashboard’ which was reviewed monthly at the divisional performance meeting and bi-monthly CCG performance meetings. However, data on the dashboard indicated concerns with key areas such as elective and emergency caesarean rates, Venous thromboembolism assessments. These appeared to be outside of the expected range for a prolonged period. This meant that we were not provided with assurance that poor clinical performance with key performance indicators was being managed effectively in a timely manner.

We also identified infection control concerns with the bathroom facilities in the maternity unit. The staff were able to evidence the actions they took to have the concerns addressed. However, there was little evidence that these concerns were addressed until the first day of our inspection.

Management of risk, issues and performance

Management of risk, issues and performance required further development to ensure standards were consistent and clinical outcomes were continuously monitored and improved.

There were infective processes to assess, monitor, and improve the quality and safety of the service. We identified a high caesarean section rate which the service did not swiftly address. This meant this particular risk had not been addressed in a timely manner and patient outcomes may have been affected.
However, risk management and quality measurements systems was found to be much improved at this inspection. It is important to note these improved processes needed further time to mature and become embedded in practice before we could assess their effectiveness.

The department used a Red/Amber/Green (RAG) rated risk register. The RAG system is a widely used method of rating for issues or status reports, based on colours used in a traffic light rating system.

The leadership team told us staff had a better understanding of the risks in the service and were more proactive in reporting and raising concerns. They told us they were confident they had a good understanding, oversight and much improved processes to manage and escalate the risks in the department.

**Information management**

Staff had access to the intranet and all the relevant policies and procedures to deliver care. Records were part electronic and part paper. Records were kept confidentially and stored appropriately and in line with regulation 17 of the Health and Social Care Act.

**Engagement**

Staff engagement had greatly improved since our last inspection. Staff reported feeling more involved and having their opinions and experience valued and respected. Staff told us the use of social medical platforms had improved the effectiveness of team communication.

In recognition that not all staff will like or use social media the team had launched a short and snappy monthly newsletter called the ‘Shout out for maternity.’ This had five main themes: risk learning, knowing how we are doing data, news, updates from Birthing Excellence Success Through Teamwork (BESTT) and the department feature topic.

The trust and also provided ‘good job’ post cards for patients and their loved ones to easily provide direct feedback about their experiences and the quality of the service.

Engagement with the public had also greatly improved since our last inspection. We were provided with evidence that showed how the service had taken a unique, transparent and bold approach to keeping the public informed on developments in the service. This included sharing information where things had not gone as well as planned as well as celebrating the success on the unit. All the information was used sensitively and in line with Regulation 17 of the Health and Social Care Act 2008. The public had welcomed this new innovate approach and received very positive comments from the local community.

On international Midwifes day the staff in the service were commented on publicly by a substantial amount of past and current local service users. A social medical page was set up for mums and their loved ones that encorced on line feedback about the service and overwhelming praise for staff and the quality of care received. Staff told us this them feel proud and much valued by their local community. They were also very pleased to see patients recommending the service to others.

The service was actively encouraging service users to provide feedback and using it to improve the patients experience.

The senior leadership team acknowledged they would like to improve their survey response rate. They felt confident the new smart phone application which was about to be launched would have a significant impact on response rates.

**Learning, continuous improvement and innovation**
It was notable that the department had made great strides to drive learning, improve patient outcomes and inspire innovation. It is possible the notable change was associated with the collaborative and multidisciplinary team approach between clinical leaders and the team in the maternity faculty. Staff repeatedly told us they felt these changes had a significant impact on their job satisfaction, clinical competency and drive to deliver better care.

The service had secured funding to develop a smart phone Maternity Application which provided mums with information throughout and after their pregnancy. The application (which was about to be rolled out formally in May) contained many useful features. Some of the functions included mood monitoring, electronic records, service feedback function, access to health information from reliable national sources in line with current best practice guidance and emergency contact numbers which were also presented in other languages for non-English speaking mothers.

The unit had taken a unique and ambitious approach to education. Examples of this include aligning the educational agenda to the top 10 clinical risks, incident reporting system, maternity emergency’s and the needs of the team. Examples of the training delivered include external assessment of all staff's competency to deal with medical emergencies.

The department had top of the range simulators and a simulation suite which staff had worked hard to fundraise for. This suite provided an opportunity for staff to experience in hospital and out of hospital emergencies. A new simulator had arrived during the inspection that was capable of simulating real birthing situations and could be taken into the clinical areas. This was to ensure that staff could experience simulated emergencies in the clinical setting for the next phase of training development.

The staff in the department were commendable fundraisers and went above and beyond on several occasions to ensure the department could access additional resources. Examples of this included the refurbishment of the bereavement room, acquiring a new kitchen fittings and fixtures, new fridges and living room furniture for the proposed staff room.

There were 40 human factors trainers in the trust who are midwives, support workers, obstetricians, theatre staff, anaesthetic staff, neonatal nurses, neonatologists, Emergency department and ambulance service. This was the largest number of human factor trainers from any provider in the UK. Audit programme had been established to measure the impact this training had on the quality and safety of care delivered.

Essential life support and simulation training in obstetrics was also provided to staff. This course concluded with an assessment of each individual clinician’s competency to undertake essential skills.
End of life care

Facts and data about this service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 2,685 deaths from December 2016 to November 2017.

(Source: Hospital Episode Statistics)

The Palliative care team delivers a face to face visiting service five days per week from 9am to 5pm Monday to Friday. Out of hours and at weekends, a telephone advisory service is available from the local hospice to support the wards.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

The palliative care team consisted of a palliative care nurse consultant and a palliative care social worker across the three hospital sites within the trust. There were two whole time equivalent clinical nurse specialists based at William Harvey Hospital and one whole time equivalent end of life care facilitator. Consultant in palliative medicine cover was provided by the local hospice for two clinical sessions a week at William Harvey Hospital.

There had been 559 referrals to the specialist palliative care team based at William Harvey hospital in the 12 months preceding our inspection. Of those 559 referrals 59% were for those patients with a diagnosis of cancer, 39% for those with a non-cancer diagnosis and the remaining 2% for were patients with both a cancer and non-cancer diagnosis. Examples of non-cancer diagnoses included sepsis, respiratory disease, heart failure and stroke.

During our inspection we visited a range of clinical areas such as the emergency department, intensive therapy unit, critical care, and wards including; care of the elderly; surgical and medical wards. We also visited the bereavement office, the chapel and the mortuary.

We met with 31 staff including; the palliative care nurse consultant; palliative care nurses; a care of the dying nurse; chaplaincy staff; bereavement staff; a mortuary manager, technicians and clinical lead; allied health professionals; matrons; ward managers; end of life care link nurses and healthcare assistants; registered nurses; consultants and junior doctors; healthcare assistants; and, porters.

We spoke with two patients and two relatives. We reviewed 15 patient records including; 10 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions; two medication records and three care records.

Is the service safe?

Mandatory training

Palliative care staff told us they completed mandatory training such as infection control, fire safety and information governance. The palliative care nurse consultant told us that all staff working within the team were up to date on their mandatory training, however we were not provided with a breakdown of this.
End of life care was mandatory as a one-time training for all staff new to the trust. This included an introduction to the ‘care of the dying patient and their family’ documentation. The end of life care facilitators planned, organised and delivered the training and there were monthly sessions held. However, there were no mandatory updates available for staff to attend, with staff having to access additional training through the end of life care link worker programme or via the link workers on the wards.

Link staff undertook additional mandatory training to provide support to other ward staff in delivering end of life care. This included an initial ‘dying in hospitals’ course and additional training on the use of the end of life care documentation and symptom control. However, while 73% of link staff had attended the ‘dying in hospitals course’, only 30% had a record of attending training in the use of the end of life care documentation and only 19% had received training in symptom control. Of the 19% who had received training in symptom control, less than half had completed all five symptom control modules. This meant that staff responsible for training other staff within the hospital had not always attended the relevant training themselves.

**Safeguarding**

Palliative care staff told us they completed safeguarding training for both adults and children. The palliative care nurse consultant told us that all staff working within the team were up to date on their safeguarding training, however we were not provided with a breakdown of this.

Staff we spoke with were aware of their responsibilities relating to safeguarding. We observed staff discussing the care of a patient who was identified as a vulnerable adult and saw that there was a focus on safeguarding involved in those discussions.

**Cleanliness, infection control and hygiene**

There were infection control and prevention systems in place to keep patients safe. The hospital in-patient areas we visited were clean. There were sufficient hand wash basins, liquid soap, paper towels, hand gels and protective equipment available. We observed staff following hand hygiene procedures and using hand gels and the protective equipment available. Staff were ‘bare below the elbows’ at all times to enable effective hand washing and minimise the risk of contamination. We observed staff following NICE QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

Infection control procedures in the mortuary were followed, for example, there was infection control guidance visible within the department and staff were able to describe the precautions they took to minimise the risk of infection. This included guidance on the categorisation of infection risks and the procedures taken to minimise risk, for example, through the use of body bags. Porters told us they had received training in infection control as part of their role in transporting the deceased.

**Environment and equipment**

The Trust had a policy for the management of medical devices that applied the MHRA Managing Medical Devices guidance (April 2014). Quality assurance was provided through monthly medical devices group meetings and we were told that compliance for maintenance of the medical devices had risen from 69% to 84% with an improvement target of 92%.

Staff told us that syringe drivers were maintained in line with guidance as part of an equipment log and that access to syringe drivers was straightforward with availability when needed. For example,
one ward sister told us they kept a syringe driver on the ward at all times and that the rest were stored in the equipment library and easily accessible. None of the clinical ward based staff we spoke with reported any concerns about the availability of syringe drivers or issues with maintenance. We saw that stickers on syringe drivers included the date of last maintenance check and the date of the next review. There were monitoring records in place for the use of syringe drivers and four hourly safety checks to ensure that the administration was correct and that the site of the cannula was satisfactory.

We also saw that patients at the end of life were nursed on air flow mattresses when necessary. In addition, staff told us that accessing equipment for patients being discharged on the rapid discharge pathway was straightforward and that equipment was generally available on the same day in the community for these patients.

We were told by mortuary staff that capacity within the mortuary was a concern. The trust had increased their capacity of freezer spaces in response to Human Tissue Authority guidance in relation to long term storage. There were 10 freezer spaces at William Harvey Hospital (WHH) and an additional five at Queen Elizabeth the Queen Mother hospital in Margate (QEQM). In addition, there were 63 fridge spaces, including three bariatric and ten semi-bariatric with an additional 30 spaces at Kent and Canterbury Hospital and 78 at QEQM. We were told that over the winter months temporary storage had been increased by 100 spaces across the trust. This included soft shell storage at WHH where temperature control could be an issue, particularly in the summer months. As a result mortuary staff told us they generally only used these temporary facilities during the winter months when it was cooler.

A business case had been established to install hard shell storage that resulted in better temperature control. In the meantime, we were told that when the temporary storage was in use, staff attended daily to manually monitor the temperatures as this was not connected to the automated system that was in place for the permanent facilities. However, despite the availability of temporary storage staff told us that they had regularly exceeded capacity over the winter, despite arrangements to transfer the deceased between sites. As a result of this we were told that the deceased were doubled up in storage spaces designed for one. Staff told us they had discussed this with the Human Tissue Authority, however this practice was not in line with Human Tissue Authority guidance as stated on their website; ‘Please note that placing more than one body on fridge trays or storing bodies in unrefrigerated areas, are not considered suitable practices’.

**Assessing and responding to patient risk**

Ward staff told us that they had received support from the palliative care nurse specialists and the care of the dying facilitator to improve how they identified patients at the end of life, including identifying patients who were deteriorating. The palliative care team operated a bleep holder system whereby nurse specialists were able to respond quickly to urgent patients need such as poorly controlled symptoms. This included prioritising referrals to the team including e-referrals based on needs and risks. In addition, the end of life care link staff were able to provide ward staff with additional training and support to better manage risks relating to patients at the end of life. Examples of this included providing advice on controlling symptoms commonly experienced at the end of life and ensuring that all aspects of the last days of life assessment and monitoring were carried out to ensure that care was delivered safely.

Specialist staff told us that the weekly palliative care multidisciplinary team meeting provided them an opportunity to review and discuss risks to individual patients. For example, in relation to rapid
discharge home to die in their preferred place of care where risks needed to be evaluated to ensure that patients and those close to them had the support they needed.

The ‘the care for the dying person and their family’ framework included the assessment of risk; for example, we saw that where regular assessments were being carried out on patients on the care of the dying plan, this included assessment of their skin integrity.

Patients at the end of life were subject to routine risk assessments as appropriate, relating to areas such as the risk of falls and pressure damage. We reviewed these risk assessments as part of our review of records and saw that these had been completed and reviewed appropriately.

**Nurse staffing**

The specialist palliative care team was largely formed of nursing staff. This included a nurse consultant who worked across all sites. In addition there were two whole time equivalent palliative care nurse specialists based at William Harvey Hospital and since the end of 2017 a whole time equivalent end of life care nurse facilitator was in post.

**Vacancy rates**

There were currently no vacancies within the specialist palliative care team. On wards within the hospital where end of life care was delivered vacancy rates differed. For example, three of the medical wards had vacancy rates of between 24% and 30% at the time of our inspection which was higher than the trust target of 13%. Surgical wards generally had vacancy rates at a similar rate or below the trust target.

**Turnover rates**

In the period of time between the last CQC inspection in September 2016 and this inspection in May 2018, there had been no turnover of staff in the end of life / palliative care teams.

**Sickness rates**

We requested sickness rates for staff that worked in end of life / palliative care but the trust did not provide this information.

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

**Bank and agency staff usage**

There was no bank or agency staff usage within the palliative care team. Bank and agency usage on the wards was higher in areas where vacancy rates were higher than the trust target, for example, on some of the medical wards.

**Medical staffing**

Consultant in palliative medicine cover was provided by a local hospice for two clinical sessions a week at each hospital site including William Harvey Hospital. In addition, consultants attended the specialist palliative care multi-disciplinary weekly meetings and provided strategic input.

At our previous inspections in July 2015 and September 2016 there was no formally adopted service level agreement (SLA) for palliative care medical input. At our last inspection in September 2016 we were told that an SLA had been drafted and was with the procurement team. We were also told that the trust would use the agreement with the hospice as a baseline and then work out the gaps in the service. However, at this inspection we were told that the SLA was still with the procurement team and had not progressed since our last inspection. This meant that there was no contractual framework for the provision of medical cover. This presented an area of risk for the trust, although the nurse consultant told us they believed that the risk was small as the
informal arrangement had been in place for a number of years and was not on a risk register. The
provision of medical cover was below the Royal College of Physicians (RCP) guidance of one
whole time equivalent consultant per 250 beds.

**Vacancy rates**

As the medical cover for palliative care was provided by the hospice vacancy data was not
collected by the trust.

**Turnover rates**

As the medical cover for palliative care was provided by the hospice turnover rates were not
collected by the trust.

**Sickness rates**

As the medical cover for palliative care was provided by the hospice, data relating to sickness
rates was not collected by the trust.

**Bank and locum staff usage**

Bank and locum medical staff were not used within palliative care.

**Records**

Written referrals to the palliative care team were sent via the electronic patient administration
system. When reviewing patients on the ward the palliative care clinical nurse specialists (CNS’)
recorded their notes on the electronic patient record system and then printed them out to store in
the patient's paper record. They used stickers in the notes to highlight advice given so that this
would stand out and was easily and quickly accessible to ward staff.

The palliative care team used a patient tracking list (PTL) for patients identified as being at the end
of life. This alerted the end of life care facilitator when a patient was commended on the ‘care of
the dying patient and their family’ care plan. The end of life care facilitator told us that when it was
decided that a patient was in the last days of life and agreed that they would commence the plan,
staff stopped monitoring patient’s vital signs. They would record this on the mobile clinical
monitoring system by indicating that vital signs were no longer recorded due to the patient being at
the end of life. However, we were told that sometimes the alert was not raised on the end of life
care PTL because staff had indicated that clinical observations were no longer required rather
than the patient was at the end of life. The palliative care team were prompting staff to complete
the record so that the alert was raised correctly. The patient tracking list stored information that
included the patient’s preferred place of care at the end of life, spiritual support needs and ‘do not
attempt cardiopulmonary resuscitation’ (DNACPR) decisions.

The care needs of patients in the last days and hours of life were assessed using the ‘care of the
dying patient and their family’ care plan. The care plan had been further developed from its original
version in October 2016. The plan included a record of end of life conversations form, an initial
holistic assessment and ongoing daily review. The plan was based on the Leadership Alliance
Five Priorities of Care for the dying patient. Specialist staff told us their focus since the end of life
care facilitator had been in post had been to increase the use of the plan across the trust. We
reviewed audit results from March 2018 that showed the overall use of the plan for patients in the
last days and hours of life across the trust was at 77%. This was an improvement on previous
results. Results for William Harvey Hospital showed that the care plan had been utilised for 53% of
patients at the end of life which was lower than the other hospitals within the trust. This meant that
patients being cared for at the end of life at William Harvey Hospital were less likely to be cared for using the plan.

We reviewed the care records of three patients at the end of life and found that these had been inconsistently completed. For example, one patient had a recorded assessment for commencement of the ‘care of the dying patient and their family’ plan but did not have a record of regular monitoring and comfort rounds that were required to be of a minimum of four hourly. Another patient’s care plan assessment was not fully completed with key questions not answered. In addition, the patient’s condition had improved since a decision to treat an acute infection and we were told a decision had been taken to discontinue the care of the dying plan while monitoring the patient’s response to treatment. However, we found that entries continued to be made in the care of the dying monitoring record. This had the potential to result in confusion for staff about the care being delivered to the patient. A third patient had been identified to commence on the care of the dying plan more than 26 hours before we reviewed their notes but the plan had not yet been commenced. Ward staff told us this was because they were waiting for medical staff to complete the initial assessment. We checked with the end of life care facilitator who told us that they had not yet received an alert for the patient on the PTL, although we subsequently found that the alert had been raised later in the day.

The palliative care team undertook four monthly trust wide audits of care records for patients at the end of life. We reviewed an audit that had been carried out between December 2017 and March 2018. The audit showed that records of end of life care conversations were completed on 85% of patients where the care plan was in use compared with 5% of patients where the care plan was not in use. In 57% of patients where the care plan was in use there was a holistic assessment of their needs recorded compared with 35% of patients where the care plan was not in use. The daily review plan document was completed daily for 63% of patients. An action plan was in place to address the shortfalls in the completion of the care plan record. The action plan included the dissemination of results and raising awareness of the care plan during end of life care training sessions. However, the action plan was not detailed or site specific, for example it did not include specific action at William Harvey Hospital where the use of the plan was lower than other hospitals within the trust.

Specialist palliative care staff we spoke with told us they were aware that the quality of the plans needed to improve and that their focus had been on increasing the use of the plan initially before then focusing on the quality of the record. There was no detailed improvement plan in place specific to William Harvey Hospital.

We viewed a DNACPR audit report dated February 2018 where it had been identified that improvements following regular audits had not been made. As a result, wards and divisions had been tasked with identifying action to make improvements. However, the action plan attached to the audit was blank. This meant that we were unable to identify specific action taken to ensure improvements.

We reviewed 12 DNACPR forms and found that these were generally completed well, with the exception of mental capacity assessments. Forms were kept in the front of patient’s health records, had been appropriately authorised and included a record of discussions with the patient and their family.

**Medicines**

Staff we spoke with told us that medicines for use in end of life care were readily available on the wards and could be accessed in a timely way from the onsite pharmacy. General prescribing guidance was available on the trust intranet in the form of a ‘guidance for patients in the last hours
or days of life’ procedure. This included guidance for the control of symptoms such as pain, restlessness and agitation, respiratory tract secretions, nausea and vomiting and breathlessness. There was a flow diagram in place to guide prescribing staff in a number of areas, including how to convert oral morphine to a 24 hour infusion of morphine. The guidance also provided staff with the contact details of the palliative care team if symptoms persisted.

The palliative care team nurses were not all nurse prescribers, however within the William Harvey team one of the clinical nurse specialists and the end of life care facilitator were both prescribers. The second clinical nurse specialist was working towards their non-medical prescribing qualification. The palliative care nurse consultant told us that the focus of the specialist nurses was to support prescribing in end of life care rather than to undertake the prescribing themselves. We observed the clinical nurse specialist providing this support to a junior doctor on the ward, showing them where to access the guidance and answering their questions about anticipatory prescribing.

We observed a number of patients who had been prescribed end of life care medicines in anticipation of their experiencing symptoms commonly found in patients at the end of life. This meant that staff were able to administer medicines to manage symptoms based on the trust guidance without having to wait for a doctor to prescribe them at the point that the patient was experiencing the symptom.

We reviewed the records of two patients who had been prescribed anticipatory medicines. One was prescribed in line with the trust policy; the other included a dose of levomepromazine (for nausea and vomiting) that was below the dose recommended in the guidance. The clinical nurse specialist ‘CNS’ told us that this was because the trust guidance recommended a starting dose of 6.25mg but that the hospice guidance stated 5mg as a starting dose. Subsequently specialist staff had recommended a starting dose in line with the hospice policy to ensure alignment of prescribing, particularly for those patients likely to be going to the hospice or the community where doses were different. This meant there was a potential for confusion among general medical staff who were relying on trust guidance and advice from the palliative care team in relation to prescribing anticipatory medicines. We spoke to the palliative care nurse consultant about this issue and she told us she had been aware it was an issue but thought it had been resolved.

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 March 2017 to February 2018, the trust reported no incidents classified as never events within end of life care.

Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from March 2017 to February 2018.
Incidents were reported using the electronic incident reporting system. The end of life care staff told us that incidents relating to end of life care were collated and reported to the end of life care board although these were minimal. However, while we saw evidence of complaints being collated and reported we did not see this in relation to incidents in the minutes of meetings. In addition, there was no standing ‘agenda’ items on the end of life care board meeting agenda to discuss incidents as they occur. The palliative care nurse consultant told us that end of life care incidents were minimal and when we requested data of incidents relating to end of life care this was not provided.

During the inspection we became aware that a practice of placing two deceased patients in a fridge space designed for one had been happening during particularly busy periods. Although a risk assessment had been carried out and the matter had been escalated, it had never been reported as an incident. This meant that a formal, electronic, trust wide record of each occurrence was not available.

We were told of an incident where a patient had been prescribed levomepromazine at a psychiatric dose for a patient at the end of life for symptoms of nausea and vomiting. Staff told us that the incident had been addressed and that the specialist nurses had supported medical staff to prescribe in accordance with the anticipatory prescribing guidelines. However, the incident had not been reported using the electronic reporting system and staff told us they had not thought to report it as the error had not caused harm to the patient. This suggests that a culture of reporting incidents in order to identify opportunities for learning in relation to end of life care may not be consistent. This meant that themes may not be identified and opportunities for learning to be shared may be missed.

Is the service effective?

Evidence-based care and treatment

The trust had an understanding of the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 and the foundations for the ambitions, including; personalised care planning; education and training; and, involving, supporting and caring for those important to the dying person.

End of life care was managed across the trust in line with National Institute for Health and Care Excellence (NICE) guidance. For example, there was evidence that the trust had developed services in line with NICE guidance NG31 Care of dying adults in the last days of life. This included aspects of end of life care such as the identification of people at the end of life; assessment, care planning and review; care in the last days of life; and, anticipatory prescribing. In addition, the trust’s ‘care of the dying patient and their family’ care plan was in line with NICE quality standard QS144 Care of dying adults in the last days of life. This included assessing signs and symptoms, individualised care, anticipatory prescribing, and, hydration.

The trust had developed and updated the individual plan for the ‘care for the dying patient and their family’. This plan provided a framework across the trust for all staff, including non-specialist staff caring for patients at the end of life. The plan based on the Five Priorities of Care set out by the Leadership Alliance for Care of Dying People.

We reviewed three care plan records for patients in the last days of life. However, these were not being used consistently. For example, one patient had been identified as needing to commence
the plan more than 24 hours before, however the plan had not been commenced. A second patient remained on the plan, despite a decision several days before that they would continue with treatment and was not at that stage considered to be in the last days of life. In addition a third plan had gaps in completion, specifically around the daily evaluation.

The end of life care leads had explored the use of different evidence-based care and treatment guidance. For example, they told us they had attended training in the use of the AMBER care bundle, to support the early identification of patients in the last year of life. This in part, allows time for patients to make plans for their future care, including care for the last days of life. However, the nurse consultant told us that following a pilot they had opted not to continue with this approach. We were told that a pilot was currently underway for the use of treatment escalation plans (TEP) to identify ceilings of care for patients, led by a consultant within the trust. In addition, the trust had plans to introduce the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process. ReSPECT is a national programme for creating a summary of personalised recommendations for a person’s clinical care in a future emergency in which they do not have capacity to make or express choices. At the time of our inspection some staff we spoke with told us they thought more work needed to be done on recognising patients in the last year of life.

**Nutrition and hydration**

The ‘care of the dying patient and their family’ plan of care included guidance on the assessment of nutrition and hydration with reference and a link to General Medical Council (GMC) end of life care guidance that included the ethical considerations of clinically assisted hydration. In addition, four hourly comfort measures that were recorded in the daily delivery of care record included a prompt for staff to offer fluids and nutrition.

An ‘end of life care plan’ documentation audit carried out between December 2017 and March 2018 included analysis of the records relating to the assessment and care delivery regarding nutrition and hydration in the last days of life. This audit involved a review of 68 records of patients where the ‘end of life care plan’ had been used and 20 records where it had not been used. In cases where the patient was being cared for using the ‘end of life care plan’ 59% had been assessed in relation to their ability to drink in the last 24 hours of life compared with 55% of patients where the ‘end of life care plan’ was not used. Nutrition assessments had been recorded 57% of the time for patients on the ‘end of life care plan’ compared with 60% of patient where the ‘end of life care plan’ was not in use. Discussions about hydration with patients were recorded in 19% of cases compared with 5% where the end of life care plan was not in use. Of those where it was not discussed 69% had a record as to why compared with 71% where the end of life care plan was not in use. Discussions with the nominated person important to the patient were recorded 40% of the time compared with 47% of the time where the end of life care plan was not in use. Discussions about nutrition with patients were recorded in 13% of the time compared with 45% where the end of life care plan was not in use. Of cases where nutrition was not discussed 58% had a record as to why compared with 67% where the end of life care plan was not in use. Discussions with the nominated person important to the patient were recorded 29% of the time compared with 40% where the ‘end of life care plan’ was not in use. This meant that patients at the end of life were not always having their nutrition or hydration assessed irrespective of whether the ‘end of life care plan’ was in place or not.

An action plan relating to the audit included action to disseminate results across the organisation through raising awareness at end of life care education initiatives and through the work of the end
of life care link nurses on the wards. However, the action plan did not include details of how this would be done.

The ‘care of the dying patient and their family’ care plan included a record of mouth care for patients at the end of life. On one ward we viewed a mouth care guide that was in use to support the assessment and delivery of mouth care and this included a pictorial guide.

**Pain relief**

Anticipatory medicines were prescribed for patients at the end of life. Guidance for prescribing anticipatory medicines to manage commonly experienced symptoms at the end of life was available in the form of a symptom control booklet and flow charts available on the trust intranet through the end of life care web page. This guidance was in line with NICE clinical guideline CG140: opioids in palliative care. Medical and nursing staff on the wards were familiar with the guidance and knew how to access it.

Patients and relatives we spoke with told us that staff were quick to respond when patients experienced pain and other symptoms and that nursing staff were proactive in assessing levels of pain and other symptoms on a regular basis. One relative told us that staff had continued to adjust the patient’s pain relief so as to better control their pain. One patient told us that they had experienced pain and that nursing staff had given them ‘a lot of help’ to manage it. All patients we spoke with told us that their pain was well managed. However, we did not see pain assessment tools in use and staff told us these were not generally used. Care plans included symptom assessment prompts with indicators as to if the patient was experiencing the symptom, if medicines had been administered or declined and if a medical review was required.

An audit of the end of life care documentation included records of pain. Between December 2017 and March 2018 57% of patients at the end of life who had received a holistic assessment of their needs regarding an individual plan of care and been assessed in relation to pain. An end of life care carer’s report dated April 2018 stated that a survey of bereaved relatives showed that 79% of patients received good/excellent pain relief. This was an improvement from the previous year where 40% of respondents stated that pain relief had been good/excellent. In addition, the survey results showed that in 2017 8% of relatives reported that the patient had received poor pain relief; the 2018 results showed that this had decreased to 4%. In addition in 2017 55% of relatives reported that patients had received good/excellent treatment of other symptoms, in 2018 this had increased to 71%. Patients reported as receiving poor treatment of other symptoms had decreased by 3%. This meant that there had been notable improvements to the control of patient symptoms in the last year.

We observed staff administering medicines to alleviate symptoms at the end of life and saw that they did so while assessing patient need and evaluating the effectiveness of the medicines administered.

**Patient outcomes**

**End of life care Audit: Dying in Hospital 2016**

The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed worse than the England average for all of the five clinical indicators. The trust scored particularly poorly for the measure, “Is there documented evidence that the needs of the person(s) important to the patient were asked about?”
The trust answered yes to six of the eight organisational indicators. The two organisational indicators they had not answered yes to included communication skills training in the last days or hours of life for allied health professionals and a lack of end of life care facilitators. In addition, the organisational indicator for the provision of a seven day face to face specialist palliative care service was recorded on the audit as being in place. However, the trust specialist palliative care service did not operate over the weekends or bank holidays when support from the hospice was provided by telephone.

(Source: Royal College of Physicians)

Since the 2016 survey the trust has continued to develop their ‘care of the dying patient and their family’ care plan and their end of life care service. For example, they had been awarded funding to appoint end of life care facilitators across the three sites, all of whom were in post during this inspection. There was an end of life care facilitator based at William Harvey Hospital and part of their role was to undertake regular documentation audits in order to measure performance following the national audit in 2016.

Since the national audit in 2016 the trust had further developed their ‘care of the dying patient and their family’ plan to include records of end of life care conversations, a holistic assessment plan, on-going daily review, a communication diary and care after death. Quarterly audits of the documentation have evidenced improvements since the national audit. For example following the most recent audit in March 2018, 99% of records showed that in the last episode of care it had been recognised that the patient would probably die in the coming hours or days. This was an improvement of 19% since the 2016 audit. In addition, in March 2018 there was documented evidence 96% of the time that there had been a discussion with the nominated person important to the patient that the patient would probably die in the coming hours or days. This was an improvement of 20% since the 2016 audit. The internal audit undertaken by the trust showed improvement in all five clinical indicators since the 2016 audit.

The trust were participating in the 2018 national Dying in Hospital audit and told us they would be collecting data for this in June 2018.

**Referrals to the Palliative care team**

Referrals to the palliative care team at William Harvey Hospital in the last 12 months were for a variety of reasons. Most commonly, referrals were due to rapid decline and symptom control. Other referral reasons were for hospice assessment, psychiatric support and social support. Of the 559 referrals, 59% were for those patients with a diagnosis of cancer, 39% for those with a non-cancer diagnosis and the remaining 2% for were patients with both a cancer and non-cancer diagnosis. Examples of non-cancer diagnoses included sepsis, respiratory disease, heart failure and stroke.
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**Competent staff**

**Appraisal rates**

All members of the palliative care team had received an appraisal in the last year. Clinical supervision was also available for members of the palliative care team to opt into if they wished to; however we were told that this was optional.

There were end of life care link staff on all wards and clinical areas within William Harvey Hospital. The trust had trained 100 members of staff to be end of life care link workers so that ward staff had access to staff who had been specially trained in end of life care. This included symptom management training, anticipatory prescribing and the use of the ‘care of the dying patient and their family’ care plan. End of life care link staff met on a monthly basis with the end of life care facilitator to prioritise action in relation to cascading information and providing training for ward staff. In total there were 37 link staff based at William Harvey hospital. All link staff had a contract that included their link role and a commitment with key performance indicators (KPIs) identified. KPIs included that link staff would have a genuine interest in end of life care and a commitment to promoting best practice, that they would maintain the end of life resource folder in their clinical area and that they would provide basic training in end of life care for ward based staff in their area.

Of those 37 link staff 27 had attended the ‘dying in hospitals’ course provided by the palliative care team. Seven link staff had undertaken symptom control training and eleven had attended training in the revised end of life care documentation and care after death training. We were told it was the link staff responsibility to then train staff on the wards with support from the end of life care facilitator. However, while 73% of link staff had attended the ‘dying in hospitals course’, only 30% had a record of attending training in the use of the end of life care documentation and only 19% had received training in symptom control. Of the 19% who had received training in symptom control, less than half had completed all five symptom control modules. Staff we spoke with told us it was sometimes difficult to release staff to attend training as the wards were short staffed and busy. However, this meant that staff identified as being responsible for training others in end of life care issues had not necessarily been trained themselves.

Staff we spoke with on the some of the wards, particularly those where vacancy rates and the use of bank and agency staff were high told us they had not consistently received formal training in end of life care. For example, two healthcare assistants we spoke with on one ward told us
they had received training on end of life care as part of their induction but not since. They told us they did not know who the end of life care link nurse was and that they were not aware of how to access training. One staff member told us they did not always know what to say to patients at the end of life or their families and would therefore appreciate having more formal training. On the same ward a ward sister we spoke with was unaware who the end of life care link worker was or how end of life care had been influenced by the link worker system. This was a ward that had a high proportion of bank and agency staff usage.

E-learning end of life care training was available for staff and we were told that there had been a focus on registered nurses completing it in the previous year and that healthcare assistants were to get the opportunity to complete this during the current year. One particular focus of the training was around the early recognition of patients in the last year of life and there was information about this contained in the end of life care resource folders on the wards. However, there was no specific framework in place for the recognition of patients in the last year of life and not all staff had been able to undertake the e-learning module. Staff we spoke with told us that recognition of patients in the last year of life was dependent on the clinician responsible for their treatment and care. For example, we were told by staff on one ward that one of the consultant’s was proactive in recognising patients at the end of life and supporting them to holistically plan their care. However, staff responses were mixed in relation to questions about training to support them to recognise patients in the last year of life. This meant that recognition of patients in the last year of life and support for them to be involved in planning their care in advance could be inconsistent.

All ward staff within the hospital had access to end of life care resource folders. This included information on the assessment of patient need at the end of life; symptom management; last days of life; verification of death; and, the preparation of the deceased before transferring the body. The folders also included the policy for tissue and organ donation, information on chaplaincy and spiritual care services, and faith practices that may be relevant to caring for patients at the end of life and after death. The resource folders were managed by the end of life care link staff on the wards, who took responsibility for ensuring they were maintained and that the information was rolled out and accessible to all ward staff as appropriate.

One end of life care link nurse on one of the surgical wards told us they would meet with new staff to go through the resource folder when they commenced in post. This included familiarising them with the ‘care of the dying patient and their family’ care plan, anticipatory prescribing and symptom management at the end of life. They also told us they provided ‘shadowing’ support for new staff when caring for patients at the end of life and that there were opportunities for informal teaching on the ward. For example, there were ‘10 minute teaching sessions’ that allowed for sharing of information and updates to evidence based practice. One specific example they gave us was a presentation that one of the ward nurses gave on mouth care.

Some of the wards we visited had a high number of bank or agency staff working due to higher than average staff vacancies. The end of life care facilitator told us that they and the link nurses would provide bank and agency staff with the same level of support and input as permanent staff in order to make sure that care was consistent.

The trust intranet included an end of life care page where staff could access up to date guidance on caring for patients at the end of life. This included information about anticipatory prescribing and access to policies relating to end of life care. Staff consistently referenced the page when speaking with us and knew how to access it.
Multidisciplinary working

Weekly palliative care multidisciplinary team meetings were held at William Harvey Hospital. These included attendance from the hospice palliative care consultant, the palliative care clinical nurse specialists (CNS’) and end of life care facilitator, chaplaincy staff and social work representation. The end of life care working groups were also multidisciplinary and we saw that membership included matrons and medical consultants from across different specialities. In addition there was a trust wide palliative care multi-disciplinary meeting held every few weeks. This included the opportunity for palliative care staff to identify patients for a case review with input from colleagues.

The end of life care board had representation from across a range of services including renal, palliative care, oncology, cardiology, surgery and critical care. This meant that the trust had developed a degree of ownership for end of life care from a range of different specialisms and modalities.

Records of multi-disciplinary referrals and interventions in patient notes were clearly recorded. For example, we viewed records of visits from the palliative care team and saw that information was recorded in a way that staff could easily access it and gain up to date information on advice following a visit. In addition, we viewed clear records of multi-disciplinary communication from allied health professionals who had been involved in the patient’s care.

The palliative care team was made up of clinical nurse specialists and an end of life care nurse facilitator for each site. In addition there was a palliative care nurse consultant and a social worker who worked across all three hospital sites and a part time counsellor who was based at QEQM and KCH.

Seven-day services

The trust did not currently provide a face to face seven day specialist palliative care service. We were told that this was because of a lack of resource and that it had been discussed at the end of life care board meetings. However, the lack of a seven day face to face specialist palliative care service was not on the risk register or included in future development plans.

The palliative care team operated between 8.30am and 4.30pm Monday to Friday with Consultant on call cover. Out of hours support was available from the hospice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

We requested data around the training completion rates for Mental Capacity Act and Deprivation of Liberty Safeguards for the palliative / end of life care staff. All 11 staff required to undertake this training had completed the training.

The trust ‘do not attempt cardiopulmonary resuscitation’ policy dated May 2018 stated that where patients were identified as not having mental capacity to be involved in a discussion about resuscitation a mental capacity assessment must be carried out in line with the mental capacity act (2005). The policy also states that where a patient lacks capacity consulting with those close to the patient in these cases is not only good practice but is a requirement of the Human Rights Act 1998 and the Mental Capacity Act 2005.

We reviewed the ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) records for patients where a decision not to resuscitate had been made. We reviewed 12 records in total, seven of which were for patients who had mental capacity. In all of these cases we saw that the decision had been made following discussion with the patient and where appropriate their relatives. The
remaining four assessments were for patients who were identified as not having mental capacity. In three out of four cases we saw that the decision had been discussed with the family of the patient or their nominated representative. We saw evidence of one mental capacity assessment in place; the other three did not have mental capacity assessments. This meant that not all patients identified as lacking mental capacity had received a formal assessment that had been recorded in their record.

**Is the service caring?**

**Compassionate care**

We observed patients being treated with dignity and respect in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. Relatives spoke positively about the compassion shown to patients at the end of life. For example, one relative told us that their mother had been treated with great care and compassion and that staff consistently went the extra mile. They also told us that staff showed kindness in their approach with the family, for example, by providing them with extra pillows and blankets to promote their comfort and by providing regular refreshments. Another family confirmed that staff had been wonderful and that they took time to add extra touches to ensure their loved one was comfortable. They told us ‘it’s as though they’ve known dad for a long time and really care about him’.

Patients were positive about the care they had received. One patient told us that nothing was too much trouble for staff and that when they had struggled to adjust to needing help with receiving personal care staff had been reassuring and made them feel comfortable. They told us that staff were patient with them when they were slow and they felt respected as an individual. Another patient told us they had chosen to have the curtains closed around their bed some of the time and that staff regularly checked on them to see if they wanted the curtains opened. We saw that patient’s privacy and dignity were respected when receiving personal care, with curtains closed and staff communicating with patients in quiet, discreet voices. Patients and their relatives told us that staff responded in a timely, appropriate and compassionate way when they experienced pain or other symptoms.

Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. Religious and spiritual needs were assessed as part of the ‘Care of the dying patient and their family’ care plan; this included identifying any religious or spiritual needs of the family. In addition, there was a section within the plan to identify any psychological or social issues affecting the patient or their family. Spiritual support was available from the chaplaincy and from volunteers working within the chaplaincy department.

A compassion symbol was in use on the wards to help staff, including those not directly involved in the patient’s care such as porters and domestic staff to identify patients at the end of life. This meant that all staff knew to be respectful and to create a dignified and compassionate environment for the benefit of the patient and their family.

We spoke with porters about the transfer of the deceased to the mortuary. They told us that there were clear processes in place and that they had observed ward staff dealing with the deceased appropriately and with compassion. Mortuary staff told us that where possible care after death ensured that spiritual and cultural wishes of the deceased and their family and carers were honoured. However, they also told us that there were strict controls in place in the case of the jurisdiction of the coroner and that this sometimes resulted in having to explain to relatives that their legal obligations took precedence. Staff told us they would liaise with the coroner in complex situations.
We were told that ward staff had identified and reported issues with the quality of the shrouds used in the care of the deceased in that they did not promote the dignity of patients. As a result, the issue was presented to the end of life care and a business case agreed to invest in improving the quality of the shrouds in order to promote dignity at the end of life.

Staff working within the mortuary told us that capacity issues had at times impacted on their ability to ensure the privacy and dignity of the deceased person in the way they would like. For example, we were told that during the winter when the mortuary was at capacity and they had stored more than one body in a space designed for single storage. This was against the Human Tissue Authority guidance on contingency arrangements for mortuaries during busy periods, which stated; please note that placing more than one body on fridge trays or storing bodies in unrefrigerated areas, are not considered suitable practices. This meant that it was not evidenced that patient’s privacy and dignity after death was always maintained.

There were canvas property bags available on the wards, designed for the use of storing the property of patients who had died. The bags were easily identifiable to staff so that if they saw relatives with the bags they knew they had been bereaved. This meant that the service ensured bereaved relatives were treated with compassion by all staff when leaving the hospital following the death of their loved one. Members of the palliative care team told us that the use of the bags were shared with all staff on induction so that everyone working within the trust knew what the bags symbolised. This included staff such as parking attendants who may come into contact with the family in the hospital grounds.

Comfort care packs had been designed by the end of life care facilitators. These were for relatives staying with patients at the end of life and included various toiletries to promote comfort.

**Emotional support**

Ward staff demonstrated a good understanding of the impact that a person’s care, treatment or condition will have on their wellbeing and those close to them. The palliative care team clinical nurse specialists provided additional support for patients and family members with complex psychosocial issues.

Information booklets were available throughout the trust for patients and family members to provide guidance on what to expect at the end of life. This included information on the changes to expect in the last weeks, days and hours of life. In addition, the contact details for a range of organisations providing support at the end of life or for bereavement were included in the booklets.

Chaplaincy staff and volunteers provided emotional and spiritual support to patients and those close to them. The support provided was based on spiritual and emotional needs irrespective of religious beliefs or faith. We were told that the local hospice provided bereavement support to relatives where a patient has used their service, otherwise staff would signpost relatives to other support agencies. Memorial services were held in the chapel where bereaved relatives would be invited to the services, this included service’s for adults and for infants.

Ward staff provided emotional support to patients and family members at the end of life. Patients and relatives we spoke with consistently told us that staff provided emotional support through the end of life process. For example, one family told us that ward staff had helped them to come to terms with the impending death of their loved one so that they could focus on spending quality time with them at the end of life.
Understanding and involvement of patients and those close to them

Patients and relatives told us that staff communicated with them in a way that they could understand their care, treatment and condition. For instance, one relative told us that staff took the time to explain everything to them in a way that they could understand.

Patients and relatives told us they felt involved in their care at the end of life. We saw that there were guidance booklets for patients and relatives about end of life care. The patient booklet included prompts for them to record their wishes and preferences. The booklet for relatives provided information on what to expect in the final hours of life including changes to breathing, a reduction in eating and drinking and changes in skin colour.

Patients and relatives we spoke with told us that staff were quick to respond to questions and that they felt they had received a good degree of explanation as to what was happening and what to expect. The ‘care of the dying patient and family’ care plan included a record of end of life care conversations. However, these were not always completed in the records we reviewed.

Patients’ preferred place of care and their individual choices and preferences featured as a primary focus when planning care in the last days of life. The individual plan of care for patients at the end of life included sections to record decisions and conversations with patients and their loved ones.

Members of the palliative care team told us that where patients with protected and other characteristics were being cared for at the end of life, the use of hospital passports and ‘this is me’ records would help to guide staff on how to communicate with them. They also told us they involved family and carers in decision making about care and took time with patients to communicate in a way they could understand.

Information about community and advocacy services were available in the patient and carer information guides. Staff told us they would support patients to access other services by liaising with them and signposting as needed. Patients and those close to them were involved in planning and making shared decisions about their care and treatment and this was confirmed by the patients and relatives we spoke with.

The compassion symbol for use to place on doors or curtains surrounding the bed of a patient in the last days or hours of life had been designed collaboratively between the hospital and the local hospice. A prompt to use the symbol to identify patients at the end of life was included in the ‘care of the dying patient and their family’ care plan. This included a section to complete where the use of the symbol had been discussed with the patient or their family and there was evidence of recording that the patient or family had been involved in this discussion and had agreed to its use.

Is the service responsive?

Service delivery to meet the needs of local people

The palliative care team operated between 9am and 5pm Monday to Friday. Out of hours support was available from a local hospice and out of hours specialist palliative care consultant cover was provided via a consultant on-call rota. Staff we spoke with on the wards knew how to access specialist palliative care support.

There was no dedicated palliative care ward and patients were nursed on the general wards in the hospital and where possible patients at the end of life were nursed in side rooms. However, we were told that this was not always possible as not all wards had side rooms and where they did, often patients with infectious conditions would take priority. We saw that patients nursed on bays...
within wards could have their curtains drawn around them to provide additional privacy for them and their family.

Open visiting was in place for patients at the end of life and relatives were able to stay with them. There were facilities available within the hospital for relatives to take a break, including showering facilities and a kitchen they were able to use. However, survey and audit results showed that relatives were not always made aware of the facilities. There was access to the garden from the relative’s suite and the environment had been designed to provide a peaceful and restful space. Relatives we spoke with told us that staff were responsive to their needs and would provide refreshments and blankets or pillows to promote their comfort. However, staff told us there were no camp bed facilities for relatives to sleep and they had to rest in chairs next to the patient bed if they wanted to stay close rather than using the relatives’ room.

There were limited quiet rooms for staff to hold potentially difficult conversations with relatives on the wards. For example, staff on wards told us they often had to use ward offices or to speak with relatives. On the intensive therapy unit (ITU) there was a relative’s room available, however staff told us this was small and often would not accommodate larger families. The trust was aware that there were some issues with space to speak with relatives. On one ward (Kings D), a relative’s room had been developed with the use of charitable funds and staff told us that this room was accessible to other wards on that floor.

Mortuary staff told us that because the mortuary provided a ‘public mortuary’ service where post mortems were undertaken they discouraged relatives from viewing their loved ones in the mortuary viewing room. They preferred that relatives viewed bodies on the ward or through the funeral director once the body had been released. Viewing facilities at William Harvey Hospital were available and included facilities for relatives, however the environment was not conducive to creating an environment suitable for viewing. Staff told us they could make changes to the environment to make it more appropriate for viewing, such as pulling curtains across and making sure that viewings took place at times when post mortems were not being held. The palliative care nurse consultant told us the lack of appropriate viewing at William Harvey had been identified and they were planning on developing a business case to improve the facilities. However, there was no clear timeframe for this.

Staff we spoke with told us there were contact details on the intranet for how to access interpreters for patients that did not speak English as a first language. This could either be face to face or by telephone. They told us that sometimes staff working within the hospital would provide communication support where they spoke the same language of the patient or family.

There were information leaflets available for patients and family members. However, the ones on the wards were printed in English only. This meant that patients and relatives not able to speak English would require additional support to understand the information provided.

**Meeting people’s individual needs**

The ‘care of the dying patient and their family care plan’ included the assessment of spiritual and religious needs. The chaplaincy team provided spiritual support for patients and their families inclusive of different faiths and cultures. The chaplaincy service had access to a variety of faith leaders in the community to provide specialist support. There was information on the trust intranet and in the care of the dying resource folders about different religious practices relevant to caring for patients at the end of life. Information included details of care after death practices of different religions and faiths. The mortuary worked with staff and relatives to secure the release of the deceased in a timely way where possible, to meet the different religious and faith needs.
There was a framework in place to ask patients at the end of life about their preferred place of death, however this was generally in the last days of life so did not always support advance care planning.

Staff told us that where possible they would facilitate the discharge of patients to their preferred place of care at the end of life. However, staff told us that there were sometimes difficulties arranging care packages in the community for patients on the fast track or rapid discharge pathways at the end of life and that this could cause delays. We were told there was a hospice at home service available in the community via the local hospice for patients thought to be in the last three days of life or to provide interim support in the community where packages of care could be set up during that time. We were told during inspection that issues with fast track discharge were on the end of life risk register; however, when we requested the risk register from the trust we were told that there were no risks currently identified. This meant that there were inconsistent responses to whether or not risks associated with fast track discharge were still an issue or not.

The most recent documentation audit results between December 2017 and March 2018 showed that 78% of patients at the end of life were asked about their preferred place of care and this was recorded. The trust did not record the percentage of patients at the end of life who had been discharged to their preferred place of care. Data provided by the trust showed that 47% of patients did not have their preferred place of care discussed with them. Of the 291 patients at William Harvey hospital who were involved in a discussion about their preferred place of care 30% preferred to go to the hospice, 17% preferred to stay in hospital, 14% wanted to go home and 28% were identified as not appropriate to have the conversation. Discharge data over the last 12 months showed that on average 28% of patients were discharged home at the end of life.

We were told that patients would generally be asked about their preferred place of death at the point where the decision had been made that they were likely to be in the last days of life. This was not in line with the end of life care interagency policy that recommended an early conversation between the health care professionals, patient and carer/family to ensure that all parties are confident that the patient and family wishes have been fully explored and considered. This may explain the high numbers of patients unable to participate in the conversation and the higher number of patients who wanted to go to the hospice or stay in hospital. It was therefore likely that the stage of illness may have impacted on the patient’s decision making, whereas if there was more time given to planning in advance of deteriorating health then the decision making may have been different. This possibility was supported by results from a carer’s survey that showed that while only 25% of respondents stated that the patient had discussed their preferred place of death with their family, none of them had identified that place as the hospital.

The trust did not have a framework for advance care planning in place. In addition, there was no formal framework in place for identifying patients in the last year of life. The palliative care nurse consultant told us that this was being addressed as part of the three tier regional end of life care strategy in which the trust were involved. They told us that there was a focus of the strategy on identifying patients in the last year of life within primary care and sharing information across organisational boundaries so as to promote the involvement of patients and those close to them in making advance decisions about their treatment and care. The trust were piloting a treatment escalation plan that included identifying ceilings of treatment for individual patients; however these were not consistently completed in the records we reviewed.

The specialist palliative care nurse consultant told us they were planning on implementing the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process in the near future. This process would provide a framework for recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. The process
would include a best interest discussion with family members where a patient did not have mental capacity to be involved in the decision.

We saw some evidence of advance care planning records but this was inconsistent. The quality of these records was dependent on the individual clinicians involved in the patient’s care due to the lack of trust wide formal process. Those that we did see included a patient at the end of life who had a record of their funeral wishes and two others that included comprehensive detail of a patient’s advance wishes for their end of life that had been recorded following a conversation with their consultant or ward staff. For example, one included a record of a discussion about if the patient, who was being prepared for discharge, wished to come back into hospital should they have an infection or other acute episode of illness. This meant that although there was no framework or consistency for advance care planning there were some areas of good practice identified during inspection.

The palliative care team provided support to the ward staff when caring for patients with additional needs such as a learning disability or dementia. We observed one of the CNS’ providing input to one of the medical team about anticipatory prescribing and discharge back to the preferred place of care for one patient with a learning disability. Staff were aware of the need for the patient to be in their home environment and while they had provided facilities for a carer to stay with the patient they were also prioritising discharging them home with support.

The palliative care team and ward staff had a focus on the individual needs of patients including those with dementia, learning disabilities or mental ill health. The individual plan for the dying person included an assessment of individual needs and staff told us they would work closely with other specialists in order to provide appropriate individual care.

**Access and flow**

Ward staff told us that the palliative care team were responsive to the care of patients at the end of life. We reviewed records of patients at the end of life and saw that once a referral had been made to the team, patients were reviewed soon after. The palliative care team processed and prioritised referrals so that they could meet the needs of patients and their families.

Feedback from ward staff and records of assessments by the palliative care team showed that palliative care nurses would often review patients on the day of referral.

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</tbody>
</table>

The above table shows that 80% of patients referred to the palliative care team were seen on the day of referral. Fourteen percent of patients were seen within 24 hours of referral, 2% within 48
hours and a further 2% within 72 hours. This meant that 98% of patients were seen by the palliative care team within 72 hours of referral.

The palliative care team had developed a patient tracking list (PTL) so that they would be alerted to patients at the end of life who had been commenced on the ‘care of the dying patient and their family’ care plan. Once the alert had been received, the end of life care facilitator would attend the ward to provide support to staff providing the care. Staff we spoke to told us that this support had been timely. The PTL was also shared across services with the hospice so that they were aware of the patients on the care of the dying plan. This was particularly useful as the hospice provided out of hours support to the trust.

A project to relieve the effect of ‘winter pressures’ on beds and the impact on patients at the end of life, the trust had worked together with the hospice to deliver a project that had been initiated by the clinical commissioning groups (CCGs) in the area. This involved hospice beds being dedicated for use by patients on hospital wards who had been identified as being in the last days of life. Patients identified as eligible may not normally have met the hospice criteria, for example in relation to experiencing non-complex symptoms. The initiative meant that patients who did not want to go home or were unable to go home were able to die in the hospice rather than hospital environment. Staff were uncertain if the project would be repeated.

The average length of stay for patients at the end of life being cared for at William Harvey Hospital was 17 days compared with an average of 16 days at Queen Elizabeth the Queen Mother hospital and an average of 12 days at Kent and Canterbury Hospital. On average 28% of patients were discharged home at the end of life.

Learning from complaints and concerns

Summary of complaints

Information on how to complaint was seen on posters and leaflets in the hospital. Complaints relating to the care of patients at the end of life were reviewed by the end of life care board. Members of the palliative care team told us they received information about complaints in relation to themes identified, however were not aware of the specific details of the complaints received. Ward staff we spoke with could not recall complaints relating to end of life care. The palliative care nurse consultant told us that complaints relating to end of life care were minimal.

We reviewed summaries of five complaints that had been reported to the end of life care board since December 2017. Themes had been identified from these complaints, including communication and concerns about the quality of care provided. Minutes from the end of life care board meetings showed that complaints were discussed. However, it was unclear from the records of the discussions how the information was used to identify and share learning.

Is the service well-led?

Leadership

The medical director was the lead for end of life care across the trust. Day to day leadership was provided by the palliative care nurse consultant, end of life care facilitators and clinical nurse specialists. Palliative consultant cover was provided by the hospice and included dedicated time to be involved strategically.
The specialist division lead nurse and medical director were the executive leads on the end of life care board. The trust had previously had a non-executive lead but we were told they had stepped down earlier in the year and had not yet been replaced.

Staff we spoke with told us that the end of life care leads were visible and approachable. There was an end of life care facilitator in post at William Harvey Hospital. The overarching governance structure for end of life care was through the end of life care board which had representation from a range of specialisms within the trust. This meant that leadership for end of life care was shared across a range of services.

Ward based end of life care leadership was the responsibility of ward managers and end of life care link nurses. The link nurses were contracted to take a lead role for end of life care within their clinical area. Link nurses we spoke with were enthusiastic and demonstrated a genuine commitment to promoting good quality end of life care. However, in some clinical areas where staffing was an issue and there was a high number of bank and agency usage not all staff knew who their link nurse was. In addition, data we received from the trust showed that not all link nurses had attended regular training or link staff meetings. Staff we spoke with said that this was largely due to the workload of the clinical areas and the difficulty releasing staff for training and to attend meetings.

Vision and strategy

The trust did not have an internal end of life care strategy. However, the palliative care team had been involved in the development of an interagency strategy for EOLC. In addition, they had developed working groups within the trust to improve end of life care, one for each hospital site. The working group at William Harvey Hospital had been in operation for nine months and was led by one of the clinical matrons. Meetings were recorded and we were told the group was in the process of developing a structure to move forward and had themes they were working on. However, there was no clear action plan in place for the group at the time of our inspection.

The palliative care nurse consultant told us that the implementation of the interagency strategy was being led by the local clinical commissioning groups (CCGs) and involved representation from other healthcare providers, social care, the third sector, patients and the public. There was a third tier section of the strategy that focused on acute services.

The vision for end of life care across East Kent was for everyone to have the best possible end of life experience. This included them being treated as an individual with dignity and respect, without pain and other symptoms, in the company of close friends and/or family and to be cared for and die in the place of their choice. Staff we spoke with on the wards and within the palliative care team had an understanding of the vision of end of life care. For example, all staff were aware of the implementation of the compassion symbol across the trust and the importance of dignity and respect and involving close friends and family in care at the end of life. In addition, the use of the ‘care of the dying patient and their family’ plan had a record of patient’s preferred place of care at the end of life and staff understood the importance of this and worked together to try and facilitate this where possible.

Culture

There was a culture of improving end of life care within the trust. The majority of staff we spoke with were aware of developments since our last inspection such as the compassion project and the role of the end of life care facilitator.

All staff we spoke with told us they worked to prioritise the care of patients at the end of life, however on some wards and clinical areas there was a shortage of permanent staff which resulted
in additional pressure. For example, on some wards staff we spoke with were not aware of who their link nurse for end of life care was and told us they had not received training in the use of the ‘care of the dying patient and their family’ plan. However, we were told that regular bank and agency staff were in place where possible to make sure that disruption to continuity of care was kept to a minimum.

Staff we spoke with were aware of the requirements of the duty of candour. Staff knew that they had a duty to inform patients and their families when things went wrong. There were no incidents reported where the requirements of the duty of candour applied in relation to end of life care. Staff confirmed that openness with patients and those close to them was encouraged and supported by staff at all levels. Mortuary staff told us that families were not informed of the use of a single tray to store two bodies in the mortuary.

**Governance**

The palliative care team reported within the specialist services division of the trust. The head of nursing for the specialist services division was the chair of the end of life care board.

The trust end of life care board fed into the East Kent End of Life Care Strategy clinical commissioning group (CCG) led interagency work stream and the palliative care nurse consultant was a member of this group. They regularly attended the interagency quarterly forums and sub groups co-ordinated by the CCGs. The end of life care board was accountable to the trust's quality committee via the patient experience group.

We reviewed minutes of end of life care board meetings where there was reference to the interagency work streams and improvement plans, location based working groups and a review of identified end of life care initiatives. However, we did not see evidence of action plans and activities linked to the interagency strategy and monitored through the end of life care board governance processes. In addition, while we saw that complaints and compliments and identified themes were reviewed by the end of life care board, there was no evidence that incidents or significant events relating to end of life care were reviewed as part of this process.

The three location based working groups were based at each of the hospital sites. At William Harvey hospital the group was chaired by one of the hospital matrons. The meetings were held monthly and agendas set around feedback from the end of life board, lessons learnt, positive news stories and the compassion project. In addition, the meeting minutes we reviewed included reference to a review of action. Of the three sets of minutes we looked at, two indicated the action had been reviewed, one stated that the action had not been reviewed. However, the details of the action were not part of the minutes and staff had told us that actions were loose and needed to be firmed up in relation to the end of life care strategy.

An East Kent interagency policy for end of life care had been developed as part of the interagency strategy work that the palliative care nurse consultant had been involved in. The policy had clear areas of responsibility for each organisation within the group. This was broken down into three tiers with East Kent University Hospitals NHS Foundation Trust providing secondary care through the third tier of the policy.

Areas of end of life care identified through the policy and agreed by the end of life care board within the trust involved aspects of end of life care such as;

- The management of acute episodes of ill health
- The provision of planned treatments
- The timely involvement of specialist palliative care as needed
• Identification of patients at risk of dying in the coming year so that they could be entered onto the palliative/end of life register in the community
• The use of anticipatory/advance care planning.

There were areas of provision that were not being focused on. For example, there was no evidence of a trust wide approach to advance care planning and no framework to identify patients at risk of dying in the coming year. Action plans to achieve these objectives were not recorded.

**Management of risk, issues and performance**

We reviewed corporate and pathology risk registers to identify risks relating to end of life care or care after death. The pathology risk register included a risk relating to the body storage capacity. The risk had been identified in February 2017 and reviewed in April 2018. The cause of the issue was identified as delays to death certification, coroner’s delays, and delays in collecting the deceased. Risk control included the purchase of temporary storage to increase capacity, while working on each of the areas identified as a causative factor to reduce delays. The risk had been identified as moderate, however did not include that, over the winter months in particular, bodies were stored over capacity, with more than one body stored in a space meant for single use. While we were told that the mortuary staff had taken a ‘bed management’ approach to the capacity issues where capacity was discussed on a daily basis, there was no evidence that this had been escalated within the trust as a risk. For example, it was not included on the corporate risk register, had not been reported via the electronic incident reporting system and had not been recorded as raised at the end of life care board. In addition, the palliative care nurse consultant told us they were not aware of issues relating to this ‘doubling up’ within the mortuary to create capacity.

We were told that a palliative/end of life care risk register had been developed following a previous inspection and that the only risk identified had been relating to issues with fast track discharge. When we requested a copy of the risk register from the trust we were told that there were no risks identified and that previous risks had been mitigated. Staff we spoke with during inspection told us that the risks relating to fast track discharge were an ongoing issue. In addition, risks such as those relating to the mortuary capacity or a lack of resource to deliver a seven day face to face palliative care service had not been identified as part of the end of life care risks.

A risk identified on the mortuary risk register relating to the deceased not being properly prepared following the last offices policy had been discussed by the end of life care board. In addition the care after death policy had been updated and audits undertaken so that mortuary staff could report findings to the end of life care board and clinical areas involved. Additional training would then be provided to staff.

The palliative care team monitored performance through the use of audit and there was some evidence of improvement. We saw audits in relation to the care plan documentation and a carers’ survey. Data showed some areas of improvement following the audits. For example, the use of the ‘care of the dying patient and their family’ care plan had increased year on year as a result of this regular monitoring of performance. However, action plans were not always comprehensive or timely. A carer’s survey that showed deterioration in satisfaction did not include new action to address the concerns.

**Information management**

The palliative care team collated performance information in a number of areas. For example, they audited the records of patients in the last days of life in order to measure performance and monitor patient outcomes. An audit tool was used, based on the End of life care Audit: Dying in Hospital 2016 national audit. Information was used to monitor the use of the ‘care of the dying
Staff had access to up to date patient information. Paper based records were used for the care of patients at the end of life with electronic systems also in use. For example, the patient tracking list provided up to date information to the palliative care team and the care of the dying facilitator as to which patients were in the last days or hours of life. This enabled close monitoring by the care of the dying facilitator in order to provide support to ward staff around patient care. However, we were told that one issue with the system was that an alert would only be created when ward staff indicated on the electronic system for assessing patient vital signs, that the patient was at the end of life. Some staff had chosen the wrong box, indicating that clinical observations were no longer required rather than that the patient was at the end of life; this did not trigger an alert to the palliative care team. This issue was being addressed by the end of life care facilitators and link staff who were raising awareness amongst ward staff to the issue.

The electronic end of life care alert used across the trust enabled information to be accessible to staff across the trust, including that the focus of care had changed for the patient. This enabled better coordination of patient care and for the end of life and palliative care staff to have an overview of patients at the end of life across the trust. This information was also accessible to hospice staff.

The trust did not participate in a regional Electronic Palliative Care Co-ordination System (EPaCCS), where patient records for those at the end of life could be accessed in the hospital, community and hospice. We were told that this had been discussed by the local network of services involved in the local end of life care strategy, however was not yet in place.

Members of the specialist palliative care team recorded their notes using computers that were in their office or ward based computers that could be accessed at the time of their review of patients. This meant that they could record up to date advice and recommendations about patient care so that it was quickly accessible to staff.

**Engagement**

An end of life carer’s survey was carried out annually. Surveys were distributed by relative support officers to people attending to collect the death certificate of deceased adults. Four hundred and fifty surveys had been sent out for the 2018 survey and 84 had been completed. Questions focused on themes around such as preferred place of care, symptom control, spiritual care, emotional care, dignity and respect, bereavement, communication and care after death.

We reviewed the 2018 carer’s survey report and saw areas where there had been a reduction in satisfaction. Particular areas that had deteriorated were people’s experience of; communication; dignity and respect; emotional support they received, including at the time of death; care after death; and, the overall level of care. The deterioration in satisfaction ranged between 6% and 21%. There was one area of improvement where relatives’ perception of the patient experiencing poor relief of pain and other symptoms was less than it was in the previous survey.

The actions to address the issues identified as a result of the survey report were not clear. The conclusion and recommendations were largely repeated from the 2017 report and actions were
ongoing without clear detail or planned timelines. This meant that there was no clear plan in place as to how the trust were going to ensure improvements in satisfaction.

The palliative care team had undertaken a staff survey to gain feedback from general staff on end of life care and the priorities of the end of life care service. The results of this survey showed there were areas that needed improvement such as raising the profile of the chaplaincy service, highlighting the use of the trust end of life care web page and raising awareness of the out of hours service from the hospice. There was clear action plan with completion dates relating to this.

Staff we spoke to said that they felt they had the opportunity to influence the end of life care service, particularly those identified as end of life care link staff. One such example was that ward staff had identified and reported issues with the quality of the shrouds used in the care of the deceased. This resulted in improvements to the shrouds being used.

During our inspection it was the national Dying Matters week. We saw there were a number of hospice run sessions that could be accessed by staff and the public aimed at raising awareness of issues faced by patients at the end of life and their families. In addition the care of the dying facilitator was running a session at the time of our inspection, where they provided support and information to staff on issues relating to end of life care. There were not specific Dying Matters initiatives at William Harvey Hospital aimed at members of the public.

**Learning, continuous improvement and innovation**

There was evidence of learning, continuous improvement and innovation. The palliative care team collected data through the audit of end of life care documentation, carer surveys and a staff survey on end of life care. The results of surveys and audits were monitored by the end of life care board.

Since the End of life care Audit: Dying in Hospital 2016 national audit, the trust had improved their ‘care of the dying patient and their family’ plan and undertaken quarterly audits with demonstrable improvements. In particular there were improvements in the recognition of patients in the last days and hours of life and in recording conversations about this with relatives.

The palliative care team were working towards improving tracking and monitoring of patients at the end of life. A patient tracking list (PTL) had been developed so that when patients were identified as being in the last days or hours of life the care of the dying facilitator would be alerted. The facilitator would then review the patient record, identify any learning for staff relating to end of life care and provide support for medical and nursing staff as required.

The compassion project within the trust was implemented in May 2017 in collaboration with the local hospice. The aim of the project was to promote dignity, respect and compassion at the end of life in an acute hospital setting and consisted of a compassion symbol that was used to identify patients at the end of life. This meant that all staff including clinical and non-clinical could work together to improve the experience of patients and their family at the end of life. The project was funded by a legacy donation from the past Kent & Canterbury Hospital senior matron and local hospice trustee. The Project had received national recognition, and had featured in a number of national publications including the Nursing Times.

End of life comfort care packs had been developed for use by families of those at the end of life who were staying overnight to be with them. The comfort packs included a variety of toiletries.

The palliative care nurse consultant told us they were most proud of the passion of staff to ‘get it right’ and that they felt the trust were moving forward in terms of end of life care, particularly since the employment of end of life care facilitators at each site within the trust. The end of life care facilitators were sponsored by Macmillan Cancer Support for an initial two year period when a business case would be developed for trust board approval to continue to fund the posts.
Urgent and emergency care

Kent and Canterbury Hospital has an Urgent Care Centre which was open 24 hours a day, seven days a week including bank holidays. The service provides care to approximately 30,000 patients a year.

The Kent and Canterbury Emergency Care Centre has three separate areas, a Level 3 minor injury unit (including a four-bed paediatric unit), vascular and urological emergency unit and a resus unit.

The minor injuries unit (MIU) provides treatment for minor illness and injury to children over one year old and adults.

The vascular and urology emergency unit provides care to people of all ages with urgent vascular or urological conditions.

The resus area had three bays, two for adults and one for children. This unit was primarily used for vascular and urology emergency patients. These patients are treated in the resus then transferred within the hospital if they can be treated at Kent and Canterbury.

The resus unit is sometimes used for self-referred patients who need to be transferred to the emergency departments at William Harvey Hospital or Queen Elizabeth the Queen Mother Hospital due to their condition. In these cases, patients are transferred to the other hospital by emergency ambulance, but treated in resus area until the ambulance arrives.

Urgent and emergency services were last inspected in 2016 when overall, we rated the service as requires improvement. Our inspection was unannounced and we inspected all five key questions. We have performed a focused review of the emergency services at Kent and Canterbury hospital. This report summarises our findings. However, there is insufficient information to rate this service.

Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

The trust has three urgent and emergency departments:

- Kent & Canterbury Hospital
- Queen Elizabeth The Queen Mother Hospital
- William Harvey Hospital

(Source: Trust Routine Provider Information Request)

Activity and patient throughput
Total number of urgent and emergency care attendances at East Kent Hospitals University NHS Foundation Trust compared to all acute trusts in England.

There were 210,305 attendances from April 2016 to March 2017 at East Kent Hospitals University NHS Foundation Trust as indicated in the chart above.

(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 from 2015/16 to 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>Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>42,009</td>
</tr>
<tr>
<td>Discharged*</td>
<td>131,5</td>
</tr>
<tr>
<td>Referred*</td>
<td>8,058</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>2,223</td>
</tr>
<tr>
<td>Died in department</td>
<td>188</td>
</tr>
<tr>
<td>Left department#</td>
<td>9,708</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
</tr>
<tr>
<td>Not known</td>
<td>14,493</td>
</tr>
</tbody>
</table>

* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

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

A breakdown of compliance for mandatory courses from January 2017 to December 2017 for medical/dental staff in urgent and emergency care is shown below:

No site at the trust had met the target for mandatory training set for medical staff.

A breakdown of compliance for mandatory courses from January 2017 to December 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>14</td>
<td>15</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>14</td>
<td>15</td>
<td>87%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>15</td>
<td>21</td>
<td>80%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>11</td>
<td>15</td>
<td>73%</td>
<td>No</td>
</tr>
</tbody>
</table>

Kent and Canterbury Hospital met the target for five and four training modules.

(Source: Routine Provider Information Request (RPIR) – Mandatory and Statutory Training tab)
Updated data for Kent and Canterbury Hospital, detailed below, showed that compliance with the trust target for mandatory training had improved and was meeting the target in five out of the six training modules for nursing staff. The only module to be below target was fire safety training.

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>14</td>
<td>15</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>13</td>
<td>15</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>13</td>
<td>15</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>13</td>
<td>15</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>15</td>
<td>21</td>
<td>82%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>11</td>
<td>15</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The service had improved their mandatory training rates. Rates for every mandatory training module had increased. Four areas exceeded the 85% target, one met the target and one fell 3% below the target. This showed a commitment to ensuring staff had training and competency required to work in the department.

**Safeguarding**

**Safeguarding training completion rates**

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

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

A breakdown of compliance for safeguarding training courses from January 2017 to December 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>10</td>
<td>15</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>9</td>
<td>15</td>
<td>60%</td>
<td>No</td>
</tr>
</tbody>
</table>

The site failed to meet the target for safeguarding for two training modules.

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

Not all emergency department staff had level two safeguarding children training as a minimum. This was not in line with the Safeguarding Children’s Standard produced by the Royal College of Emergency Medicine’s clinical effectiveness committee or in line with the Royal College of Emergency Medicine (RCEM): Emergency Department Care (2017) Quality standard 42.

The service had not achieved their target for nursing staff compliance in safeguarding children level three and safeguarding adults level two. These rates were worse than the target trust target of 85%.

However, staff we spoke with knew who the safeguarding lead was and understood their responsibilities to safeguarding both adults and children. Staff we spoke with could identify the
differing signs of abuse and could give examples of when they had made a safeguarding referral. Staff showed us how the system required them to tick relevant safeguarding boxes on the system and told us this ensure safeguarding issues were considered.

The safeguarding team was responsible for assessing the case and alerting the local authority. Staff told us the safeguarding team was accessible to answer questions or discuss concerns. A member of the safeguarding team visited the department weekly to review all children and young person’s records for safeguarding issues. Staff described how any concerns raised about safeguarding were shared at the monthly minor injury unit team meeting.

Environment and equipment

The department included a four-bed paediatric unit, vascular and urology emergency department and a resus area.

The resus area had three bays, two for adults and one for children. Equipment in the resus area was very well organised with colour coded drawers and clearly labelled equipment in glass fronted cabinets. The cabinets made it easy to see when a piece of equipment was missing. We checked 35 adult supplies; all were present, in date and sealed.

The resus bay for children that was organised in the same way and had all sizes of equipment for children. We checked 12 paediatric supplies all were present, in date and sealed. We observed equipment check sheets were routinely carried out and completed for equipment in the resus area.

We observed equipment check sheets were carried out daily and completed for equipment in all areas of the Emergency Care Centre.

The resus trolley was located centrally so that it was accessible to the entire unit. It was sealed so that it could be easily accessed by staff in an emergency, but not in other situations. The trolley had an audit sheet which reflected that the trolley was checked daily. We spoke to a staff member who performed this audit and explained the process for ensuring equipment and supplies were present and how they ordered replacements as necessary.

We audited the trolley with a staff member who could locate all supplies requested except for one piece of equipment that was missing. The staff member immediately actioned this to restock the trolley. This meant that in an emergency, staff would have the supplies they needed to quickly treat critically ill patients.

Assessing and responding to patient risk

Emergency Department Survey 2016

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the</td>
<td>7.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td>ambulance crew before your care was handed over to the emergency</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>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>6.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be</td>
<td>6.0</td>
<td>trusts</td>
</tr>
<tr>
<td>examined later. From the time you arrived, how long did</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
you wait before being examined by a doctor or nurse?

| Q33. In your opinion, how clean was the emergency department? | 8.2 | About the same as other trusts |
| Q34. While you were in the emergency department, did you feel threatened by other patients or visitors? | 9.5 | About the same as other trusts |

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

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

The median time from arrival to initial assessment was better than the overall England median in all of the months over the 13 month period from February 2017 to January 2018.

In January 2018 the median time to initial assessment was two minutes compared to the England average of nine minutes.

**Ambulance – Time to initial assessment from February 2017 and January 2018 at East Kent Hospitals University NHS Foundation Trust**

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

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

**Kent & Canterbury Hospital**

From July 2017 there was a large increase in the monthly number of ambulance journeys with turnaround times over 30 minutes at Kent & Canterbury Hospital. As of February 2018, 62% of ambulance journeys had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Kent & Canterbury Hospital**
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Kent & Canterbury Hospital

Feb-17

(Source: National Ambulance Information Group)

We spoke to several staff members about ambulance wait times at Kent and Canterbury Hospital. Staff told us they did not record this as the unit was a minor injuries unit, but all staff members we asked told us they had never seen an ambulance waiting at the site.

Updated data for May 2018 at Kent and Canterbury Hospital, showed 40% of ambulance handovers were completed in under 15 minutes. Data showed that 4% of patients waited over 30 minutes to be handed over and only 2% of patients waited over an hour to be handed over.

The department had inclusion criteria which included emergency urology and vascular care and minor injuries for adults and children over the age of one.

Staff told us that when the unit first became a minor injuries unit, there was confusion about the kind of patients that could be seen there. They told us that this has greatly improved, ambulance staff now call before bringing patients to the unit to discuss patients before taking them to Kent and Canterbury if they are not sure if the patient is appropriate. They told us that generally, when ambulance personnel called it was to ask whether patient symptoms meant they should be brought to the vascular and urology unit.

They told us they did not have problems with ambulances bringing inappropriate patients and patients who came to the minor injuries unit who did not fit in the inclusion criteria were generally self-referred patients. These patients would be sent by ambulance or referred to an emergency department in the trust that could provide the right care.

At Kent and Canterbury Hospital, we saw that staff could describe markers and appropriate actions when patients showed signs of sepsis and that they carried sepsis reminder cards so they had this information to hand. When patients with suspected sepsis were identified they were transported by blue light ambulance to one of the emergency departments in the trust.

Staff told us they were concerned that, because this was a nurse led unit, there was no one in the emergency care centre who could urgently prescribe IV antibiotics for sepsis patients in line with national guidance. The unit relied on the on-call registrar to come to the unit from another part of the hospital to see the patient, however, there had been confusion about whether this was part of the registrar’s role.

Senior staff on the unit told us that they were aware of the issue and had addressed it in the long and short term. In the longer term, two nurses in the department were on a nurse prescriber course so they would be able to prescribe this and other medicines. In the shorter term, it was clarified within the hospital that a registrar was to come to prescribe antibiotics to the patient.

Senior staff told us they had liaised with the medical director to ensure that the current process for the on-call registrar to come to the unit to prescribe IV antibiotics for these patients was a priority.
Senior staff verified that the ‘hot’ registrar, who was available to support all departments at the hospital, came to the department to prescribe antimicrobials as a priority.

Additionally, we saw the matron had requested patient group directions (PGDs) so nurses on the unit could administer antibiotics to possible septic patients without a doctor seeing the patient or writing and individual prescription. PGDs allow named, authorised health professionals to supply and administer specified medicines, to a pre-defined group of patients needing treatment for a condition described in the PGD. However, this had not yet been authorised and was not justified by best clinical practice or in line with the National Institute of Care Excellence, Medicine practice guideline MPRG2 PGDs which states ‘in most circumstances, PGDs for antimicrobials are not appropriate’.

**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 February 2017 to February 2018 the trust reported 2,395 “black breaches”, with December 2017 having the highest number just over 350.

![Total black breaches chart](image)

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

**Nurse staffing**

The trust reported their registered nursing staff numbers as below as of December 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent and Canterbury Hospital</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>77</td>
<td>82</td>
</tr>
<tr>
<td>William Harvey Hospital</td>
<td>94</td>
<td>104</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>189</strong></td>
<td><strong>207</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.
From January 2017 to December 2017, the trust reported a vacancy rate of 15% in urgent and emergency care;

- Kent and Canterbury Hospital: 22%
- Queen Elizabeth The Queen Mother Hospital: 18%
- William Harvey Hospital: 11%

This is in comparison to the trust target vacancy rate of 10% or less.

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

We saw that the department was fully staffed. However, there were three staff members currently out on long-term leave which meant the department could not cover all shifts internally. Senior staff told us they never used external agency or bank staff but used NHS agency staff when they were needed. However, we saw on the day that of inspection two NHS agency staff had been booked on the rota but had not arrived to cover their shift. Staff told us this was not uncommon. At the time we were present, we saw that the NHS agency staff member was not needed. Staff and senior staff told us that when the unit became busier later in the day, managerial staff (who are not assigned a clinical role on the rota) would provide clinical assistance to cover the absences. Senior staff coverage was the mitigation for the known issue around agency staff failing to arrive to cover planned shifts.

Turnover rates

From January 2017 to December 2017, the trust reported a turnover rate of 17% in urgent and emergency care;

- Kent and Canterbury Hospital: 15%
- Queen Elizabeth The Queen Mother Hospital: 21%
- William Harvey Hospital: 16%

This is in comparison to the trust target turnover rate of 13% or less.

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

Sickness rates

From January 2017 to December 2017 reported an overall sickness rate of 4% in urgent and emergency care. A breakdown by site for nursing staff is as below;

- William Harvey Hospital: 5%
- Queen Elizabeth The Queen Mother Hospital: 3%
- Kent and Canterbury Hospital: 8%

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

Bank and agency staff usage
Medical staffing

The trust reported their staffing numbers for medical staffing as of December 2017.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent and Canterbury Hospital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>William Harvey Hospital</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>43</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

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

Vacancy rates

From January 2017 to December 2017, the trust reported a vacancy rate of 38% in urgent and emergency care;

- Kent and Canterbury Hospital: 22%
- Queen Elizabeth The Queen Mother Hospital: 67%
- William Harvey Hospital: 46%

This is in comparison to the trust target vacancy rate of 10% or less.

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

Turnover rates

From January 2017 to December 2017, the trust reported a turnover rate of 12% in urgent and emergency care;

- Kent and Canterbury Hospital: 29%
- Queen Elizabeth The Queen Mother Hospital: 13%
- William Harvey Hospital: 12%

This is in comparison to the trust target turnover rate of 13% or less.

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

Sickness rates

From January 2017 to December 2017 reported an overall sickness rate of 4% in urgent and emergency care. A breakdown by site for medical staff is as below;

- William Harvey Hospital: 1%
- Queen Elizabeth The Queen Mother Hospital: 0%
- Kent and Canterbury Hospital: 2%

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

Bank and locum staff usage

This was a nurse led unit thus there was no bank or locum medical staff usage.
Staffing skill mix

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

Staffing skill mix for the 46 whole time equivalent staff working in Urgent and Emergency Care at East Kent Hospitals University NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>34%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Medicines

We reviewed 22 refrigerated medicines in the unit. All medicines reviewed were in date, labelled clearly and marked for refrigeration. Medicines were checked daily by departmental staff and staff told us pharmacy came to the department twice a week to check medicines. Staff told us they ordered medicines when stock was low and they could not remember running out of any medicines.

There was an insulated medicines transport box in the department. Medicines were transported in these boxes to ensure they did not become warm during transport.

The provider checked and recorded refrigerator temperatures daily.

However, temperatures were not controlled to ensure medicines remained safe and effective. Room temperatures were not measured and when staff recorded out of range fridge temperatures, these were not reported or escalated. We reviewed fridge temperatures recorded from 1 January through 16 May 2018. Over this period, out of range temperatures were recorded on 32 occasions. However no further action was taken. This meant medicines which needed to be refrigerated in a specific temperature range might have become less effective or ineffective. This is of concern in a resus area where staff rely on the effectiveness of medicines in emergency situations.

When we raised this matter to the matron, they responded promptly by contacting the pharmacy to verify whether medicines stored in the fridge would still be effective given the recorded
temperatures. They provided assurances they were getting a room temperature thermometer, educating staff and setting up an escalation log so out of range temperatures were escalated and followed up on in the future.

**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 March 2017 to February 2018, 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 5 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from March 2017 to February 2018.

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

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (40% of total incidents)
- Treatment delay meeting SI criteria with two (40% of total incidents)
- Medication incident meeting SI criteria with one (20% of total incidents)

(Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

**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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, six falls with harm and eight new urinary tract infections with a catheter from February 2017 to February 2018 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Kent Hospitals University NHS Foundation Trust**

![Graph showing prevalence rate of pressure ulcers.](image)

Total falls (6)

Total CUTIs (8)

Insert commentary on any trends.

*(Source: Safety thermometer - Safety Thermometer)*

**Is the service effective?**

**Evidence-based care and treatment**

**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 about the same as than other trusts.

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

Food and drink was not served in the department due to the nature of the unit. However, food and drink machines were available.

**Pain relief**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 5.5 for the question "How many minutes after you requested pain relief medication did it take before you got it? This was about
the same as other trusts.

The trust scored 7.3 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

Staff in the department could provide pain medications to patients who were in pain.

**Competent staff**

**Appraisal rates**

From April 2017 to December 2017, 72% of staff within urgent and emergency care at the trust had received an appraisal compared to a trust target of 85%

Kent and Canterbury Hospital had a 78% appraisal completion rate.

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

**Seven-day services**

The service was open 24 hours a day, seven days a week including bank holidays. X-ray facilities were available to support the department Monday through Friday from 8am to 8pm and Saturday and Sunday from 8 am until 4pm.

**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 worse than the England average from January 2017 to December 2017.

As of January 2017, the trust performance was 72.9% compared to the England average of 86.7%.
### Understanding and involvement of patients and those close to them

**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 20 of the 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>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.4</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>8.7</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</td>
<td>6.8</td>
<td>Worse than other</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>opportunity to do so?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information</td>
<td>7.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>about your condition or treatment was given to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical</td>
<td>7.1</td>
<td>About the same as other</td>
</tr>
<tr>
<td>or nursing staff to help you?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing</td>
<td>8.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td>and another will say something quite different. Did this happen to you</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>in the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>7.4</td>
<td>About the same as other</td>
</tr>
<tr>
<td>your care and treatment?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity</td>
<td>8.5</td>
<td>About the same as other</td>
</tr>
<tr>
<td>while you were in the emergency department?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment,</td>
<td>6.5</td>
<td>About the same as other</td>
</tr>
<tr>
<td>did a doctor or nurse discuss them with you?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency</td>
<td>5.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td>department, did a member of staff help to reassure you?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a</td>
<td>7.8</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results</td>
<td>7.6</td>
<td>About the same as other</td>
</tr>
<tr>
<td>of your tests?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you</td>
<td>8.9</td>
<td>About the same as other</td>
</tr>
<tr>
<td>could understand?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you</td>
<td>9.4</td>
<td>About the same as other</td>
</tr>
<tr>
<td>were to take at home in a way you could understand?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to</td>
<td>4.9</td>
<td>About the same as other</td>
</tr>
<tr>
<td>watch out for?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual</td>
<td>5.0</td>
<td>About the same as other</td>
</tr>
<tr>
<td>activities, such as when to go back to work or drive a car?</td>
<td></td>
<td>trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into</td>
<td>4.9</td>
<td>About the same as other</td>
</tr>
<tr>
<td>account when you were leaving the emergency department?</td>
<td></td>
<td>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>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>5.8</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>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

**Is the service responsive?**

### Meeting people’s individual needs

#### Emergency Department Survey 2016

The trust scored “worse than” other trusts for two questions of the three Emergency Department Survey questions relevant to the responsive domain and “about the same” as other trusts for the remaining one questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>6.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.3</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

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

Staff were responsive to the needs of individuals. Staff described prioritising patients living with dementia and learning disabilities when possible to minimise the stress and confusion associated with waiting in a medical facility.

Staff communicated with individuals so they could understand and manage their own care. Staff described how they used their training to adapt their communication style for different patients. This meant they spoke to different patients in a way they would understand. This could mean using simple language and basic information, use of drawings or pictures, or involving a patient’s carer where appropriate.

Link nurses were available to provide expertise about patients with learning disabilities and dementia. Staff knew who their link nurses were and how to access them.
Access and flow

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 did not meet the standard for ten months over the 12 month period from February 2017 to January 2018.

Performance against this standard showed improvement from October 2017. As of January 2018, the median time to treatment was 58 minutes compared to the England average of 57 minutes.

However, below data is not specific to the Kent and Canterbury site and may not accurately reflect service at this site.

Ambulance – Time to treatment from February 2017 to January 2018 at East Kent Hospitals University NHS Foundation Trust

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

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 ED.

The trust did not meet the standard from February 2017 to January 2018.

The trust breached the standard 12 times from February 2017 to January 2018.

From October 2017 the trust showed signs of improvement but this declined in the winter months.
Four hour target performance - East Kent Hospitals University NHS Foundation Trust

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

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From February 2017 to January 2018, East Kent Hospitals University NHS Foundation Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted started the reporting period better than the England average but has decreased since October 2017 to worse than the England average with January 2018 showing signs of improvement.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - East Kent Hospitals University NHS Foundation Trust

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from February 2017 and January 2018, eight patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in August 2017 (two patients), December 2017 (two patients) and January 2018 (two patients)

<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>Feb-17</td>
<td>322</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>242</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>210</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>386</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>224</td>
<td>1</td>
</tr>
<tr>
<td>Jul-17</td>
<td>423</td>
<td>1</td>
</tr>
<tr>
<td>Aug-17</td>
<td>447</td>
<td>2</td>
</tr>
<tr>
<td>Sep-17</td>
<td>554</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>586</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>624</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1082</td>
<td>2</td>
</tr>
<tr>
<td>Jan-18</td>
<td>877</td>
<td>2</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 February 2017 to January 2018 the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was worse than the England average.

As of January 2018, the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 3.9%, compared to the England average which was 3.0%.

Percentage of patient that left the trust without being seen - East Kent Hospitals University NHS Foundation Trust

(Source: Source: NHS Digital - A&E quality indicators)
Median total time in A&E per patient (all patients)

From February 2017 to January 2018, the trust’s monthly median total time in A&E for all patients was consistently similar the England average. In January 2018, the trust’s monthly median total time in A&E for all patients was 169 minutes, which is worse than that of the England average which was 153 minutes.

Median total time in A&E per patient - East Kent Hospitals University NHS Foundation Trust

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

Is the service well-led?

Leadership

The department was led by a matron who was supported by two Band 7 nurses. A team of senior nurses was managed by the Matron, they worked with the matron to provide the day-to-day running and co-ordination of the department. The matron worked across three sites at the trust so was not on site every day.

Staff told us they generally felt supported by the leaders in the minor injuries unit. However, they reported that the more senior management were not visible or accessible. One staff member told us they would not know any members of senior management if they walked through the department.

Vision and strategy

The trust had a vision and values. The values were:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect sit at the heart of everything we do
People feel confident we are making a difference

Staff we spoke with felt confident they were working toward these values.

The trust had been working on the clinical strategy with the clinical commissioning groups and sustainability and transformation partnerships to develop the plans in line with regional needs for several years. The new strategy was expected to be foundational for many of the decisions about the trust in the future and would affect the trust’s governance and leadership.

Staff in the department voiced concerns about when decisions would be made and how this would affect their department and individual jobs. The department had changed from a full emergency department to a minor injuries unit several years earlier and staff voiced concerns about whether the department would remain a minor injuries unit or change again.

Culture

Staff felt supported, valued and respected by their peers. We observed staff in each unit of the department (minor injuries unit and vascular and urology) worked as close teams and there were positive working relationships between these staff. However, we observed and staff told us that each part of the unit worked separately and there was not always colleague to colleague support between areas.

All staff we spoke with told us they were very proud of their own work and that of their colleagues. They felt that the teams worked together to manage patient care. Staff told us they felt the teams were closer than in other departments they had worked in.

There was a strong culture of openness and transparency. For example, staff told us about errors they had made, for instance when a patient could be driven to another hospital by private car rather than blue lighted. They could discuss the incident and how learning had been shared.

We reviewed a governance newsletter from December 2017, this had an entire page on duty of candour and described the principles.

The trust was committed to improving staff awareness and understanding to ensure they met duty of candour. For example, the trust had made commitments to improve staff understanding. The Trust told us they had a trust wide training programme due in June 2018 and 10 band seven nurses were booked onto this training between July and November 2018.

However, staff told us they felt unsure about their own future due to lack of surety around the trust’s future strategy. Some staff told us they did not believe senior management listened to their views about changes in the trust, so they had stopped engaging in communications and programs about change.

Learning, continuous improvement and innovation

The department provided examples of innovation in the department. For instance, they had instituted a virtual fracture click to provide virtual support to patient with fractures who came to the minor injuries department. This clinic allowed patients to speak with a nurse who had access to electronic notes, x-rays and consultant review without having to return to the hospital.

The department used an electronic records system which forced note takers to consider safeguarding, venous thromboembolism (VTE) and other patient risks before progressing through the patient’s notes.
The department was training a nurse to become an emergency nurse practitioner (ENP) in conjunction with a local college to extend the skills base in the department without having to hire more staff.

**Surgery**

**Facts and data about this service**

Kent and Canterbury hospital is one of five hospitals that form East Kent Hospitals University NHS Foundation Trust. The hospital is located on the outskirts of the City of Canterbury. It provides a range of surgical services including general surgery, urology, vascular and ophthalmology.

The surgical service at Kent & Canterbury hospital consists of six main operating theatres, three operating theatres for day surgery and one theatre in the ophthalmology suite. There are two surgical wards, Clarke ward (urology) and Kent ward (vascular). Clarke ward had capacity for 36 inpatient beds and Kent ward had 20 inpatient beds.

The trust had 53,563 surgical admissions from November 2016 and October 2017. Emergency admissions accounted for 15,456 (29%), 29,881 (56%) were day case, and the remaining 8,266 (15%) were elective.

(Source: Hospital Episode Statistics)

**Is the service safe?**

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

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

**Mandatory training**

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

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

A breakdown of compliance for mandatory courses from January 2017 and December 2017 for medical/dental and nursing/midwifery staff in surgery at Kent & Canterbury hospital is shown below:

**Mandatory Training Completion by module – Medical and Dental Staff**

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling Level 1</td>
<td>52</td>
<td>66</td>
<td>76%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>50</td>
<td>70</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>51</td>
<td>66</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>51</td>
<td>66</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>46</td>
<td>66</td>
<td>68%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>36</td>
<td>66</td>
<td>53%</td>
<td>No</td>
</tr>
</tbody>
</table>
Mandatory Training Completion by module – Nursing and Midwifery Staff

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>108</td>
<td>113</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>104</td>
<td>113</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>101</td>
<td>113</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>104</td>
<td>113</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 1 year</td>
<td>96</td>
<td>113</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>84</td>
<td>113</td>
<td>76%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Mandatory training was available to all hospital staff and was completed via face-to-face training or through e-learning. Each matron of the various surgical areas kept an electronic record of their staff’s training needs. One matron told us, they printed a list of outstanding mandatory training and the staff who were due for refresher courses every month. It was the responsibility of the staff to book themselves on to a course.

Staff told us they received notifications of outstanding training from their managers. Staff said face to face courses were easy to access and were booked months in advance which allowed managers to cover their shifts. Training courses were held at a number of locations, so staff were able to choose a location that suited them. For courses held on site, matrons were able to send additional staff, if they had adequate staffing levels and if the course leader had capacity for more staff to attend. However, due to staff shortages, staff were asked to cancel training to ensure there were enough staff in the department. This was a common occurrence particularly during the winter months.

Staff were encouraged to undertake online training during quiet periods. The matrons and staff said they were given time to complete online training.

At the last inspection, we told the trust it should ensure staff in surgical areas complete all their required mandatory training. Although the trust had made some progress, we found that in some areas mandatory training rates remained low for some staff groups, particularly for medical and dental staff and in some topics, such as information governance.

Safeguarding

The trust had a safeguarding children team within the child health division and an adult safeguarding team. The teams received safeguarding support from the local council. East Kent Hospitals Trust’s safeguarding teams had an arrangement to share information with the local Clinical Commissioning Groups (CCGs) and other agencies.

The hospital had a safeguarding policy which was in date and included Female Genital Mutilation (FGM). The policy was accessible to all staff via the trust intranet. Staff demonstrated a variable understanding of their safeguarding responsibilities and safeguarding procedures. Some staff were unable to tell us what constituted abuse and junior staff demonstrated a limited understanding. However, they said they would raise any concerns they had with a senior member of staff. Staff were not aware of who the safeguarding lead was.

External governance was provided through the participation with Kent Safeguarding Children Board audit program, serious case reviews and bi annual section 11 submission. Section 11 audit
is a local safeguarding effectiveness assessment which local agencies and organization self-assess the extent at which they meet the safeguarding requirements and standards as set out in section 11 of the Children Act 2004.

**Safeguarding training completion rates**

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

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

A breakdown of compliance for safeguarding courses from January 2017 and December 2017 for medical/dental and nursing/midwifery staff in surgery is shown below:

**Safeguarding Training Completion by module – Medical and Dental Staff**

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>66</td>
<td>66</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Control (Level 1)</td>
<td>50</td>
<td>70</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>36</td>
<td>66</td>
<td>55%</td>
<td>No</td>
</tr>
</tbody>
</table>

As of April 2018, the compliance for safeguarding for medical and dental staff was 79%, which did not meet the trust target.

**Safeguarding Training Completion by module – Nursing and Midwifery Staff**

<table>
<thead>
<tr>
<th>Training Module</th>
<th>Staff Trained</th>
<th>Eligible Staff</th>
<th>Completion Rate</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adult (Level 1)</td>
<td>113</td>
<td>113</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adult (Level 2)</td>
<td>87</td>
<td>113</td>
<td>81%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>17</td>
<td>25</td>
<td>72%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>41</td>
<td>88</td>
<td>39%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request P18)

**Cleanliness, infection control and hygiene**

All areas we visited including the storage areas were visibly clean and free from dust. The service employed housekeeping staff who were responsible for keeping the wards and theatre areas clean. Patients said they had seen the housekeeping staff cleaning throughout the day.

Cleanliness audits were undertaken weekly on the surgical wards. On Clarke ward results showed 98.6% compliance in April 2018 and 98.5% compliance in May 2018. Results on Kent wards showed 98.8% compliance in April 2018 and 98.56% compliance in May 2018.

In theatres, we observed all staff wore the correct uniform. This included theatre scrubs, hats and masks. We observed that staff were bare below the elbows.
Hand sanitiser was available at the entrance to each ward area. There was clear signage instructing all staff and visitors to wash their hands and to follow the trust policy on infection prevention when entering or exiting the clinical areas. Staff were observed washing their hands in line with the World Health Organisation’s “Five Moments of Hand Hygiene” guidance between personal care activities with patients and utilising the hand sanitiser where appropriate.

Patients were screened for Methicillin-resistant *Staphylococcus aureus* (MRSA) and Clostridium difficile. The governance report in May 2018 reported zero cases of MRSA and Clostridium difficile for the month of April 2018.

Each surgical area had a link nurse for infection, prevention and control who conducted local audits. In April 2018 Clark ward achieved 100% for bare below the elbow, 100% hand hygiene and 100% for commode cleaning. On Kent ward, the ward achieved 94% for bare below the elbow, 100% for hand hygiene and 60% for commode cleaning. We saw an action plan for commode cleaning with a resolution date as this fell below the 90% target. The wards displayed these local audit results on the ward’s notice board and they were visible to staff, patients and visitors.

Staff demonstrated good infection control practices in theatre including waste management, specimen handling, surgical techniques and maintenance of sterile field.

Staff labelled sharps bins correctly, identifying the date, signature and location of origin. The bins were not over filled, which reduced the risk of injury to staff.

There were appropriate waste segregations throughout the wards and theatres. Waste bins were colour coordinated to identify the type of waste being disposed. We observed staff disposing of clinical, domestic and recyclable waste in line with the trust policy.

Staff cleaned theatre equipment appropriately between cases using disinfectant wipes in adherence to the trust decontamination procedure. The hospital used single use, sterile instruments. The single use instruments we saw were within their expiry dates. The service had arrangements for sterilisation of reusable instruments, which was done offsite. We saw that this process was efficient and effective at meeting requirements.

Electrical equipment including endoscopy stacks, rapid infusers and syringe drivers appeared clean. We saw use of ‘I’m clean’ stickers. This meant staff knew that equipment was clean and safe to use.

Kent & Canterbury Hospital did not undertake trauma and orthopaedic cases therefore no data relating to surgical site infection was submitted to Public Health England (PHE).

**Environment and equipment**

The theatres were clean and bright. There had been improvements to the environment since our last inspection. Improvements had been made to the walls, there were new surfaces and flooring in main theatres.

Staff accessed the theatres by key card. Visitors accessed the theatres by ringing the reception using the phone near the theatre entrance and waiting for authority to enter from staff. This enhanced the level of security of the unit by limiting access to restricted areas and permitting only authorised personnel to enter.

The ward areas and theatres had access to resuscitation trolleys. In main theatres there were large, clear signs indicating the different trolleys available. There was a trolley for difficult
intubation, paediatrics, adult airway and vascular. We saw staff checked the trolleys in theatres daily and completed a checklist. The trolleys were orderly and all consumables checked were in date. This meant in the event of an emergency staff knew that the medication was safe to use and the equipment was easy to locate.

Records indicated that staff checked equipment in the anaesthetic room and completed a daily checklist. This was in line with guidance from the Association of Anaesthetists of Great Britain and Ireland (AAGBI) (2012) checking anaesthetic equipment.

Each piece of equipment had been tested for electrical safety within the last 12 months as part of the planned preventative maintenance (PPM) programme. The trust had a policy for the management of medical devices that applied the medicines and healthcare products regulatory agency (MHRA) managing devices guidance (April 2014). We saw records showing equipment was maintained and serviced in line with manufacturers guidance.

The wards and theatres had access to bariatric equipment, which included a hoist and patient trolleys, for the safe moving and handling of patients. The trolleys could safely hold patients with a body weight of up to 250kg.

The ophthalmology unit was purpose built with one theatre and a recovery room. There was a waiting room in the unit for pre-assessment and post-operative patients to wait and a member of the administration or nursing staff supervised this area.

The ophthalmic suite treated children. There was no separate area for children to wait or recover post-surgery. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Immediate post anaesthesia recovery 2013 guidelines states that “children have special needs reflecting fundamental psychological, anatomical and physiological differences to adults. These are best met by having a designated, separate paediatric recovery area that is child-friendly”.

There was a unisex changing room and toilet for staff to use. Staff said they did not feel comfortable using the changing room and refused to change in there at busy periods.

We observed that lead aprons in main theatres were not hung correctly and many had sustained damage. Improper storage of the aprons has the potential to reduce the integrity of the lead, leading to ineffective protection from radiation.

Staff kept equipment generally clean but some equipment had sustained damage. In theatre four one stool had a tear on the back support that had been taped up. We noticed the surgical stool used by surgeons, was damaged on top of the padding. This created an infection risk as cleaning and decontamination would not be effective, which would allow microorganisms to grow.

On Clarke ward, we found the drawers to the resus trolley to be unlocked. One drawer stored adrenaline and saline flushes, which meant unauthorised persons could access these. We informed the ward matron who immediately resolved the issue with a temper evident tag.

The resus trolley on Kent ward was not been checked daily in accordance with trust policy. We saw that on 7, 22 January, 6, 12, 15, 17, 21, 28 February, 24, 29, 15, 16 March and 2,12,16,19,20,24,31 April the checks were not completed or signed to confirm the trolley was checked to be safe for immediate use.

**Assessing and responding to patient risk**

At the last inspection, we observed that staff did not always undertake risk assessments and failed to act upon them. We saw evidence of change in practice. A series of risk assessments were completed including venous thromboembolism (VTE), skin damage, falls and nutrition. We reviewed 11 sets of patient records and noted that assessments were recorded in the patient records.
A theatre team brief was held before each theatre list was started. The team discussed each patient, shared information about antibiotics prescribed, previous operations, the patient’s medical history and the anaesthetist’s care plan. This allowed risks to be identified and plans to be made prior to surgery commencing.

The hospital used the national early warning score (NEWS) to identify a deteriorating patient. Scores were calculated and recorded on a handheld electronic observation device. Staff could describe when they would seek medical help to review a patient and what information they divulged to effectively communicate the seriousness of the situation. Staff in theatres were observed assessing patients and recording early warning scores every 15 minutes. On the wards, the frequency of observations depended on the procedure that had been undertaken and the patient’s medical history.

We observed nursing staff competently using a handheld device to record patient observations and this was used alongside the paper records. Staff told us they were able to access patient information remotely, which was essential especially for deteriorating patients. Doctors were able to review a patient’s recent observations and make a decision on the care to provide whilst in transit, therefore avoiding unnecessary delays in commencing vital treatment.

The service used the national early warning score (NEWS) to monitor triggers of sepsis and staff demonstrated a good understanding of sepsis its recognition and treatment. The sepsis pathway was available in patients’ notes.

The World Health Organization (WHO) surgical safety checklist identifies three phases of an operation: before the induction of anaesthesia (sign in), before the incision of the skin (time out) and before the patient leaves the operating room (sign out). In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation.

We observed theatre staff in theatre four and the ophthalmic suite completing the WHO checklist on five occasions. One patient had two procedures in a single session. All three phases of the WHO checklist were completed for each procedure in line with national guidance.

Monthly audits from May 2017 to April 2018 showed an overall compliance score of 99% across all surgical areas for Kent & Canterbury Hospital.

A ‘stop before you block’ poster was displayed in the anaesthetic room of theatre four as a visual aid when performing a nerve blocking procedure. The National Patient Safety Agency (NPSA) states that ‘stop before your block’ procedures should be used when patients are undergoing an anaesthetic to prevent any avoidable patient harm caused by wrong site anaesthetic block.

Staff were observed conducting pressure area care assessments pre-operatively, in recovery and once the patient was back on the ward. We spoke to a tissue viability nurse who told us, each patient is assessed to ensure they have the right equipment. The nurses encouraged early mobilisation and provided any assistance needed to change position in bed. The hospital provided equipment to prevent pressure sore developing which included gel heels, hip pads and air mattress.

**Nurse staffing**

The surgical unit used an acuity tool and their professional judgement to assess the dependency of the patients which determined nurse staffing levels. Surgical matrons reviewed staffing levels on an ongoing basis and where shortages were identified, additional staff could be sought. Staff told us they were often moved from one area of surgery to another if they had the required skill mix and if it was safe to do so. Staff from Buckland Hospital, which was part of East Kent...
Hospitals University NHS Foundation Trust, were rostered to fill nursing shifts on the Kent & Canterbury site.

Theatres had a core group of staff who worked permanently in one area. Other staff (predominately junior staff) rotated between main theatres and day surgery on a six month cycle.

The wards displayed the planned versus the actual staffing levels. We checked on both Kent and Clarke wards to ensure the numbers displayed were accurate and saw they were. We saw that there was always a senior nurse in charge of each shift, in all surgical areas.

Staff in the ophthalmic unit said there was only one nurse available to care for post-operative patients and this was evident from the staff roster provided by the hospital. One recovery nurse was insufficient to deliver the one to one care required particularly when there were two post-operative patients needing care.

Staff told us that although recovery nurses were rostered to supervise patients in the waiting room and recovery area, they could not guarantee that a member of staff was always available. Staff were often called away to the surgical wards or to the other side of the ophthalmic unit, which meant patients were left unattended. Furthermore, there was no call bell available for patients to call for assistance if a member of staff was not present.

The service provided us with the daily staff allocation for the ophthalmic suite to assure us that patient safety is maintained by an adequate number of trained staff. Were staff shortages posed a patient safety risk, staff with the required skill mix were rostered from the day surgery or main theatres to the ophthalmic suite.

During the inspection, staff raised a concern relating to frequently working extended hours. For example, as part of their rostered duty, which did not include extra shifts staff, staff could be rostered to work a day shift from 8am to 6pm and then provide on call cover until 8am the following day. They were expected to work a day shift the next day. This breached the European working time directive (EWTD) which states that there should be 11 hours rest a day.

The concern had previously been escalated to the trade unions which resulted in a meeting attended by 58 members of staff. The trust had replied at the time, that the time when staff were not called in was considered to be their rest period. Following our inspection, the trust reviewed their policy and advised the CQC that the practice had ceased and staff rostered according to the EWTD.

The trust has reported their nurse staffing numbers below as of December 2017

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Harvey Hospital</td>
<td>176</td>
<td>195</td>
</tr>
<tr>
<td>Queen Elizabeth The Queen Mother Hospital</td>
<td>107</td>
<td>121</td>
</tr>
<tr>
<td>Kent and Canterbury Hospital</td>
<td>107</td>
<td>119</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>390</strong></td>
<td><strong>435</strong></td>
</tr>
</tbody>
</table>

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

From January 2017 to December 2017, the trust reported a vacancy rate of 20% in surgery.

- Kent and Canterbury Hospital: 20%
- Queen Elizabeth The Queen Mother Hospital: 30%
- William Harvey Hospital: 17%

This is in comparison to the trust target vacancy rate of 10% or less.

There were 12 whole time equivalent vacancies for theatres at the time of our inspection. The service had recently recruited four band 2 staff, three band 3 staff and two band 5 staff to fill the vacancies.

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

Turnover rates

From January 2017 to December 2017, the trust reported a turnover rate of 12% in surgery.

- Kent and Canterbury Hospital: 10%
- Queen Elizabeth The Queen Mother Hospital: 17%
- William Harvey Hospital: 11%

This is in comparison to the trust turnover target rate of 13% or less.

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

Sickness rates

From January 2017 to December 2017, the trust reported an overall sickness rate of 5% in surgery. A breakdown of nursing staff sickness rates by site is as below:

- William Harvey Hospital: 3%
- Queen Elizabeth The Queen Mother Hospital: 7%
- Kent and Canterbury Hospital: 6%

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

Bank and agency staff usage

From February 2017 to January 2018, the trust reported a bank and agency usage rate of 59% in this core service;

- Kent & Canterbury Hospital: 52%
- Queen Elizabeth The Queen Mother Hospital: 61%
- William Harvey Hospital: 62%

On the first day of our inspection (16 May 2018), there was one locum staff in theatres. The matron told us the service rarely used locum staff. The trust used staff provided by an NHS agency staff provider.

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

All specialities reported that consultant on call cover was available providing 24 hours access to consultant led care.

Junior medical staff and middle grade doctors provided weekend ward cover, with cover available from consultants on call. Weekend ward rounds were led by the junior doctors. Junior doctors told us they felt supported and they received sufficient training for their roles. Patient were reviewed daily by the medical team who conducted a ward round. Ward rounds were led by junior doctors during the weekend.

During our inspection the medical staffing and skill mix was sufficient in all areas we visited. Staff confirmed this; for example, junior doctors and registrars told us they received adequate consultant supervision. Nurses explained that there was a very responsive medical team consisting of junior and middle grade doctors and a consultant who supported the wards.

We spoke with a surgeon in the ophthalmic suite who told us that the Friday clinic had been stopped because the hospital could not provide anaesthetic cover. The surgeon explained that the waiting list was growing as demand for the service had increased and most patients required general anaesthesia. As a result, patients were kept on the waiting list longer. The surgeon also expressed his frustration with the trust for booking an anaesthetist for that day’s clinic, because all procedures for the clinic were conducted under local anaesthetic. Therefore, an anaesthetist was not required to be present so was sent away. This showed that there was a lack of planning and poor communication within the surgical service which resulted in a waste of resources.

The trust has reported their medical staffing numbers below as of December 2017

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Harvey Hospital</td>
<td>127</td>
<td>131</td>
</tr>
<tr>
<td>Queen Elizabeth The Queen</td>
<td>95</td>
<td>97</td>
</tr>
<tr>
<td>Mother Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kent and Canterbury Hospital</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>290</td>
<td>296</td>
</tr>
</tbody>
</table>

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

Vacancy rates

From January 2017 to December 2017, the trust reported a vacancy rate of 10% in surgery;

- Kent and Canterbury Hospital: 13%
- Queen Elizabeth The Queen Mother Hospital: 10%
- William Harvey Hospital: 10%

This is in comparison to the trust target vacancy rate of 10% or less.

(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.
From January 2017 to December 2017, the trust reported a turnover rate of 6% in surgery.

- Kent and Canterbury Hospital: 10%
- Queen Elizabeth The Queen Mother Hospital: 4%
- William Harvey Hospital: 6%

This is in comparison to the trust turnover target rate of 13% or less.

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

**Sickness rates**

From January 2017 to December 2017, the trust reported an overall sickness rate of 5% in surgery. A breakdown of medical staff sickness rates by site is as below:

- William Harvey Hospital: 1%
- Queen Elizabeth The Queen Mother Hospital: 1%
- Kent and Canterbury Hospital: 1%

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

**Bank and locum staff usage**

From February 2017 to January 2018, the trust reported a bank and locum usage rate of 43% in this core service.

- Kent & Canterbury Hospital: 54%
- Queen Elizabeth The Queen Mother Hospital: 43%
- William Harvey Hospital: 37%

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

**Staffing skill mix**

In December 2017, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was the same.
Staffing skill mix for the whole time equivalent staff working at East Kent Hospitals University NHS Foundation Trust

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

We looked at 11 sets of patient records across two wards and the theatre areas and saw they were comprehensive and well documented. The records included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with patient and families. Staff complied with guidance on record keeping issued by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), the professional regulatory bodies for doctors and nurses.

Patient records were easily accessible to those who needed them, such as doctors, nurses and other healthcare professionals. The service used patient pathway documents which remained with all the patient’s records through their surgical journey. Staff were able to review the document at any stage to review the care that had been provided thus far or check the consent form.

Ward clerks effectively managed the records to ensure they were available on site for clinic appointments or for admission. Records were temporarily kept onsite for the duration of the patients stay or until discharge from the service. When records were no longer needed, the medical records department collected them and transferred them offsite for storage.

The trust had an efficient tracking system for patient records. Records were neatly arranged in an orderly manner and this enabled notes to be tracked to a specific location. The records were kept locked to prevent unauthorised access.

On Kent ward patient admission notes were kept in a cupboard which was closed but not locked in front of the nurse’s station. Staff told us this was locked out of hours and during the day there was always a member of staff at the station.

However, on Clarke ward, we did see two sets of loose discharge letters in the medicines room. We informed staff at the time of the inspection who immediately filed them with the associated patient records.
Medicines

Staff stored medicines and controlled drugs (medicines requiring extra security and monitoring due to their potential for misuse) in locked cupboards. However, the clinical area where medicines were prepared for administration was cramped and was used to store food and drinks for staff. There was a risk of food becoming contaminated if it came into contact with dirty surfaces.

From 1 May 2018 to the date of our inspection, staff had checked and recorded fridge temperatures daily. Temperatures were within the manufactures’ recommended ranges. However, we found some medicines in the fridge had expired, which meant that they were unsafe to consume or may not be as effective.

We reviewed 11 sets of patient prescriptions and medication records. Records were well completed, with medication, doses, allergies and signatures all recorded correctly.

Medicines safety alerts were cascaded to staff by the ward manager. Staff had knowledge of recent alerts. Staff were supported to report and learn from incidents by their managers. Staff said they informed patients when errors relating to their medicines had occurred.

The service used two different medicine charts, one chart was for day case patients and the other for patients admitted overnight. The day case chart did not have space for patients’ regular medicine to be prescribed. This meant that if they required a lunchtime dose of their medicine from home, for example, it was not recorded. Staff could not be assured whether a patient had missed or taken a dose. If a patient needed to stay overnight, a new inpatient chart had to be written.

We reviewed medicine charts for five patients on Kent ward and two patients on Clarke ward. We noted that body weights were not always recorded on the chart. We saw that one patient was self-administering their medicines, but the ward had not assessed the patient as being safe to do this.

On another medicine chart we saw pain relief had been prescribed regularly and on a ‘when required’ basis. Although the patient had not received the full amount of both, the maximum safe daily dose would have been exceeded, if they had. This medicine chart had not been reviewed by the pharmacist. We also noted that one patient had three missed doses and there was no reason recorded on the chart.

The wards had a dedicated pharmacist available Monday to Friday. We spoke to the pharmacists who told us that a challenge they had was because of nursing staff missing doses. The pharmacist encouraged staff to speak to doctors and/or pharmacist first who would review the patient and decide when and what medication to omit.

Incidents

All staff had access to the reporting system via the trust intranet. There was awareness by staff of how to report an incident and all said they were confident in using the electronic system used by the hospital.

Staff throughout the surgical service told us incidents were discussed at handovers, team briefings and at staff meetings. We saw communication folders located in the staff rooms which the ward and theatre matrons used to share incidents. This was to ensure all staff including those who were not present for team briefings were informed.

Incidents reported using the reporting system were sent to the nominated individual to investigate. The theatre matron said support was given to staff involved in the incidents from their line manager or colleagues. Staff we spoke with told us they were interviewed about incidents they had being involved in but did not receive feedback or support at the end of the investigation.
From March 2017 to February 2018, Kent & Canterbury reported one serious incident for the surgical division. The incident occurred in January 2018 during the surgical removal of the lower wisdom teeth. The drill used overheated and burnt the patient’s lip, which in turn resulted in the development of an infection. The drill was removed from the theatre and an investigation was still underway at the time of our inspection. We saw the duty of candour letter in relation to this case, informing the patient affected they would receive a copy of the final investigation report when completed.

The service notified the relevant person that an incident had occurred in line with the Health and Social Care Act 2008 (Regulated Activities) Regulation 20: Duty of Candour. The intention of the regulation is to ensure organisations were open and transparent with people who use the service. We reviewed five duty of candour letters including one relating to this serious incident. The trust explained what had happened and informed the recipient that an investigation was being carried out and they would share their final report findings.

Although staff said incidents and learning from incidents were regularly discussed and shared via team briefings and the communication documents. Only one member of staff was able to give us an example of a recent incident. The incident occurred as a result of theatre staff omitting to inform ward staff of a delay, which resulted in a patient having to be nil by mouth for longer than necessary. The nurse completed an incident form in order to improve communication between staff and therefore deliver better patient care.

Staff were unable to tell us of any changes to practice as a result of an incident. We could not be assured that the service was using learning from incidents to improve the care provided.

**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 March 2017 to February 2018, the trust reported one incident classified as a never event for surgery. This was a surgical/invasive procedure incident meeting SI criteria.

There were no never events reported at Kent & Canterbury hospital from March 2017 to February 2018. We saw incidents from other hospital sites were shared in the outcome with learnings (OWL) newsletter. This was to help staff identify potential risks within their own unit and take action to prevent incidents from happening.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 14 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from March 2017 to February 2018.

Of these, the most common types of incident reported were

- Treatment delay meeting SI criteria with five (36% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with three (21% of total incidents).
- Pressure ulcer meeting SI criteria with two (14% of total incidents).
- Medication incident meeting SI criteria with two (14% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (7% of total incidents).
All other categories with one (7% of total incidents).

(Source: Strategic Executive Information System (STEIS))

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 ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 24 new pressure ulcers, five falls with harm and 18 new urinary tract infections in patients with a catheter from February 2017 to February 2018 for surgery.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and new urinary tract infections in patients with a catheter at East Kent Hospitals University NHS Foundation Trust

Total Pressure ulcers (24)

Total Falls (5)

Total CUTIs (18)

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

Trust policies and procedures were evidence based and adhered to national guidance. Practice guidelines were available to staff on the trust intranet to ensure practice remained in line with national guidance.

All staff we spoke with could identify how to locate policies. Staff confirmed that policies were regularly reviewed and updated. They were notified of updates at briefings, study days or via the communication documents. Policies and standards on the intranet were within their review date. However, in theatres the majority of printed documents were out of date which meant there was a risk of staff following out dated guidelines or practices for the care of patients.

The surgical service carried out pre-operative investigations and assessments in accordance with the National Institute for Health and Care Excellence (NICE) guidelines.

Staff had various procedures to follow for management of patients. For example, we saw guidelines for a local protocol for the screening and treatment of sepsis. This was an adaptation of the NICE guidance, NG51 Sepsis recognition, diagnosis and early management. Staff were trained in the management of sepsis. We saw a dedicated sepsis trolleys in the surgical assessment unit and in theatres.

Staff were able to demonstrate their knowledge of the sepsis pathway. We reviewed one patients’
medical records and noted that the staff had followed the sepsis pathway in accordance with trust policy. The sepsis form had been completed and signed by both the nurse and the doctor. Both the nurse and the doctor had documented actions taken and medication prescribed.

Patients were assessed for risk of venous thromboembolism prior to surgery. We saw evidence that patients were given compression stockings and prescribed prophylaxis medication, in line with NICE guidance.

**Nutrition and hydration**

Nursing staff assessed all patients’ nutritional and hydration needs using the malnutrition universal screening tool (MUST) at admission. MUST is a simple five step tool designed to identify adults at risk of malnutrition and categorizes them as being at low, medium or high risk.

The wards ensured the environment was conducive to people enjoying their meals and being able to safely consume their food and drinks. The trust had protected meal times when all ward based activities were stopped to enable staff to serve food and give assistance and support to patients. Patients were able to eat their food at their own pace, in a relaxed environment.

We reviewed a varied food menu, which catered for patients’ individual religious, cultural or dietary needs as well as texture modification. The menu included 16 different meat and fish dishes and vegetarian choices from curries and roast dinners to pasta dishes.

We saw that water was available and in reach for those who were able to drink.

Information about pre-operative starvation times (nil by mouth) was given during the patients’ pre-admission visit. Patients having a general anaesthetic were advised not to eat solid food or drink milk or juice with pulp in the six hours prior to surgery. Patients were able to drink non-alcoholic clear fluids up to two hours before anaesthetic.

Patients had access to a dietician. Staff used an automated referral system to alert the dietician of patients at risk of malnutrition.

**Pain relief**

We saw pain relief was discussed pre-operatively, in recovery and on the wards. Day surgery patients were encouraged to take some paracetamol before leaving their home. This meant that patients had good pain control prior to having a surgical procedure.

Pain relief was taken into consideration prior to discharge. Staff ensured that patients had understood the arrangements that had been made. Pain medication prescribed post operatively was included in the patients discharge letter.

Nurses administered medicines in a safe manner and signed the prescription and administration chart or recorded the reasons why people had refused to take their pain medicines.

There were different methods of managing patient’s pain. Pain relief was given by mouth (oral), injection, suppositories, epidural and patient controlled analgesia (PCA).

Pain relief was recorded as part of the observation record sheet. The service used a numerical pain assessment score. Zero meaning that the patient had no pain and three meaning severe pain. A severe pain score prompted a review by a clinician.

Patients had access to an outreach pain team for acute pain. There was a separate chronic pain team.
Patients that we spoke to were positive about the way that their pain had been managed. They informed us that if they had been in pain, staff had responded quickly. Patients on the wards told us they had received their medicines in a timely manner and that nurse came back to check if additional medications were needed.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

From November 2016 to October 2017, all patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Trauma & orthopaedics patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

All patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at the trust had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- General surgery patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & orthopaedics patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing relative risk of readmission for elective admissions](image)

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

**Non-Elective Admissions – Trust Level**

![Graph showing relative risk of readmission for non-elective admissions](image)

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

*(Source: HES - Readmissions (November 2016 – October 2017))*
Kent & Canterbury Hospital

From November 2016 to October 2017, all patients at Kent & Canterbury Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at Kent & Canterbury Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Vascular surgery patients at Kent & Canterbury Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Kent & Canterbury Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

All patients at Kent & Canterbury Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at Kent & Canterbury Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Vascular surgery patients at Kent & Canterbury Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- General surgery patients at Kent & Canterbury Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - Kent & Canterbury Hospital

![Elective Admissions Chart](chart1)

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

Non-Elective Admissions - Kent & Canterbury Hospital

![Non-Elective Admissions Chart](chart2)

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
National Bowel Cancer Audit

In the 2017 National Bowel Cancer Audit for East Kent Hospitals University NHS Foundation Trust, 60.2% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate of 69.5%. The 2016 figure was 51.4%.

- The risk-adjusted 90-day post-operative mortality rate was 3.7% which was as expected. The 2016 figure was 3.5%.
- The risk-adjusted 2-year post-operative mortality rate was 20.0% which was as expected. The 2016 figure was 18.5%.
- The risk-adjusted 30-day unplanned readmission rate was 7.7% which was as expected. The 2016 figure was not reported.
- The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 76.0% which was a negative outlier. The 2016 figure was 75.6%.

(Source: National Bowel Cancer Audit 2017)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.0% for Abdominal Aortic Aneurysms, indicating that the trust was as expected. The 2016 figure was 1.6%.

Within Carotid Endarterectomy, the median time from symptom to surgery was seven days, which was better than the national standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was as expected at 1.5%. The 2016 figure was 0.5%.

(Source: National Vascular Registry 2017)

National Oesophago-Gastric Cancer Audit

In the 2016 National Oesophago-Gastric Cancer National Audit (NOGCCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 3.6%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure had poor quality data.
The trust was not eligible for the 90-day post-operative mortality rate metric in either 2015 or 2016.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 40.0%, which was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 performance on groin hernias was about the same as the England average.

For hip replacements, performance was about the same as the England average.

For Knee replacements, performance was better than the England average.

(Source: NHS Digital)

**Competent staff**

All new staff including agency workers undertook either a comprehensive local induction or an agency specific induction. We reviewed five recently completed induction in theatres. The
induction included, the theatre philosophy, who is who, their roles and responsibilities, the off-duty roster, leave and study leave and the theatre uniform policy.

Patients we spoke with reported a high level of confidence in medical and nursing staff’s knowledge and skills.

The service had an education facilitator who worked closely with the university’s link lecturer and they were responsible for supporting both staff and students. The practice facilitator kept a record of staff development which included courses and conferences attended. Staff were supported to complete their revalidation for the Nursing and Midwifery Council (NMC).

Trainee doctors reported feeling well supported by senior staff and having good training opportunities. Similarly, nursing and theatre staff told us there were plenty of development opportunities within the surgery division.

Educational opportunities were good and available for staff who wanted to progress. Most of the staff we spoke with had or were currently being supported by the trust to undertake further training to earn additional qualifications. Staff said the trust allowed them to apply and undertake one module per year.

The trust had a training plan for staff to apply for funding towards a course. Staff would discuss their intentions with the education facilitator or their line manager, who would decide whether the course would be beneficial to the service and the staff member. If approved, the facilitator submitted the application to the trust’s training facilitators to approve the funding. Although most staff had a positive experience and were granted approval, one member of staff told us that it had been difficult to gain funding for a master’s course. They had been on the waiting list for over two years for a master’s course.

Nursing staff were competency assessed in a number of areas including cannulation. Additionally, clinical staff with extended roles had undertaken competency based assessments to show they met the requirements of the role. A record of all competencies was stored electronically by the education facilitator. We saw two examples for competencies for the administration of medicines.

At the time of our inspection the theatre staff were supporting five operating department practitioner students and ten student nurses. Previously, paramedic and midwifery students had had an opportunity to shadow staff in theatres.

We spoke to three students, and all spoke positively about their placements. Each student had been allocated a mentor and a co-mentor and they received additional support from the education facilitator and other staff within the department. One student said she had “had the opportunity to visit and observe many areas of surgery”.

Kent & Canterbury hospital had provisions for speciality vascular and urology surgery. In order for surgeons to maintain core clinical competencies for general surgery, they need to operate on a breadth of patients with complex needs. This was not the case at the time of our inspection, which posed a potential patient safety concern.

The lack of surgical variety meant there was inadequate compliance with standards for medical education and training for trainee doctors. The General Medical Council (GMC) and Health Education England (HEE) could deem training in particular areas as unsafe or inadequate. The trust acknowledged this risk and it was placed on the corporate risk register.
Appraisal rates

From April 2017 to December 2017, 89% of staff within surgery at the trust had received an appraisal compared to a trust target of 85%.

Kent and Canterbury Hospital had an 86% appraisal completion rate.

Staff we spoke with said they had an annual appraisal. Appraisals enable staff and managers to identify training needs, track progress and enhance clinical practice. Staff were notified of when an appraisal was due a month in advance. Staff completed an appraisal form with a list of objectives they wished to undertake in the forthcoming year. At the appraisal meeting with their manager, they discussed whether the objectives were achievable and what support they required to achieve these. This was evident in two appraisals we randomly selected to review.

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

Multidisciplinary working

Staff told us there was good teamwork between various professionals within the surgical service. Evidence from interviews and general observations indicated that staff worked well together and we were able to assess and plan ongoing care and treatment in a timely manner. For example, we heard a conversation between a physiotherapist and a nurse regarding the progress of a patient. The patient was to be encouraged to walk with a walking frame with the assistance of the nurses and relatives. The patient had been given exercises to do and we heard the physiotherapist advising the nurse on how best to facilitate rehabilitation.

The daily handover procedure for the theatre team to ward staff included input from anesthetists and consultants. We saw close working relationships between theatre and ward staff and staff from other departments. In two sets of patient notes we reviewed, there were written handovers from the intensive care unit (ITU) to the ward on the situation, background, assessment, recommendation (SBAR) principle. This meant ward staff were aware of what immediate actions to take relevant to each individual patient.

One junior doctor told us there was a multidisciplinary team meeting every Wednesday afternoon. This was attended by nursing staff, physiotherapist, occupational therapist, and junior doctors and consultants. Staff discussed all patients in detail. We attended a meeting and saw concerns or changes to care plans were also discussed and shared amongst all attendees.

Ward rounds were conducted each morning, with junior doctors, the discharge team and nursing staff in attendance. Patient care, therapy and discharge planning for every patient on the wards was discussed.

There was an inpatient physiotherapy service that specialised in vascular surgery. Patients who have undergone amputation naturally shift their centre of gravity over the residual limb. Physiotherapists regularly worked with amputee patients to re-educate them on weight bearing and maximising muscle strength and joint mobility. The physiotherapist encouraged this so patients could gain a good level of independence before being discharged home or into the community.

Seven-day services

Day surgery was open Monday to Friday 7am to 8pm and occasionally had a weekend operating list. The ophthalmology suite was open Monday to Thursday from 9am to 5pm and Fridays 9am to 1pm. The urology suite worked Monday to Friday from 7am to 8pm.

The on-call arrangements included one consultant, one registrar and one senior house officer
(SHO) for each speciality (urology and vascular). If the on-call consultant was required on site, they were contactable via their mobile through the switchboard service. Middle grade and junior doctors were on site when on-call.

A consultant anaesthetist was available Monday to Friday 8am to 7pm. Outside these hours; they were available from home via a resident registrar. During the weekend, consultant anaesthetist cover was provided between 8am and 2pm. Outside these hours they were available from home via a resident registrar.

The pharmacy department provided cover Monday to Friday from 9am to 5.30pm and on Sunday from 9am to 12pm. There were arrangements to support surgery out of hours via an on-call system.

Diagnostic services such as CT and X-ray were available 24 hour a day. One radiographer provides diagnostic cover for the surgical division.

**Health promotion**

Staff advised patients to give up or cut down on smoking and alcohol consumption to help speed up the recovery process and reduce complications. The trust had a stop smoking service. Staff could refer patient to the service by phone and patient were able to self-refer. The service offered patients inpatient bedside behavioural support, nicotine replacement therapy (NRT) while in hospital or to take home on discharge if appropriate. NRT was also offered to patients who did not wish to quit but were struggling while in hospital. The service continued to support patients post discharge in the community.

Staff provided patients with verbal information and literature on the specific aftercare needed for their procedure. Patients were encouraged to partake in their own recovery process to maximise their potential, with the aim to return normal function as quickly as possible. We saw physiotherapists and occupational therapists demonstrating functional activities for patients to do including sitting, standing and walking.

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

Patients we spoke with told us they had received information regarding the procedures they were undergoing verbally and in written form before surgery. Staff discussed all aspects of the treatments, including medication to be taken and the possible risks and benefits before delivering care. All consent was obtained on the day of the procedure. We reviewed 11 patient care records and each contained fully completed consent forms signed and dated by both the patient and consultant. Consent forms were available in the patient records for staff to review before starting treatment.

We followed a patient pathway from the ward to the theatre and witnessed that appropriate consent was taken. The scrub nurse checked for consent again during the World Health Organisation (WHO) time out as per guidelines.

The trust had a policy for surgical patients who lacked capacity to consent. If staff had doubts about a patient’s ability to consent due to learning disabilities, short-term memory loss, dementia or brain impairment, they completed a capacity assessment. Confirmation of lack of capacity prompted a conversation with the patient’s next of kin, the power of attorney for health or an Independent. This was to ensure that decisions were made in the patients’ best interest. This was followed by the completion of a Mental Capacity Advocate (IMCA) referral. Additionally, the service completed the Department of Health’s consent form 4. Healthcare staff use this form for adults who are unable to consent to examination, treatment or care.

Staff introduced themselves to every patient and relative. We observed that staff asked patients
Mental Capacity Act and Deprivation of Liberty training completion

At the time of our inspection, the trust reported that Mental Capacity Act and Deprivation of Liberty training had been completed by 100% of the medical staff. The completion rate for nursing staff was 100%.

We requested Mental Capacity Act training and Deprivation of liberty training for the surgical division. The trust only provided completion rates for pre-assessment staff who achieved a 100% compliance rate.

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

Is the service caring?

Compassionate care
To gain an understanding of the service users’ view of the service and experience, we spoke with six patients and two relatives.

Patients who spoke with us on all the surgical areas we visited commented positively on the care they had received. Patients felt staff respected their privacy and dignity. We observed that staff maintained the dignity of a patient during surgery by ensuring patients were adequately covered at all times.

We reviewed a patient feedback file. The feedback was consistently positive with comments such as “the ward was well run and nurses took time to explain what was going on”. Another patient wrote “the care and kindness was above and beyond duty” and they felt “comfortable and reassured at all times by staff and doctors”.

Staff provided reassurance for patients who were anxious. On the vascular ward, one patient was anxious about the procedure they were to have. Staff were calm, reassuring and supportive. Individual preferences were taken into account for example the patient had requested to be accompanied to the anaesthetic room by a relative.

In the ophthalmology suite, the screen in the second recovery area did not give patients the privacy and dignity of a purpose-built recovery room. Patients and visitors in the waiting room were able to hear and could walk around the screen and into the recovery area.

Friends and Family test performance
From December 2016 to November 2017 the Friends and Family Test response rate for surgery at Kent & Canterbury Hospital was 24% which was worse than the England average of 29%.

Kent ward had the highest response rate with 32% and Clarke ward and the urology suite had the lowest response rate with 21% each.

A breakdown of the friends and family test performance by ward for medical wards at the trust with total responses over 100 is below. The monthly and annual performance figures represent recommendation percentages.
Emotional support

Staff understood the impact that a person’s care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. We observed staff delivering kind, compassionate care, aimed to provide the best experience to all who used the service.

We saw staff making patients comfortable, answering questions and ensuring the patient was caused as little distress as possible.

The trust had a vascular amputee support group, which met between 11am and 1pm on the second Friday of every month. The group enabled members to build on shared personal experiences and focused on individual strengths and working towards the patient’s wellbeing.

The surgical service had access to a multi-faith chaplaincy team who were available for counsel and prayer 24 hours a day. There was information and leaflets about the chaplaincy service displayed on the wards.

Understanding and involvement of patients and those close to them

Communication between staff and patients was good. Discharge and post operation care was considered pre-operatively. Patients and their relatives were involved in the discussions to ensure the appropriate arrangements were in place to support recovery.

We observed a nurse discussing pressure area care with a patient who had returned from theatre. The nurse gave the patient a leaflet to explain pressure area care and the patients’ role in helping their own recovery process. The leaflet included advice on pressure care for when the patient returned home.

Patient records we reviewed included discussions with the patient’s relatives. One relative told us she was kept informed and involved in her mother’s care and changes to care. Staff telephoned the daughter to inform her that her mother had developed a chest and a urinary tract infection so the discharge was to be delayed until the patient was well enough. The relative was able to liaise with the ward staff and make post discharge arrangements that suited the her, the patient and the ward.

In theatres, carers and relatives were encouraged to come into the anaesthetic room to provide support for the patient. Once the surgery was complete, relatives of children were escorted into the recovery room from a side entry, so children could recover with their relative present.
However, one patient told us they did not feel involved in their discharge planning. The patient felt pressured into being discharged before they were ready to go home. The patient told us they sensed some conflict between the consultant, occupational therapist and their local district council.

**Is the service responsive?**

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

**Average length of stay**

**Trust Level – elective patients**

From December 2016 to November 2017, the average length of stay for all elective patients at the trust was 3.0 days, which is lower compared to the England average of 3.9 days.

- For trauma & orthopaedics elective patients at the trust was 3.8 days, which is as expected compared to the England average of 3.9 days.
- For urology elective patients at the trust was 1.7 days, which is lower compared to the England average of 2.5 days.
- For general surgery elective patients at the trust was 2.6 days, which is lower compared to the England average of 3.9 days.

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

Note: Top three specialties for specific trust based on count of activity.

**Trust Level – non-elective patients**

The average length of stay for all non-elective patients at the trust was 4.6 days, which is as expected compared to the England average of 5.0 days.

- The average length of stay for general surgery non-elective patients at the trust was 4.0 days, which is as expected compared to the England average of 3.8 days.
- The average length of stay for trauma & orthopaedics non-elective patients at the trust was 9.1 days, which is as expected compared to the England average of 8.8 days.
- The average length of stay for urology non-elective patients at the trust was 1.2 days, which is lower compared to the England average of 2.9 days.
Non-Elective Average Length of Stay – Trust Level

Kent & Canterbury Hospital - elective patients

From December 2016 to November 2017 the average length of stay for all elective patients at Kent & Canterbury Hospital was 2.0 days, which is lower compared to the England average of 3.9 days.

- The average length of stay for urology elective patients at Kent & Canterbury Hospital was 1.7 days, which is lower compared to the England average of 2.5 days.
- The average length of stay for vascular surgery elective patients at Kent & Canterbury Hospital was 3.9 days, which is lower compared to the England average of 5.2 days.
- The average length of stay for general surgery elective patients at Kent & Canterbury Hospital was 1.7 days, which is lower compared to the England average of 3.9 days.

Elective Average Length of Stay - Kent & Canterbury Hospital

Kent & Canterbury Hospital - non-elective patients

The average length of stay for all non-elective patients at Kent & Canterbury Hospital was 1.7 days, which is lower compared to the England average of 5.0 days.

- The average length of stay for urology non-elective patients at Kent & Canterbury Hospital was 1.2 days, which is lower compared to the England average of 2.9 days.
- The average length of stay for vascular surgery non-elective patients at Kent & Canterbury Hospital was 4.9 days, which is lower compared to the England average of 10.8 days.
- The average length of stay for general surgery non-elective patients at Kent & Canterbury Hospital was 4.1 days, which is as expected compared to the England average of 3.8 days.
Meeting people’s individual needs

Surgery staff pre-assessed the patient to ascertain, plan and communicate reasonable adjustments that may be required for preoperative, admission, and post-operative and discharge requirements. Staff said it was important that all plans made were documented and communicated to those involved in the patient’s care to ensure continuity of care was maintained.

The trust employed link nurses with various specialties, including a learning disability nurses. They provided specialist support to patients and the nursing staff caring for them.

There was a specialist dementia team lead by a matron and a consultant physician with nurse specialist presence on site to support staff across inpatient and outpatient areas. There was a comprehensive link nurse network for dementia and allocated dementia champions on the surgical wards.

The trust was trialling the “My Healthcare Passport”. The passport was designed for people living with dementia or those with learning disabilities but could be used for other people with complex needs. Patients, relatives or carers filled in the passport so patients’ needs were identified at the earliest opportunity. Staff told us this was important for identifying problems quickly as it contained information about the patient’s identification, disabilities or impairments, likes and dislikes and medication the patient was currently taking.

We saw two examples of when appointment and treatment times had been arranged to meet the patient’s individual needs. One patient told us that the hospital did not give her a choice of which hospital site she preferred to have her surgery. She contacted the department and it was rearranged promptly to a hospital site that was convenient for her.

We noted that there were leaflets available on a number of different procedures and conditions. These were available in different languages and larger print. Staff knew of the availability of translation services for people who did not speak English as their first language.

The integrated discharged team attended ward rounds and discussed discharge care needs with the patient and staff caring for the patient. We reviewed a discharge plan and saw that the patient had been made homeless. The team worked with local agencies to arrange emergency accommodation that was safe and would suit the patient’s new needs as an amputee.

Pre-assessment staff identified patients requiring communication assistance at the pre-assessment appointment. Arrangements were made prior to admission to ease the process. We saw written information in English, however, staff assured us all patient information documents
were provided upon request in other languages as well as in alternative formats including easy read, braille, audio and large print.

Discharge expectations were discussed at pre-admission for planned admissions or at the time of admission for emergency cases. The integrated discharge team worked with the ward staff and community services to meet each individual’s needs when planning ongoing care in the community for surgery patients. For example, the team arranged ongoing physiotherapy or rehabilitation care from local community providers.

Access and flow

Main theatres at the Kent & Canterbury hospital site consisted of six theatres. During our inspection five of the six theatres were in use in accordance with demand. There was no list for theatre one.

At the last inspection, we recommended that the service should improve theatre utilisation. Theatres were now using a daily tracking system. The theatre utilisation target was 80% however between May 2017 and May 2018 50% of all theatres exceeded the target. Only 16% achieved an occupancy rate of 100% or greater in the same time period.

In the anaesthetic room, we saw a theatre activity improvement poster on the wall. It had clear instructions of what is expected of all the theatre team and included the time certain events should take place. For example, send for patient at 8.30am.

A hospital’s admission policy ensured patients received a pre-operative assessment. All patients were assessed and this meant patients were identified as being safe for surgery and unnecessary cancellations were avoided where possible.

We observed the flow of patients to have some delays. Theatres reported 89.1% of on time starts. In one instance in day surgery, theatre one and two were both undertaking orthopaedic lists. The first patients on the lists both required a block to give anaesthesia appropriately. However, only one ultrasound machine was available. This resulted in theatre two’s list being delayed by 25 minutes while the team waited for the ultrasound machine to become available.

Theatres reported their two top reasons for a late start were due to the surgeon not being ready on time and the list order changing.

In ophthalmology a second recovery area had been created by using a screen to divide the waiting room in two and it contained two reclining chairs. Patients who were observed to be in stage two of post anaesthetic recovery (responsive/mobile), were placed in the second recovery area to free up the main recovery room for the next patient.

Staff told us at times the theatre list included three general anaesthesia patients in succession. As the recovery time can vary for each patient, this had the potential to cause delays. Therefore, patients were moved to the second recovery area to maintain a timely operative list whilst continuing post anaesthetic care.

Staff expressed their concerns regarding moving patients too quickly to the second recovery area, as some patients need to be lying down post-operatively. Staff were also concerned that the closest resuscitation trolley was in the recovery room on the other side of the ophthalmic department. Staff said they “felt isolated” if they “required immediate help with a deteriorating patient”. Staff indicated that they had escalated their concerns to the senior managers and no action had been taken to address their concerns.

We raised our concerns with the theatre matron and the trust took immediate action to resolve the safety concern. All patients receiving general anaesthesia were to be sent to the day surgery ward
from the recovery room for discharge. The unit was suitably staffed and purpose built to house patients in the post recovery stage.

The discharge team worked closely with other healthcare professionals, social care services and community teams. This was to ensure the patient’s discharge support needs were met before being discharged home or to another healthcare provider.

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

From January 2017 to December 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery. This was generally below the England average and was shown to be stable during the reporting period.

As of December 2017, 57% of this group of patients were treated within 18 weeks versus the England average of 72%. Recent data from January to April 2018 showed that there had been no improvements in referral to treatment time for admitted pathways within the 18-week timeframe.

(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, all of the specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>63%</td>
<td>77%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>62%</td>
<td>72%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>45%</td>
<td>61%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0%</td>
<td>71%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>0%</td>
<td>83%</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 showed no noticeable trend, and was generally higher than the England average.

As of Q3 2017/18, this trust cancelled 150 surgeries. Of the 150 cancellations 5% weren’t treated within 28 days.
Over the two years, the percentage of cancelled operations at the trust was lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Learning from complaints and concerns

Staff told us that they handled complaints at ward level and reported to the ward or theatre manager. However, if a patient was not satisfied with response, staff directed patients to the patient advice and liaison service (PALS).

Information on how to make a complaint was accessible to patients and visitors. We saw posters and leaflets on how to complain or leave feedback displayed in theatres, surgical wards and in the pre-assessment unit. All patient information leaflets had details on how to contact PALS with compliments or complaints.

Theatre and ward matrons told us, they shared information about concerns and complaints to each individual theatre team. This was to ensure all members of staff received learning. Some of the surgical wards and theatres found it difficult to hold regular meetings. To ensure the latest information was shared with everyone, the units had a communication document. We reviewed the communication document in theatres and saw evidence that concerns were shared. The matron told us the book was effective as staff were able to read it in their free time. However, there was
no evidence that staff read the document which meant we could not be assured staff were learning from complaints.

Summary of complaints

From February 2017 to February 2018, the surgery unit at Kent & Canterbury received 37 formal complaints. There were no complaints referred to the ombudsmen. Ten of the complaints were related to unexpected outcome/post-operative complications. At the time of our inspection, seven of the complaints were under investigation.

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

Is the service well-led?

Leadership

Staff spoke positively about the leadership at a ward and departmental level. They told us their immediate leaders were visible, enthusiastic and had an open door policy so staff always felt supported.

Surgical services were consultant led and surgical staff in all areas reported that they were well supported by consultant leads. Staff of all levels said that senior staff were approachable.

Nursing leadership at the local level was good with the majority of staff confirming that their line manager and matron were approachable, responsive and involved staff in the ward development.

There was mixed feedback from staff about the visibility and level of support from senior leadership in the trust. Most of the staff we spoke with did not know the executive board members with one member staff saying they were “faceless”. Theatre leaders acknowledged that junior and newer members of staff were not aware of the divisional leads as they were not visible within the department.

Vision and strategy

The vision for the trust was “improving health and wellbeing”. Staff were not aware of the trust’s vision and strategy. Senior staff in charge of the daily running of the surgical unit told us they did not have a local vision or strategy. This was attributed to the uncertain future configurations of the hospital.

Staff had been informed of different strategies or developments that did not come to fruition. They felt that this had a direct effect on recruitment and morale as they did not know what the long-term future was for the hospital.

Staff told us they used the trust values every day and objectives set at their appraisal meetings were based on the values. However, staff we spoke with could not tell us what the trust’s values were.

Culture

Surgical staff told us they were happy to work in the department and were positive about working at the hospital. We observed good working relationships between the consultants and the nursing and theatre staff.
Most staff we spoke with told us if they witnessed poor practice, they would have no hesitation to raise their concerns. Staff said they were encouraged to be open and honest and raise any issues as soon as possible. Others had mixed feelings about their role and felt apathetic about speaking out as they felt nothing would be done. One member of staff told us they had raised a concern with senior managers about patient safety but their concern was not addressed.

We were told that within the trust there was a focus around respecting one another and wellbeing. In the ward newsletter, we saw that staff were encouraged to attend the mental health first aiders training. The course’s aim was to help staff recognize when their staff were anxious, depressed or have any other mental health issues and to know what to do to support them.

**Governance**

Governance arrangements were well established. The surgical clinical governance committee at Kent & Canterbury Hospital met once every month for three hours. Attendees of this meeting were mostly lead clinicians and senior matrons. We were told the meeting was an open forum so all surgical staff were welcome to attend, however due to staffing requirements it was difficult for other staff to attend.

There was one meeting for all hospital sites, so attendees dialled into a conference call. This ensured that there was a continuity of governance across all sites and that they worked in unison.

The clinical governance meetings were used for reviewing and discussing operational policies and procedures. Each surgical speciality presented their progress or current performance to the rest of the group.

We reviewed the monthly governance report for May 2018. The trust used this to drive the governance meetings. The report addressed topics such as but not limited to clinical incidents, clinical audits, risk register and complaints and compliments. On the topic of clinical incidents, we saw a summary of the incidents, what recommendations had been made and actions taken to mitigate the risk of such an incident occurring. There was a record of outstanding duty of candour letters and with the surgical area they belonged to as a reminder to action these.

The surgical divisions presented a governance and patient safety report to the patient safety board. We reviewed the most recent report from May 2018. The report covered mortality and morbidity and the implementation of National and local surgical safety checklists. (NatSSIPs and LocSSIPs)

Each speciality held a monthly mortality and morbidity meeting. These meeting fed into the divisional clinical governance meeting and there was evidence of this in the governance report. We reviewed the meeting minutes and presentations. Each case was discussed in detail, actions taken and learning points were recorded. For example, the learning points identified in a vascular case in the November 2017 meeting included; identifying bleeding earlier and having patients reviewed by senior clinicians immediately. Other points noted were improving communication at handover and the documentation of handover at the sign out stage of the theatre booklet.

Staff meetings did not take place regularly; the last staff meeting in theatres was in 2017, whilst on Clarke ward the last meeting was held in February 2018. Staff used safety huddles and morning briefings as a regular way of passing information. The area matrons said that the communication documents allowed for information to be shared, however this did not allow information to flow from frontline staff up to divisional leads.
Management of risk, issues and performance

Surgery reported its risks to the divisional risk register and the corporate risk register. Risk were categorised in order of priority from extreme to moderate. At the time of our inspection, the risk register provided by the trust showed that there were five open risks for the division. The risk register was not site specific and all risks on the register pertained to other hospital sites other than Kent & Canterbury hospital.

During our inspection the theatre matron told us there eight risks on the risk register for the surgical unit at Kent & Canterbury hospital, with the most recent risk relating to ventilation in surgery. This did not reflect the information provided in the risk register.

Theatre leads told us they were in the process of implementing their National Safety Standards for Invasive Procedures (NatSSIPs) policy. The surgery unit had NatSSIPs meetings already in place which representatives of theatre staff attended. The aim was to utilise information shared at the meetings to develop individual team briefs for each surgical speciality.

Information management

The trust had invested in a number of information systems to share, monitor and improve the quality of care. There was an electronic system and paper records that staff showed us they could access. The trust was in the process of adopting a digital strategy to go paperless for clinical information. We observed that both the electronic system and paper-based system were currently in use.

The ward clerks told us, patient information was electronically stored on the medical records system. Staff were able to gather information or create a temporary patient record as all the patient’s medical history, assessments, test results, GP letters and appointments were stored in one easily accessible location.

Records were requested a few days prior to admission from the records department. Staff said the records department was responsive and it was rare not to receive patient records. The ward clerks demonstrated how they created a temporary file in the event a patient’s medical records were missing. Once the service had discharged the patient and the original patient records had been located, the records department destroyed the temporary file to avoid duplication of data.

Staff had access to information using computers that were available within the service. This included access to the internet and intranet, where hospital policies and procedures as well as the email system were located.

At discharge, the ward clerks ensured that a copy of the discharge letter was given to the patient and one was filed into the patient’s records. Another copy of the letter was sent electronically to the patient’s GP. The letter included the procedure undertaken, medication prescribed and a summary of the care plan. This meant that there was a continuity of care away from the hospital setting.

Engagement

An annual staff survey was conducted across the hospital, findings were analysed to determine staff opinion and satisfaction. In the 2017 NHS staff survey, the trust achieved its highest response rate to date at 50.3%, which demonstrated a willingness of staff to engage and provide honest feedback.

The results showed that staff morale and engagement had declined since the previous year. Staff also said they knew who their senior leaders were, but did not believe they were involved in the decision making and their feedback was not acted upon. The trust acknowledged that there was a need to develop immediate managers to support and engage their teams. As a result, the trust had set up listening events and staff forums to encourage more engagement. Each area of the
trust had a staff feedback meeting.

Some staff who had attended the listening events, felt that they were informative, and a step in the right direction. However, due to low staffing levels and the running of theatre lists in the surgical unit, most staff had not had the opportunity to attend.

Patients and their relatives were encouraged to give their views on the service provided to help improve services for the future. All patient information leaflets we saw had the contact details for the Patient Advice and Liaison Service. We also saw patient satisfactory questionnaires were available on each ward. These forums gave patients and their relatives the opportunity to give the service feedback to improve the quality of care given.

**Learning, continuous improvement and innovation**

Clarke ward had opened an admissions bay. The bay was staffed from 7am to 3pm, to prepare patients for theatre in a timely manner therefore reducing delayed start times in theatre. Patient records were prepared the day before ensuring tests had been completed and results were present and ready for surgery. This helped to prevent cancellations on the days of surgery and increase theatre utilisation.

The surgery department provided a hospital at home service. This was a virtual ward where eligible patients were considered inpatients but cared for in the comfort of their own home and received high quality, complex care including drain removal and intravenous therapy administration. Hospital at home allowed patients to be safely discharged quickly and avoid admission to hospital. Furthermore, patients avoided being at risk of falls, delirium and decline and contracting hospital acquired infections, usually associated with long hospital stays.

Hospital at home had a significant positive financial impact as it released inpatient beds for additional activity and was cost effective at approximately £70 per night compared with an estimated £250 for an inpatient bed. The service had capacity for 32 virtual beds and they had submitted a business case to expand the service to 45 beds.

**End of life care**

**Facts and data about this service**

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 2,685 deaths from December 2016 to November 2017.

(Source: Hospital Episode Statistics)

The Palliative care team delivers a face to face visiting service five days per week from 9am to 5pm Monday to Friday. Out of hours and at weekends, a telephone advisory service is available from the local hospice to support the wards.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

The palliative care team consisted of a palliative care nurse consultant and a palliative care social worker across the three hospital sites within the trust. There were 1.8 whole time equivalent clinical nurse specialists based at Kent and Canterbury Hospital and one whole time equivalent
end of life care facilitator. Consultant in palliative medicine cover was provided by the local hospice for two clinical sessions a week at Kent and Canterbury Hospital.

There had been 533 referrals to the specialist palliative care team based at Kent and Canterbury hospital in the 12 months preceding our inspection. Of those 533 referrals 60% were for those patients with a diagnosis of cancer, 40% with a non-cancer diagnosis. Examples of non-cancer diagnoses included sepsis, respiratory disease, heart failure and stroke.

During our inspection we visited a range of clinical areas such as wards including; care of the elderly; the renal ward; surgical and medical wards. We also visited the bereavement office, the chapel and the mortuary body store.

We met with 25 staff including; the palliative care nurse consultant; palliative care nurses; an end of life care facilitator; chaplaincy staff; bereavement staff; a mortuary manager, technicians and clinical lead; allied health professionals; matrons; ward managers; end of life care link nurses and healthcare assistants; registered nurses; consultants and junior doctors; healthcare assistants; and, a student nurse.

We spoke with six patients and one relative. We reviewed 17 patient records including; 13 ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) decisions; two medication records and two care records.

**Is the service safe?**

**Mandatory training**

Palliative care staff told us they completed mandatory training such as infection control, fire safety and information governance. The palliative care nurse consultant told us that all staff working within the team were up to date on their mandatory training. The End of Life Care training matrix reflected as of 30 April 2018, 82% or 91% of staff complied with all mandatory training modules, this meant, staff met, or were 3% below the 85% training target for all mandatory training.

End of life care was mandatory as a one-time training for all staff new to the trust. This included an introduction to the ‘care of the dying patient and their family’ documentation. The end of life care facilitators planned, organised and delivered the training and there were monthly sessions held. However, there were no mandatory updates available for staff to attend, with staff having to access additional training through the end of life care link worker programme or via the link workers on the wards.

Link staff undertook additional mandatory training to provide support to other ward staff in delivering end of life care. This included an initial ‘dying in hospitals’ course and additional training on the use of the end of life care documentation and symptom control. However, while 74% of link staff had attended the ‘dying in hospitals course’, only 32% had a record of attending training in the use of the end of life care documentation and only 19% had received training in symptom control. Of the 19% who had received training in symptom control, all except for one link nurse had completed all five symptom control modules. Three of the five who had completed all five modules worked on the intensive therapy unit. This meant that staff responsible for training other staff within the hospital had not always attended the relevant training themselves.

**Safeguarding**

Palliative care staff told us they completed safeguarding training for both adults and children. The palliative care nurse consultant told us that all staff working within the team were up to date on
their safeguarding training. The trust submitted information that 100% of End of Life Care staff had completed Safeguarding- Adult Level 2.

Staff we spoke with were aware of their responsibilities relating to safeguarding and were able to discuss the responsibilities of their role in protecting vulnerable adults in their care.

**Cleanliness, infection control and hygiene**

There were infection control and prevention systems in place to keep patients safe. The hospital in-patient areas we visited were clean. There were sufficient hand wash basins, liquid soap, paper towels, hand gels and protective equipment available. We observed staff following hand hygiene procedures and using hand gels and the protective equipment available. Staff were ‘bare below the elbows’ at all times to enable effective hand hygiene and minimise the risk of contamination. We observed staff following NICE QS61: Statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.

Infection control procedures in the mortuary were followed, for example, there was infection control guidance visible within the department and staff were able to describe the precautions they took to minimise the risk of infection. This included guidance on the categorisation of infection risks and the procedures taken to minimise risk, for example, through the use of body bags.

**Environment and equipment**

The Trust had a policy for the management of medical devices that applied the MHRA Managing Medical Devices guidance (April 2014). Quality assurance was provided through monthly medical devices group meetings and we were told that compliance for maintenance of the medical devices had risen from 69% to 84% with an improvement target of 92%.

Staff told us that syringe drivers were maintained in line with guidance as part of an equipment log and that access to syringe drivers was straightforward with availability when needed. For example, nursing staff on Kent ward told us they could always access syringe drivers and had not experienced any delays because of a lack of availability. None of the clinical ward based staff we spoke with reported any concerns about the availability of syringe drivers or issues with maintenance.

There were monitoring records in place for the use of syringe drivers and four hourly safety checks to ensure that the administration was correct and that the site of the butterfly cannula was satisfactory. However, the syringe driver infusion monitoring record as part of the medication chart was only completed each time the driver was renewed. Four hourly checks were recorded on the ‘care of the dying patient and their family’ document but only included a single box for completion where staff undertaking the checks recorded ‘yes’ that the check had been done. This meant that four hourly checks were not detailed and did not include a record of the volume infused so far, the remaining volume to be infused, the rate of infusion and the condition of the infusion site. This had the potential to lead to inconsistencies in the checks carried out. This had been identified as an issue on one ward where staff had adapted a ‘patient controlled analgaesia pump’ monitoring form by using hand written columns to include the volume infused and the volume to be infused. This enabled staff to include the details of the checks carried out every four hours.

We also saw that patients at the end of life were nursed on air flow mattresses when necessary. In addition, staff told us that accessing equipment for patients being discharged on the rapid discharge pathway was straightforward and that equipment was generally available on the same day in the community for these patients.
We were told by mortuary staff that capacity within the mortuaries and body store across the trust was a concern. The trust had increased their capacity of freezer spaces in response to Human Tissue Authority guidance in relation to long term storage. There were 10 freezer spaces at William Harvey Hospital (WHH) and an additional five at Queen Elizabeth the Queen Mother hospital in Margate (QEQM). In addition, there were 30 refrigeration spaces at Kent and Canterbury Hospital. There were a further 63 fridge spaces at William Harvey Hospital, including three bariatric and ten semi-bariatric with an additional 78 spaces at QEQM. We were told that over the winter months temporary storage had been increased by 100 spaces across the trust.

Despite the availability of temporary storage staff told us that they had occasionally exceeded capacity over the winter, despite arrangements to transfer the deceased between sites. As a result of this we were told that the deceased were doubled up in storage spaces designed for one. We were told that this had been a rare occurrence at Kent and Canterbury Hospital as it was not a working mortuary with the deceased being brought in from Accident and Emergency or from the community. However, we were told there had been some occurrences over the winter where staff had ‘doubled up’ fridge occupancy, particularly before the weekend where there was less flexibility for moving from one site to another to create additional capacity. Staff told us they had discussed this with the Human Tissue Authority, however this practice was not in line with Human Tissue Authority guidance as stated on their website; ‘Please note that placing more than one body on fridge trays or storing bodies in unrefrigerated areas, are not considered suitable practices’.

Assessing and responding to patient risk

Ward staff told us that they had received support from the palliative care nurse specialists and the care of the dying facilitator to improve how they identified patients at the end of life, including identifying patients who were deteriorating. The palliative care team operated a bleep holder system whereby nurse specialists were able to respond quickly to urgent patients need such as poorly controlled symptoms. This included prioritising referrals to the team including e-referrals based on needs and risks. In addition, the end of life care link staff were able to provide ward staff with additional training and support to better manage risks relating to patients at the end of life. Examples of this included providing advice on controlling symptoms commonly experienced at the end of life and ensuring that all aspects of the last days of life assessment and monitoring were carried out to ensure that care was delivered safely.

Specialist staff told us that the weekly palliative care multidisciplinary team meeting provided them an opportunity to review and discuss risks to individual patients. For example, in relation to rapid discharge home to die in their preferred place of care where risks needed to be evaluated to ensure that patients and those close to them had the support they needed.

The ‘care of the dying person and their family’ framework included the assessment of risk; for example, we saw that where regular assessments were being carried out on patients on the care of the dying plan, this included assessment of their skin integrity.

Patients at the end of life were subject to routine risk assessments as appropriate, relating to areas such as the risk of falls and pressure damage. We reviewed these risk assessments as part of our review of records and saw that these had been completed and reviewed appropriately.

Nurse staffing

The specialist palliative care team was largely formed of nursing staff. This included a nurse consultant who worked across all sites. In addition there was 1.8 whole time equivalent palliative
care nurse specialists based at Kent and Canterbury Hospital and since the beginning of 2018 a whole time equivalent end of life care nurse facilitator was in post.

**Vacancy rates**

At the time of the inspection there were no vacancies within the specialist palliative care team.

**Turnover rates**

In the period of time between the last CQC inspection in September 2016 and this inspection in May 2018, there had been no turnover of staff in the end of life / palliative care teams.

**Sickness rates**

During the period from January 2018 through December 2018 the End of Life Care staff sickness rate was 3.3%.

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

**Bank and agency staff usage**

There was no bank or agency staff usage within the palliative care team.

**Medical staffing**

Consultant in palliative medicine cover was provided by a local hospice for two clinical sessions a week at each hospital site including Kent and Canterbury Hospital. In addition, consultants attended the specialist palliative care multi-disciplinary weekly meetings and provided strategic input.

At our previous inspections in July 2015 and September 2016 there was no formally adopted service level agreement (SLA) for palliative care medical input. At our last inspection in September 2016 we were told that an SLA had been drafted and was with the procurement team. We were also told that the trust would use the agreement with the hospice as a baseline and then work out the gaps in the service. However, at this inspection we were told that the SLA was still with the procurement team and had not progressed since our last inspection. This meant that there was no contractual framework for the provision of medical cover. This presented an area of risk for the trust, although the nurse consultant told us they believed that the risk was small as the informal arrangement had been in place for a number of years and was not recorded on a risk register. The provision of medical cover was below the Royal College of Physicians (RCP) guidance of one whole time equivalent consultant per 250 beds.

**Vacancy rates**

As the medical cover for palliative care was provided by the hospice vacancy data was not collected by the trust.

**Turnover rates**

As the medical cover for palliative care was provided by the hospice turnover rates were not collected by the trust.

**Sickness rates**

As the medical cover for palliative care was provided by the hospice, data relating to sickness rates was not collected by the trust.

**Bank and locum staff usage**

Bank and locum medical staff were not used within palliative care.
Written referrals to the palliative care team were sent via the electronic patient administration system. When reviewing patients on the ward the palliative care clinical nurse specialists (CNS’) recorded their notes on the electronic patient record system and then printed them out to store in the patient’s paper record. They used stickers in the notes to highlight advice given so that this would stand out and was easily and quickly accessible to ward staff.

The palliative care team used a patient tracking list (PTL) for patients identified as being at the end of life. This alerted the end of life care facilitator when a patient was commenced on the ‘care of the dying patient and their family’ care plan. The end of life care facilitator told us that when it was decided that a patient was in the last days of life and agreed that they would commence the plan, staff stopped monitoring patients’ vital signs. They would record this on the mobile clinical monitoring system by indicating that vital signs were no longer recorded due to the patient being at the end of life. However, we were told that sometimes the alert was not raised on the end of life care PTL because staff had indicated that clinical observations were no longer required rather than the patient was at the end of life. The palliative care team were prompting staff to complete the record so that the alert was raised correctly. The patient tracking list stored information that included the patient’s preferred place of care at the end of life, spiritual support needs and ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) decisions.

The care needs of patients in the last days and hours of life were assessed using the ‘care of the dying patient and their family’ care plan. The care plan had been further developed from its previous version in October 2016. The plan included a record of end of life conversations form, an initial holistic assessment and ongoing daily review. The plan was based on the Leadership Alliance Five Priorities of Care for the dying patient. Specialist staff told us their focus since the end of life care facilitator had been in post had been to increase the use of the plan across the trust. We reviewed audit results from March 2018 that showed the overall use of the plan for patients in the last days and hours of life across the trust was at 77%. This was an improvement on previous results for example; uptake of the plan had been 56% in July 2017. Results for Kent and Canterbury Hospital showed that the care plan had been utilised for 89% of patients at the end of life which was comparable to the uptake at Queen Elizabeth Queen Mother Hospital and better than the uptake at William Harvey Hospital.

We reviewed the care records of two patients at the end of life and found that these had been completed correctly. This included a recorded assessment of the needs of the patient and their family and regular, four hourly comfort rounds and reviews in relation to the plan.

The palliative care team undertook four monthly trust wide audits of care records for patients at the end of life. We reviewed an audit that had been carried out between December 2017 and March 2018. The audit showed that records of end of life care conversations were completed on 85% of patients where the care plan was in use compared with 5% of patients where the care plan was not in use. In 57% of patients where the care plan was in use there was an holistic assessment of their needs recorded compared with 35% of patients where the care plan was not in use. The daily review plan document was completed daily for 63% of patients. An action plan was in place to address the shortfalls in the completion of the care plan record. The action plan included the dissemination of results and raising awareness of the care plan during end of life care training sessions.

Specialist palliative care staff we spoke with told us they were aware that the quality of the plans needed to improve and that their focus had been on increasing the use of the plan initially before
then focusing on the quality of the record. There was a broad trust wide improvement plan in place, however this did not identify site specific issues.

We viewed a DNACPR audit report dated February 2018 where it had been identified that improvements following regular audits had not been made. As a result, wards and divisions had been tasked with identifying action to make improvements. However, the action plan attached to the audit was blank. This meant that we were unable to identify specific action taken to ensure improvements.

We reviewed 13 DNACPR forms and found that these were generally completed well, although two had not been endorsed by a senior clinician. Forms were kept in the front of patient’s health records, had been appropriately authorised and included a record of discussions with the patient and their family.

**Medicines**

Staff we spoke with told us that medicines for use in end of life care were readily available on the wards and could be accessed in a timely way from the onsite pharmacy. General prescribing guidance was available on the trust intranet in the form of a ‘guidance for patients in the last hours or days of life’ procedure. This included guidance for the control of symptoms such as pain, restlessness and agitation, respiratory tract secretions, nausea and vomiting and breathlessness. There was a flow diagram in place to guide prescribing staff in a number of areas, including how to convert oral morphine to a 24 hour infusion of morphine. The guidance also provided staff with the contact details of the palliative care team if symptoms persisted.

The palliative care team nurses were not all nurse prescribers, however within the Kent and Canterbury team one of the clinical nurse specialists was working towards their nurse prescribing qualification. The palliative care nurse consultant told us that the focus of the specialist nurses was to support prescribing in end of life care rather than to undertake the prescribing themselves. Clinical nurse specialists and medical staff we spoke with told us that the palliative care team regularly provided this support to junior doctors on the ward.

We observed patients who had been identified as being in the last days or hours of life had been prescribed end of life care medicines in anticipation of them experiencing symptoms commonly found in patients at the end of life. This meant that staff were able to administer medicines to manage symptoms based on the trust guidance without having to wait for a doctor to prescribe them at the point that the patient was experiencing the symptom.

We reviewed the records of two patients who had been prescribed anticipatory medicines. One was prescribed in line with the trust policy; the other included a dose of levomepromazine (for nausea and vomiting) that was below the dose recommended in the guidance. This meant there was a potential for confusion among general medical staff who were relying on trust guidance and advice from the palliative care team in relation to prescribing anticipatory medicines. We spoke to the palliative care nurse consultant about this issue and she told us she had been aware it was an issue but thought it had been resolved. In addition, the patient was prescribed glycopyrronium (for excessive chest secretions) every two to four hours without a maximum dose. This meant there was a potential for the maximum daily dose to be exceeded.
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 March 2017 to February 2018, the trust reported no incidents classified as never events within end of life care.

Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from March 2017 to February 2018.

Source: NHS Improvement - STEIS (01/03/2017 - 28/02/2018)

Incidents were reported using the electronic incident reporting system. The end of life care staff told us that incidents relating to end of life care were collated and reported to the end of life care board although these were minimal. However, while we saw evidence of complaints being collated and reported we did not see this in relation to incidents in the minutes of meetings. In addition, there was no standing ‘agenda’ items on the end of life care board meeting agenda to discuss incidents as they occurred.

The palliative care nurse consultant told us that end of life care incidents were minimal, the trust reported there were no incidents during the reporting period. This suggests that a culture of reporting incidents in order to identify opportunities for learning in relation to end of life care may not be consistent. This meant that themes may not be identified and opportunities for learning to be shared may be missed.

During the inspection we became aware that a practice of placing two deceased patients in a fridge space designed for one had been happening during particularly busy periods. Although a risk assessment had been carried out and the matter had been escalated, it had never been reported as an incident. This meant that a formal, electronic, trust wide record of each occurrence was not available.

Is the service effective?

Evidence-based care and treatment

The trust understood the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020 and the foundations for the ambitions, including; personalised care planning; education and training; and, involving, supporting and caring for those important to the dying person.

End of life care was managed across the trust in line with National Institute for Health and Care Excellence (NICE) guidance. For example, there was evidence that the trust had developed services in line with NICE guidance NG31 Care of dying adults in the last days of life. This included aspects of end of life care such as the identification of people at the end of life; assessment, care planning and review; care in the last days of life; and, anticipatory prescribing. In addition, the trust’s ‘care of the dying patient and their family’ care plan was in line with NICE
quality standard QS144 Care of dying adults in the last days of life. This included, assessing signs and symptoms, individualised care, anticipatory prescribing, and, hydration.

The trust had developed and updated the individual plan for the ‘care for the dying patient and their family’. This plan provided a framework across the trust for all staff, including non-specialist staff caring for patients at the end of life. The plan based on the Five Priorities of Care set out by the Leadership Alliance for Care of Dying People. We reviewed two care plan records for patients in the last days of life and saw that they were completed fully and accurately.

The end of life care leads had explored the use of different evidence-based care and treatment guidance. For example, they told us they had attended training in the use of the AMBER care bundle, to support the early identification of patients in the last year of life. This, in part, allows time for patients to make plans for their future care, including care for the last days of life. However, the nurse consultant told us that following a pilot they had opted not to continue with this approach. We were told that a pilot was currently underway for the use of treatment escalation plans (TEP) to identify ceilings of care for patients, led by a consultant within the trust. In addition, the trust had plans to introduce the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process. ReSPECT is a national programme for creating a summary of personalised recommendations for a person’s clinical care in a future emergency in which they do not have capacity to make or express choices. At the time of our inspection some staff we spoke with told us they thought more work needed to be done on recognising patients in the last year of life.

Nutrition and hydration

The ‘care of the dying patient and their family’ plan of care included guidance on the assessment of nutrition and hydration with reference and a link to General Medical Council (GMC) end of life care guidance that included the ethical considerations of clinically assisted hydration. In addition, four hourly comfort measures that were recorded in the daily delivery of care record included a prompt for staff to offer fluids and nutrition.

An ‘end of life care plan’ documentation audit carried out between December 2017 and March 2018 included analysis of the records relating to the assessment and care delivery regarding nutrition and hydration in the last days of life. This audit involved a review of 68 records of patients where the ‘end of life care plan’ had been used and 20 records where it had not been used. In cases where the patient was being cared for using the ‘end of life care plan’ 59% had been assessed in relation to their ability to drink in the last 24 hours of life compared with 55% of patients where the ‘end of life care plan’ was not used. Nutrition assessments had been recorded 57% of the time for patients on the ‘end of life care plan’ compared with 60% of patient where the ‘end of life care plan’ was not used. This meant that patients at the end of life were not always having their nutrition or hydration assessed irrespective of whether the ‘end of life care plan’ was in place or not.

Discussions about hydration with patients were recorded in 19% of cases compared with 5% where the end of life care plan was not in use. Of those where it was not discussed 69% had a record as to why compared with 71% where the end of life care plan was not in use. Discussions with the nominated person important to the patient were recorded 40% of the time compared with 47% of the time where the end of life care plan was not in use. Discussions about nutrition with patients were recorded 13% of the time compared with 45% where the end of life care plan was not in use. Of cases where nutrition was not discussed 58% had a record as to why compared with 67% where the end of life care plan was not in use. Discussions with the nominated person
important to the patient were recorded 29% of the time compared with 40% where the ‘end of life care plan’ was not in use.

An action plan relating to the audit included action to disseminate results across the organisation through raising awareness at end of life care education initiatives and through the work of the end of life care link nurses on the wards. However, the action plan did not include details of how this would be done.

The ‘care of the dying patient and their family’ care plan included a record of mouth care for patients at the end of life.

**Pain relief**

Anticipatory medicines were prescribed for patients at the end of life. Guidance for prescribing anticipatory medicines to manage commonly experienced symptoms at the end of life was available in the form of a symptom control booklet and flow charts available on the trust intranet through the end of life care web page. This guidance was in line with NICE clinical guideline CG140: opioids in palliative care. Medical and nursing staff on the wards were familiar with the guidance and knew how to access it.

Patients and relatives we spoke with told us that staff were quick to respond when patients experienced pain and other symptoms and that nursing staff were proactive in assessing levels of pain and other symptoms on a regular basis. One patient told us that staff responded promptly to their request for pain relief, another patient told us they were given regular pain relief medication and could request additional doses for breakthrough pain. All patients we spoke with told us staff responded quickly to expressions of pain and took appropriate action to manage it. However, we did not see pain assessment tools in use and staff told us these were not generally used. Care plans included symptom assessment prompts with indicators as to if the patient was experiencing the symptom, if medicines had been administered or declined and if a medical review was required.

An audit of the end of life care documentation included records of pain. Between December 2017 and March 2018 57% of patients at the end of life who had received a holistic assessment of their needs regarding an individual plan of care and been assessed in relation to pain. An end of life care carer’s report dated April 2018 stated that a survey of bereaved relatives showed that 79% of patients received good/excellent pain relief. This was an improvement from the previous year where 40% of respondents stated that pain relief had been good/excellent. In addition, the survey results showed that in 2017, 8% of relatives reported that the patient had received poor pain relief; the 2018 results showed that this had decreased to 4%. In addition, in 2017, 55% of relatives reported that patients had received good/excellent treatment of other symptoms, in 2018 this had increased to 71%. Patients reported as receiving poor treatment of other symptoms had decreased by 3%. This meant that there had been notable improvements to the control of patient symptoms in the last year.

We observed staff administering medicines to alleviate symptoms at the end of life and saw that they did so while assessing patient need and evaluating the effectiveness of the medicines administered.

**Patient outcomes**

*End of life care Audit: Dying in Hospital 2016*
The trust participated in the End of life care Audit: Dying in Hospital 2016 and performed worse than the England average for all of the five clinical indicators. The trust scored particularly poorly for the measure, “Is there documented evidence that the needs of the person(s) important to the patient were asked about?”

The trust answered yes to six of the eight organisational indicators. The two organisational indicators they had not answered yes to included communication skills training in the last days or hours of life for allied health professionals and a lack of end of life care facilitators. In addition, the organisational indicator for the provision of a seven day face to face specialist palliative care service was recorded on the audit as being in place. However, the trust specialist palliative care service did not operate over the weekends or bank holidays when support from the hospice was provided by telephone.

(Source: Royal College of Physicians)

Since the 2016 survey the trust has continued to develop their ‘care of the dying patient and their family’ care plan and their end of life care service. For example, they had been awarded funding to appoint end of life care facilitators across the three sites, all of whom were in post during this inspection. There was an end of life care facilitator based at William Harvey Hospital and part of their role was to undertake regular documentation audits in order to measure performance following the national audit in 2016.

Since the national audit in 2016 the trust had further developed their ‘care of the dying patient and their family’ plan to include records of end of life care conversations, a holistic assessment plan, on-going daily review, a communication diary and care after death. Quarterly audits of the documentation had evidenced improvements since the national audit. For example following the most recent audit in March 2018, 99% of records showed that in the last episode of care it had been recognised that the patient would probably die in the coming hours or days. This was an improvement of 19% since the 2016 audit. In addition, in March 2018 there was documented evidence 96% of the time that there had been a discussion with the nominated person important to the patient that the patient would probably die in the coming hours or days. This was an improvement of 20% since the 2016 audit. The internal audit undertaken by the trust showed improvement in all five clinical indicators since the 2016 audit.

The trust were participating in the 2018 national Dying in Hospital audit and told us they would be collecting data for this in June 2018.

**Referrals to the Palliative care team**

Referrals to the palliative care team at Kent and Canterbury Hospital in the last 12 months were for a variety of reasons. Most commonly, referrals were due to rapid decline and symptom control. Other referral reasons were for hospice assessment, psychiatric support and social support. Of the 533 referrals, 60% were for those patients with a diagnosis of cancer, 40% for those with a non-cancer diagnosis. Examples of non-cancer diagnoses included sepsis, respiratory disease, heart failure and stroke.
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**Competent staff**

**Appraisal rates**

All members of the palliative care team had received an appraisal in the last year. Clinical supervision was also available for members of the palliative care team to opt into if they wished to; however we were told that this was optional.

There were end of life care link staff on all wards and clinical areas within Kent and Canterbury Hospital. The trust had trained 100 members of staff to be end of life care link workers so that ward staff had access to staff who had been specially trained in end of life care. This included symptom management training, anticipatory prescribing and the use of the ‘care of the dying patient and their family’ care plan. Staff on the wards told us that some of the link staff had left but that new link staff had been identified. End of life care link staff met on a monthly basis with the end of life care facilitator to prioritise action in relation to cascading information and providing training for ward staff. In total there were 30 link staff based at Kent and Canterbury hospital. All link staff had a contract that included their link role and a commitment with key performance indicators (KPIs) identified. KPIs included that link staff would have a genuine interest in end of life care and a commitment to promoting best practice, that they would maintain the end of life resource folder in their clinical area and that they would provide basic training in end of life care for ward based staff in their area.

Of those 30 link staff 22 had attended the ‘dying in hospitals’ course provided by the palliative care team. Five link staff had undertaken symptom control training and ten had attended training in the revised end of life care documentation and care after death training. We were told it was the link staff responsibility to then train staff on the wards with support from the end of life care facilitator. However, while 73% of link staff had attended the ‘dying in hospitals course’, only 33% had a record of attending training in the use of the end of life care documentation and only 16% had received training in symptom control. Of the 19% who had received training in symptom control, 80% had completed all five symptom control modules. Staff we spoke with told us it was sometimes difficult to release staff to attend training as the wards were short staffed and busy. However, this meant that staff identified as being responsible for training others in end of life care issues had not necessarily been trained themselves.

Many of the staff we spoke with told us they had received end of life care training in relation to symptom control and the use of the ‘care of the dying patient and their family’ document. Some
staff told us they had completed online training in addition to face to face training they had received on induction. Staff knew who the end of life care link nurse was on their ward and knew who the specialist palliative care nurses and end of life care facilitator were.

E-learning end of life care training was available for staff and we were told that there had been a focus on registered nurses completing it in the previous year and that healthcare assistants were to get the opportunity to complete this during the current year. We spoke with registered nurses who told us they had completed the online training. One ward sister told us they supported new staff to complete the online modules, covering areas such as anticipatory prescribing and preparing patients for a safe discharge home to die. One particular focus of the training was around the early recognition of patients in the last year of life. There was information about this contained in the end of life care resource folders on the wards. However, there was no specific framework in place for the recognition of patients in the last year of life. Staff we spoke with told us that recognition of patients in the last year of life was dependent on the clinician responsible for their treatment and care. For example, we viewed patient records and spoke with staff on one ward and saw that conversations were being held on an ongoing basis about ceilings of treatment and the care of patients with an uncertain chance of recovery or where their condition had deteriorated over time.

All ward staff within the hospital had access to end of life care resource folders. This included information on the assessment of patient need at the end of life; symptom management; last days of life; verification of death; and, the preparation of the deceased before transferring the body. The folders also included the policy for tissue and organ donation, information on chaplaincy and spiritual care services, and faith practices that may be relevant to caring for patients at the end of life and after death. The resource folders were managed by the end of life care link staff on the wards, who took responsibility for ensuring they were maintained and that the information was rolled out and accessible to all ward staff as appropriate.

The end of life care facilitator told us they attended the wards regularly to proactively identify patients at the end of life and support ward staff in completing the ‘care of the dying patient and their family’ plan. Ward staff told us that the specialist palliative care team were visible in the clinical areas and would take time to delivery ad hoc training to staff as the need arose.

Some of the wards we visited had a high number of bank or agency staff working due to higher than average staff vacancies. The end of life care facilitator told us that they and the link nurses would provide bank and agency staff with the same level of support and input as permanent staff in order to make sure that care was consistent.

The trust intranet included an end of life care page where staff could access up to date guidance on caring for patients at the end of life. This included information about anticipatory prescribing and access to policies relating to end of life care. Staff consistently referenced the page when speaking with us and knew how to access it.

**Multidisciplinary working**

Weekly palliative care multidisciplinary team meetings were held at Kent and Canterbury Hospital. These were attended by the hospice palliative care consultant, the palliative care clinical nurse specialists (CNS') and end of life care facilitator, chaplaincy staff as well as social work representation. The end of life care working groups were also multidisciplinary and we saw that membership included matrons and medical consultants from across different specialties. In addition, there was a trust wide palliative care multi-disciplinary meeting held every few weeks. This included the opportunity for palliative care staff to identify patients for a case review with input from colleagues.
The end of life care board had representation from across a range of services including renal, palliative care, oncology, cardiology, surgery and critical care. This meant that the trust had developed a degree of ownership for end of life care from a range of different specialisms and modalities.

Records of multi-disciplinary referrals and interventions in patient notes were clearly recorded. For example, we viewed records of visits from the palliative care team and saw that information was recorded in a way that staff could easily access it and gain up to date information on advice following a visit. In addition, we viewed clear records of multi-disciplinary communication from allied health professionals who had been involved in the patient’s care.

The palliative care team was made up of clinical nurse specialists and an end of life care nurse facilitator for each site. In addition, there was a palliative care nurse consultant and a social worker who worked across all three hospital sites and a part time counsellor who was based at QEQM and KCH.

**Seven-day services**

At the time of the inspection the trust did not provide a face to face seven-day specialist palliative care service. We were told that this was because of a lack of resource and that it had been discussed at the end of life care board meetings. However, the lack of a seven-day face to face specialist palliative care service was not on the risk register or included in future development plans.

The palliative care team operated between 8.30am and 4.30pm Monday to Friday with Consultant on call cover. Out of hours support was available from the hospice.

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

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

We requested data around the training completion rates for Mental Capacity Act and Deprivation of Liberty Safeguards for the palliative / end of life care staff. All 11 staff required to undertake this training had completed the training.

The trust ‘do not attempt cardiopulmonary resuscitation’ policy dated May 2018 stated that where patients were identified as not having mental capacity to be involved in a discussion about resuscitation a mental capacity assessment must be carried out in line with the mental capacity act (2005). The policy also states that where a patient lacks capacity consulting with those close to the patient in these cases is not only good practice but is a requirement of the Human Rights Act 1998 and the Mental Capacity Act 2005.

We reviewed the ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) records for patients where a decision not to resuscitate had been made. We reviewed 13 records in total, seven of which were for patients who had mental capacity. In all of these cases we saw that the decision had been made following discussion with the patient and where appropriate their relatives. The remaining six DNACPR records were for patients who were identified as not having mental capacity. In five out of six cases we saw that the decision had been discussed with the family of the patient or their nominated representative. In the case of the remaining one we were told that the decision had just been made and that medical staff were planning on discussing this with the family when they visited. We saw evidence of four mental capacity assessments having been undertaken. One patient record included a summary of a best interest discussion with the manager of the care home the patient was resident at. Another for a patient with a learning disability with fluctuating capacity included details of extensive dialogue and discussions and the involvement of an independent mental capacity advocate (IMCA). Mental capacity assessments,
where they were indicated were not always recorded on the trust mental capacity assessment form but records indicated that the assessment had been carried out. For example, one included a summary in the patient record that they demonstrated the use of the two-stage capacity test.

Is the service caring?

Compassionate care

We observed patients being treated with dignity and respect in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. Relatives spoke positively about the compassion shown to patients at the end of life. For example, one relative told us that the staff had taken time to get to know the patient (who had dementia) and connect with them. They also told us that staff showed kindness and that they really cared. They also told us that staff respected the family’s privacy, for example by calling out ‘knock, knock’ and waiting for the family to respond before stepping into the curtained area where the patient was being cared for. Some patients told us that preserving their dignity was sometimes difficult due to the design of the wards and that patients were often nursed in bay areas with curtains rather than side rooms. However, all patients we spoke with told us that staff did their best to maintain their privacy and dignity.

Patients were generally positive about the care they had received. One patient told us that they couldn’t fault the staff and that everything they asked for was done for them. They told us they felt cared for as an individual. Another patient told us the staff were very good and reassuring. Patients and their relatives told us that staff responded in a timely, appropriate and compassionate way when they experienced pain or other symptoms.

Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. Religious and spiritual needs were assessed as part of the ‘Care of the dying patient and their family’ care plan; this included identifying any religious or spiritual needs of the family. In addition, there was a section within the plan to identify any psychological or social issues affecting the patient or their family. Spiritual support was available from the chaplaincy and from volunteers working within the chaplaincy department.

A compassion symbol was in use on the wards to help staff, including those not directly involved in the patient’s care such as porters and housekeeping staff to identify patients at the end of life. This meant that all staff knew to be respectful and to create a dignified and compassionate environment for the benefit of the patient and their family.

Mortuary staff told us that where possible care after death ensured that spiritual and cultural wishes of the deceased and their family and carers were honoured. However, they also told us that there were strict controls in place in the case of the jurisdiction of the coroner and that this sometimes resulted in having to explain to relatives that their legal obligations took precedence. Staff told us they would liaise with the coroner in complex situations.

We were told that ward staff had identified and reported issues with the quality of the shrouds used in the care of the deceased in that they did not promote the dignity of patients. As a result, the issue was presented to the end of life care and a business case agreed to invest in improving the quality of the shrouds in order to promote dignity at the end of life.

Staff working within the mortuary body store told us that capacity issues had at times impacted on their ability to ensure the privacy and dignity of the deceased person in the way they would like. For example, we were told that during the winter the mortuaries across the trust were regularly at capacity and as such they had stored more than one body in a space designed for single storage. Although we were told this hadn’t happened regularly at Kent and Canterbury Hospital, sometimes
staff had taken the decision to store more than one body in a single space to free up capacity. We were told that this had been largely to ensure that there were enough spaces ‘just in case’ across the trust over the weekend periods during the winter, when there were less staff available to respond to pressures on capacity. This was against the Human Tissue Authority guidance on contingency arrangements for mortuaries during busy periods, which stated; please note that placing more than one body on fridge trays or storing bodies in unrefrigerated areas, are not considered suitable practices. This meant that it was not evidenced that patient’s privacy and dignity after death was always maintained.

There were canvas property bags available on the wards, designed for the use of storing the property of patients who had died. The bags were easily identifiable to staff so that if they saw relatives with the bags they knew they had been bereaved. This meant that the service ensured bereaved relatives were treated with compassion by all staff when leaving the hospital following the death of their loved one. Members of the palliative care team told us that the use of the bags were shared with all staff on induction so that everyone working within the trust knew what the bags symbolised. This included staff such as parking attendants who may come into contact with the family in the hospital grounds.

Comfort care packs had been designed by the end of life care facilitators. These were for relatives staying with patients at the end of life and included various toiletries to promote comfort.

**Emotional support**

Ward staff demonstrated a good understanding of the impact that a person’s care, treatment or condition will have on their wellbeing and those close to them. The palliative care team clinical nurse specialists provided additional support for patients and family members with complex psychosocial issues.

Information booklets were available throughout the trust for patients and family members to provide guidance on what to expect at the end of life. This included information on the changes to expect in the last weeks, days and hours of life. In addition, the contact details for a range of organisations providing support at the end of life or for bereavement were included in the booklets.

Chaplaincy staff and volunteers provided emotional and spiritual support to patients and those close to them. The support provided was based on spiritual and emotional needs irrespective of religious beliefs or faith. We were told that the local hospice provided bereavement support to relatives where a patient had used their service, otherwise staff would signpost relatives to other support agencies. Memorial services were held in the chapel where bereaved relatives would be invited to the services, this included services for adults and for infants.

Ward staff provided emotional support to patients and family members at the end of life. Patients and relatives we spoke with consistently told us that staff provided emotional support through the end of life process.

**Understanding and involvement of patients and those close to them**

Patients and relatives told us that staff communicated with them in a way that they could understand their care, treatment and condition. For example, one relative told us that staff took the time to regularly explain things and involve them in discussions.

Patients and relatives told us they felt involved in their care at the end of life. We saw that there were guidance booklets for patients and relatives about end of life care. The patient booklet included prompts for them to record their wishes and preferences. The booklet for relatives provided information on what to expect in the final hours of life including changes to breathing, a reduction in eating and drinking and changes in skin colour.
Patients and relatives we spoke with told us that staff were quick to respond to questions and that they felt they had received a good degree of explanation as to what was happening and what to expect. The ‘care of the dying patient and family’ care plan included a record of end of life care conversations. We saw these recorded in patient records. Patients’ preferred place of care and their individual choices and preferences featured as a primary focus when planning care in the last days of life. The individual plan of care for patients at the end of life included sections to record decisions and conversations with patients and their loved ones.

Members of the palliative care team told us that where patients with protected and other characteristics were being cared for at the end of life, the use of hospital passports and ‘this is me’ records would help to guide staff on how to communicate with them. They also told us they involved family and carers in decision making about care and took time with patients to communicate in a way they could understand. We viewed the records of one patient with a learning disability who had fluctuating capacity and while able to make some decisions about their care, were not able to make others. Records showed that ongoing and decision specific conversations were had with the patient, involving care staff and an independent mental capacity advocate (IMCA).

Information about community and advocacy services was available in the patient and carer information guides. Staff told us they would support patients to access other services by liaising with them and signposting as needed. Patients and those close to them were involved in planning and making shared decisions about their care and treatment and this was confirmed by the patients and relatives we spoke with.

The compassion symbol for use to place on doors or curtains surrounding the bed of a patient in the last days or hours of life had been designed collaboratively between the hospital and the local hospice. A prompt to use the symbol to identify patients at the end of life was included in the ‘care of the dying patient and their family’ care plan. This included a section to complete where the use of the symbol had been discussed with the patient or their family and there was evidence of recording that the patient or family had been involved in this discussion and had agreed to its use.

### Is the service responsive?

#### Service delivery to meet the needs of local people

The palliative care team operated between 9am and 5pm Monday to Friday. Out of hours support was available from a local hospice and out of hours specialist palliative care consultant cover was provided via a consultant on-call rota. Staff we spoke with on the wards knew how to access specialist palliative care support.

There was no dedicated palliative care ward and patients were nursed on the general wards in the hospital. Where possible patients at the end of life were nursed in side rooms. However, we were told that this was not always possible as not all wards had side rooms and where they did, often patients with infectious conditions would take priority. We saw that patients nursed on bays within wards could have their curtains drawn around them to provide additional privacy for them and their family.

Open visiting was in place for patients at the end of life and relatives were able to stay with them. There were facilities available within the hospital for relatives to take a break, including showering facilities and a kitchen they were able to use. However, survey and audit results showed that relatives were not always made aware of the facilities. There was access to the garden from the relative’s suite and the environment had been designed to provide a peaceful and restful space.
Relatives we spoke with told us that staff were responsive to their needs and would provide refreshments and blankets or pillows to promote their comfort.

There were limited quiet rooms for staff to hold potentially difficult conversations with relatives on the wards. For example, staff on wards told us they often had to use ward offices or to speak with relatives. For example, on McMaster ward there was a room available that could be used for relatives but staff told us it was very small and not well designed. However, they also told us there had been discussions about using charitable funds to redesign the room to make it more appropriate for relatives and discussions. The trust was aware that there were some issues with space to speak with relatives. On one ward (Kingston), a relative’s room had been developed with the use of charitable funds and staff told us that this room was accessible to other wards for use by relatives.

Mortuary viewing facilities at Kent and Canterbury Hospital were available and included facilities for relatives. Staff told us that most relatives viewed their loved ones on the ward or later on with the funeral director. However, they were able to arrange viewings in the viewing room and could make changes to the environment to make it more appropriate for individual viewings based on the wishes of the family.

The palliative care team provided support to the ward staff when caring for patients with additional needs such as a learning disability or dementia. We viewed the records of one patient with a learning disability and spoke with staff about their care. We saw that staff had a good understanding of the individual needs of the patient and held discussions with the patient and specialists involved in their care to ensure that their wishes were being met.

The palliative care team and ward staff had a focus on the individual needs of patients including those with dementia, learning disabilities or mental ill health. The individual plan for the dying person included an assessment of individual needs and staff told us they would work closely with other specialists in order to provide individual care. We saw evidence that those involved in patients’ care were included in best interest discussions.

Staff we spoke with told us there were contact details on the intranet for how to access interpreters for patients that did not speak English as a first language. This could either be face to face or by telephone. They told us that sometimes staff working within the hospital would provide communication support where they spoke the same language of the patient or family.

There were information leaflets available for patients and family members. However, the ones on the wards were printed in English only. This meant that patients and relatives not able to speak or read English would require additional support to understand the information provided.

**Meeting people’s individual needs**

The ‘care of the dying patient and their family care plan’ included the assessment of spiritual and religious needs. The chaplaincy team provided spiritual support for patients and their families inclusive of different faiths and cultures. The chaplaincy service had access to a variety of faith leaders in the community to provide specialist support. There was information on the trust intranet and in the care of the dying resource folders about different religious practices relevant to caring for patients at the end of life. Information included details of care after death practices of different religions and faiths. The mortuary worked with staff and relatives to secure the release of the deceased in a timely way where possible, to meet the different religious and faith needs.

There was a framework in place to ask patients at the end of life about their preferred place of death, however this was generally in the last days of life so did not always support advance care planning.
Staff told us that where possible they would facilitate the discharge of patients to their preferred place of care at the end of life. However, they also told us that there were sometimes difficulties arranging care packages in the community for patients on the fast track or rapid discharge pathways at the end of life and that this could cause delays. However, if there were no issues with care packages staff told us they were generally able to discharge patients within a few hours. We were told there was a hospice at home service available in the community via the local hospice for patients thought to be in the last three days of life or to provide interim support in the community where packages of care could be set up during that time. We were told during inspection that issues with fast track discharge were on the end of life risk register; however, when we requested the risk register from the trust we were told that there were no risks currently identified. This meant that there were inconsistent responses to whether or not risks associated with fast track discharge were still an issue or not.

The most recent documentation audit results between December 2017 and March 2018 showed that 78% of patients at the end of life were asked about their preferred place of care and this was recorded. The trust did not record the percentage of patients at the end of life who had been discharged to their preferred place of care. Data provided by the trust showed that 26% of patients did not have their preferred place of care discussed with them. Of the 146 patients at Kent and Canterbury hospital who were involved in a discussion about their preferred place of care 27% preferred to go to the hospice, 26% preferred to stay in hospital, 26% wanted to go home and 7% did not have a preference. Discharge data over the last 12 months showed that on average 34% of patients were discharged home at the end of life.

We were told that patients would generally be asked about their preferred place of death at the point where the decision had been made that they were likely to be in the last days of life. This was not in line with the end of life care interagency policy that recommended an early conversation between the health care professionals, patient and carer/family to ensure that all parties were confident that the patient and family wishes had been fully explored and considered. This may have explained the high numbers of patients unable to participate in the conversation and the higher number of patients who wanted to go to the hospice or stay in hospital. It was therefore likely that the stage of illness may have impacted on the patient’s decision making, whereas if there was more time given to planning in advance of deteriorating health then the decision making may have been different. This possibility was supported by results from a carer’s survey that showed that while only 25% of respondents stated that the patient had discussed their preferred place of death with their family, none of them had identified that place as the hospital.

The trust did not have a framework for advance care planning in place. In addition, there was no formal framework in place for identifying patients in the last year of life. The palliative care nurse consultant told us that this was being addressed as part of the three tier regional end of life care strategy in which the trust were involved. They told us that there was a focus of the strategy on identifying patients in the last year of life within primary care and sharing information across organisational boundaries so as to promote the involvement of patients and those close to them in making advance decisions about their treatment and care. The trust was piloting a treatment escalation plan that included identifying ceilings of treatment for individual patients.

The specialist palliative care nurse consultant told us they were planning on implementing the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process in the near future. This process would provide a framework for recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. The process would include a best interest discussion with family members where a patient did not have mental capacity to be involved in the decision.
We saw some evidence of advance care planning records but this was inconsistent. The quality of these records was dependent on the individual clinicians involved in the patient’s care due to the lack of trust wide formal process. Those that we did see were completed well. For example, on the renal ward we were told that a renal nurse consultant took the lead on the conservative management of patients where a decision was taken to withdraw treatment. We were told that while there was no framework for advance care planning the staff knew the patients extremely well and had established relationships with them. This helped them to hold the conversations over time and plan for their future care.

We spoke with staff about one patient who had been referred to the specialist palliative care nurse and there had been a multi-disciplinary meeting about their care and discharge home. We saw that there were clear ceilings of treatments recorded in the patient’s notes and evidence of ongoing discussions with the patient. This meant that although there was no framework or consistency for advance care planning there were some areas of good practice identified during inspection.

**Access and flow**

Ward staff told us that the palliative care team were responsive to the care of patients at the end of life. We reviewed records of patients at the end of life and saw that once a referral had been made to the team, patients were reviewed soon after. The palliative care team processed and prioritised referrals so that they could meet the needs of patients and their families.

Feedback from ward staff and records of assessments by the palliative care team showed that palliative care nurses would often review patients on the day of referral.

<table>
<thead>
<tr>
<th>Palliative care referral response times WHH</th>
<th>Cancer</th>
<th>Cancer &amp; Non-Cancer</th>
<th>Non-Cancer</th>
<th>Grand Total</th>
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<tbody>
<tr>
<td>DateDiff</td>
<td>Cancer</td>
<td>Cancer &amp; Non-Cancer</td>
<td>Non-Cancer</td>
<td>Grand Total</td>
</tr>
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<td>24</td>
<td>50</td>
<td>182</td>
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<tr>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>118</td>
<td>25</td>
<td>54</td>
<td>197</td>
</tr>
</tbody>
</table>

The above table shows that 92% of patients referred to the palliative care team were seen on the day of referral. Seven percent of patients were seen within 24 hours of referral, and less than 1% within 48 hours. This meant that all patients were seen by the palliative care team within 48 hours of referral.

The palliative care team had developed a patient tracking list (PTL) so that they would be alerted to patients at the end of life who had been commenced on the ‘care of the dying patient and their family’ care plan. Once the alert had been received, the end of life care facilitator would attend the ward to provide support to staff providing the care. Staff we spoke with told us that this support had been timely. The PTL was also shared across services with the hospice so that they were aware of the patients on the care of the dying plan. This was particularly useful as the hospice provided out of hours support to the trust.

A project to relieve the effect of ‘winter pressures’ on beds and the impact on patients at the end of life, the trust had worked together with the hospice to deliver a project that had been initiated by the clinical commissioning groups (CCGs) in the area. This involved hospice beds being dedicated
for use by patients on hospital wards who had been identified as being in the last days of life. Patients identified as eligible may not normally have met the hospice criteria, for example in relation to experiencing non-complex symptoms. The initiative meant that patients who did not want to go home or were unable to go home were able to die in the hospice rather than hospital environment. Staff were uncertain if the project would be repeated.

The average length of stay for patients at the end of life being cared for at Kent and Canterbury Hospital was 12 days compared with an average of 16 days at Queen Elizabeth the Queen Mother hospital and an average of 19 days at William Harvey Hospital. On average 34% of patients were discharged home at the end of life.

Learning from complaints and concerns

Information on how to complaint was seen on posters and leaflets in the hospital. Complaints relating to the care of patients at the end of life were reviewed by the end of life care board. Members of the palliative care team told us they received information about complaints in relation to themes identified, however were not aware of the specific details of the complaints received. Ward staff we spoke with could not recall complaints relating to end of life care. The palliative care nurse consultant told us that complaints relating to end of life care were minimal.

We reviewed summaries of five complaints that had been reported to the end of life care board since December 2017. Themes had been identified from these complaints, including communication and concerns about the quality of care provided. Minutes from the end of life care board meetings showed that complaints were discussed. However, it was unclear from the records of the discussions how the information was used to identify and share learning.

Is the service well-led?

Leadership

The medical director was the lead for end of life care across the trust. Day to day leadership was provided by the palliative care nurse consultant, end of life care facilitators and clinical nurse specialists. Palliative consultant cover was provided by the hospice and included dedicated time to be involved strategically.

The specialist division lead nurse and medical director were the executive leads on the end of life care board. The trust had previously had a non-executive lead but we were told they had stepped down earlier in the year and had not yet been replaced.

Staff we spoke with told us that the end of life care leads were visible and approachable. There was an end of life care facilitator in post at Kent and Canterbury Hospital. The overarching governance structure for end of life care was through the end of life care board which had representation from a range of specialisms within the trust. This meant that leadership for end of life care was shared across a range of services.

Ward based end of life care leadership was the responsibility of ward managers and end of life care link nurses. The link nurses were contracted to take a lead role for end of life care within their clinical area. Link nurses we spoke with were enthusiastic and demonstrated a genuine commitment to promoting good quality end of life care. However, data we received from the trust showed that not all link nurses had attended regular training or link staff meetings. Staff we spoke with said that this was largely due to the workload of the clinical areas and the difficulty releasing staff for training and to attend meetings.
Vision and strategy

The trust did not have an internal end of life care strategy. However, the palliative care team had been involved in the development of an interagency strategy for EOLC. In addition, they had developed working groups within the trust to improve end of life care, one for each hospital site. The working group at Kent and Canterbury Hospital had been in operation for nine months and was led by one of the clinical matrons. Meetings were recorded and we were told the group was in the process of developing a structure to move forward and had themes they were working on. However, there was no clear action plan in place for the group at the time of our inspection.

The palliative care nurse consultant told us that the implementation of the interagency strategy was being led by the local clinical commissioning groups (CCGs) and involved representation from other healthcare providers, social care, the third sector, patients and the public. There was a third tier section of the strategy that focused on acute services.

The vision for end of life care across East Kent was for everyone to have the best possible end of life experience. This included them being treated as an individual with dignity and respect, without pain and other symptoms, in the company of close friends and/or family and to be cared for and die in the place of their choice. Staff we spoke with on the wards and within the palliative care team had an understanding of the vision of end of life care. For example, all staff were aware of the implementation of the compassion symbol across the trust and the importance of dignity and respect and involving close friends and family in care at the end of life. In addition, the use of the ‘care of the dying patient and their family’ plan had a record of patient’s preferred place of care at the end of life and staff understood the importance of this and worked together to try and facilitate this where possible.

Culture

There was a culture of improving end of life care within the trust. The majority of staff we spoke with were aware of developments since our last inspection such as the compassion project and the role of the end of life care facilitator.

All staff we spoke with told us they worked to prioritise the care of patients at the end of life, however on some wards and clinical areas there was a shortage of permanent staff which resulted in additional pressure. At the time of our inspection it was Dying Matters week and the specialist palliative care nurses and end of life care facilitator had set up a stand in the entrance to the hospital to encourage staff and members of the public to be more open about death and dying. Staff we spoke with who attended the stand were enthusiastic about end of life care. They told us they prioritised the care of patients at the end of life and their families and ensured that nurses experienced in delivering end of life care supported them.

Staff we spoke with were aware of the requirements of the duty of candour. Staff knew that they had a duty to inform patients and their families when things went wrong. There were no incidents reported where the requirements of the duty of candour applied in relation to end of life care. Staff confirmed that openness with patients and those close to them was encouraged and supported by staff at all levels. Mortuary staff told us that families were not informed of the use of a single tray to store two bodies in the body store.

Governance

The palliative care team reported within the specialist services division of the trust. The head of nursing for the specialist services division was the chair of the end of life care board.
The trust end of life care board fed into the East Kent End of Life Care Strategy clinical commissioning group (CCG) led interagency work stream and the palliative care nurse consultant was a member of this group. They regularly attended the interagency quarterly forums and sub groups co-ordinated by the CCGs. The end of life care board was accountable to the trust’s quality committee via the patient experience group.

We reviewed minutes of end of life care board meetings where there was reference to the interagency work streams and improvement plans, location based working groups and a review of identified end of life care initiatives. However, we did not see evidence of action plans and activities linked to the interagency strategy and monitored through the end of life care board governance processes. In addition, while we saw that complaints and compliments and identified themes were reviewed by the end of life care board, there was no evidence that incidents or significant events relating to end of life care were reviewed as part of this process.

The three location based working groups were based at each of the hospital sites. At Kent and Canterbury hospital the group was chaired by the renal nurse consultant. The meetings were held monthly and agendas set around aspects of end of life care such as reviewing the use of the end of life care documentation; last offices; improving communication and handover when transferring patients to Kent and Canterbury Hospital from other sites; and, a review of shared learning. The minutes we reviewed were comprehensive and included actions to address issues as they arose, with follow up and review at the next meeting.

An East Kent interagency policy for end of life care had been developed as part of the interagency strategy work that the palliative care nurse consultant had been involved in. The policy had clear areas of responsibility for each organisation within the group. This was broken down into three tiers with East Kent University Hospitals NHS Foundation Trust providing secondary care through the third tier of the policy.

Areas of end of life care identified through the policy and agreed by the end of life care board within the trust involved aspects of end of life care such as:

- The management of acute episodes of ill health
- The provision of planned treatments
- The timely involvement of specialist palliative care as needed
- Identification of patients at risk of dying in the coming year so that they could be entered onto the palliative/end of life register in the community
- The use of anticipatory/advance care planning.

There were areas of provision that were not being focused on. For example, there was no evidence of a trust wide approach to advance care planning and no framework to identify patients at risk of dying in the coming year. Action plans to achieve these objectives were not recorded.

Management of risk, issues and performance

We reviewed corporate and pathology risk registers to identify risks relating to end of life care or care after death. The pathology risk register included a risk relating to the body storage capacity. The risk had been identified in February 2017 and reviewed in April 2018. The cause of the issue was identified as delays to death certification, coroner’s delays, and delays in collecting the deceased. Risk control included the purchase of temporary storage to increase capacity, while working on each of the areas identified as a causative factor to reduce delays. The risk had been identified as moderate, however did not include that, over the winter months in particular, bodies were stored over capacity, with more than one body stored in a space meant for single use. While
we were told that the mortuary staff had taken a ‘bed management’ approach to the capacity issues where capacity was discussed on a daily basis, there was no evidence that this had been escalated within the trust as a risk. For example, it was not included on the corporate risk register, had not been reported via the electronic incident reporting system and had not been recorded as raised at the end of life care board. In addition, the palliative care nurse consultant told us they were not aware of issues relating to this ‘doubling up’ within the mortuary to create capacity.

We were told that a palliative/end of life care risk register had been developed following a previous inspection and that the only risk identified had been relating to issues with fast track discharge. When we requested a copy of the risk register from the trust we were told that there were no risks identified and that previous risks had been mitigated. Staff we spoke with during inspection told us that the risks relating to fast track discharge were an ongoing issue. In addition, risks such as those relating to the mortuary capacity or a lack of resource to deliver a seven-day face to face palliative care service had not been identified as part of the end of life care risks.

A risk identified on the mortuary risk register relating to the deceased not being properly prepared following the last offices policy had been discussed by the end of life care board. This had also been regularly reviewed as part of the end of life care working group at Kent and Canterbury Hospital. In addition, the care after death policy had been updated and audits undertaken so that mortuary staff could report findings to the end of life care board and clinical areas involved. Additional training would then be provided to staff.

The palliative care team monitored performance through the use of audit and there was some evidence of improvement. We saw audits in relation to the care plan documentation and a carers’ survey. Data showed some areas of improvement following the audits. For example, the use of the ‘care of the dying patient and their family’ care plan had increased year on year as a result of this regular monitoring of performance. However, action plans were not always comprehensive or timely. A carer’s survey that showed deterioration in satisfaction did not include new action to address the concerns.

**Information management**

The palliative care team collated performance information in a number of areas. For example, they audited the records of patients in the last days of life in order to measure performance and monitor patient outcomes. An audit tool was used, based on the End of life care Audit: Dying in Hospital 2016 national audit. Information was used to monitor the use of the ‘care of the dying patient and their family’ care plan and as a result, use had increased from 56% to 77% in the last year across the trust. At Kent and Canterbury Hospital use was at 89% in the most recent audit of the document in March 2018. Other areas where we saw evidence of performance measures in place included a carer’s survey, audits of care after death processes, and monitoring of the time taken to issue a death certificate. In addition, there was monitoring of activity within the palliative care team to provide assurance, this included monitoring of referrals and response times from the point of referral to the patient being seen. This provided a holistic view of specialist palliative care activity that focused on the volume of activity and the timeliness of the response.

Staff had access to up to date patient information. Paper based records were used for the care of patients at the end of life with electronic systems also in use. For example, the patient tracking list provided up to date information to the palliative care team and the care of the dying facilitator as to which patients were in the last days or hours of life. This enabled close monitoring by the care of the dying facilitator in order to provide support to ward staff around patient care. However, we were told that one issue with the system was that an alert would only be created when ward staff indicated on the electronic system for assessing patient vital signs, that the patient was at the
end of life. Some staff had chosen the wrong box, indicating that clinical observations were no longer required rather than that the patient was at the end of life; this did not trigger an alert to the palliative care team. This issue was being addressed by the end of life care facilitators and link staff who were raising awareness amongst ward staff to the issue.

The electronic end of life care alert used across the trust enabled information to be accessible to staff across the trust, including that the focus of care had changed for the patient. This enabled better coordination of patient care and for the end of life and palliative care staff to have an overview of patients at the end of life across the trust. This information was also accessible to hospice staff.

The trust did not participate in a regional Electronic Palliative Care Co-ordination System (EPaCCS), where patient records for those at the end of life could be accessed in the hospital, community and hospice. We were told that this had been discussed by the local network of services involved in the local end of life care strategy, however was not yet in place.

Members of the specialist palliative care team recorded their notes using computers that were in their office or ward based computers that could be accessed at the time of their review of patients. This meant that they could record up to date advice and recommendations about patient care so that it was quickly accessible to staff.

Engagement

An end of life carer’s survey was carried out annually. Surveys were distributed by relative support officers to people attending to collect the death certificate of deceased adults. Four hundred and fifty surveys had been sent out for the 2018 survey and 84 had been completed across the trust. Questions focused on themes such as preferred place of care, symptom control, spiritual care, emotional care, dignity and respect, bereavement, communication and care after death.

We reviewed the 2018 carer’s survey report and saw areas where there had been a reduction in satisfaction. Particular areas that had deteriorated were people’s experience of; communication; dignity and respect; emotional support they received, including at the time of death; care after death; and, the overall level of care. The deterioration in satisfaction ranged between 6% and 21%. There was one area of improvement where relatives’ perception of the patient experiencing poor relief of pain and other symptoms was less than it was in the previous survey.

The actions to address the issues identified as a result of the survey report were not clear. The conclusion and recommendations were largely repeated from the 2017 report and actions were ongoing without clear detail or planned timelines. This meant that there was no clear plan in place as to how the trust was going to ensure improvements in satisfaction.

The palliative care team had undertaken a staff survey to gain feedback from general staff on end of life care and the priorities of the end of life care service. The results of this survey showed there were areas that needed improvement such as raising the profile of the chaplaincy service, highlighting the use of the trust end of life care web page and raising awareness of the out of hours service from the hospice. There was clear action plan with completion dates relating to this.

Staff we spoke with said that they felt they had the opportunity to influence the end of life care service, particularly those identified as end of life care link staff. One such example was that ward staff had identified and reported issues with the quality of the shrouds used in the care of the deceased. This had resulted in improvements to the shrouds being used.

During our inspection it was the national Dying Matters week. We saw there were a number of hospice run sessions that could be accessed by staff and the public aimed at raising awareness of issues faced by patients at the end of life and their families. In addition the care of the dying
facilitator and specialist palliative care nurses were running a session at the time of our inspection, where they provided support and information to staff and members of the public on issues relating to end of life care. This ‘death café’ approach was seen to be well attended and the specialist palliative care and end of life care staff told us they had seen more than 200 people at their stand of the course of the week up to and including the time of our inspection.

**Learning, continuous improvement and innovation**

There was evidence of learning, continuous improvement and innovation. The palliative care team collected data through the audit of end of life care documentation, carer surveys and a staff survey on end of life care. The results of surveys and audits were monitored by the end of life care board. Since the End of life care Audit: Dying in Hospital 2016 national audit the trust had improved their ‘care of the dying patient and their family’ plan and undertaken quarterly audits with demonstrable improvements. In particular there were improvements in the recognition of patients in the last days and hours of life and in recording conversations about this with relatives.

The palliative care team were working towards improving tracking and monitoring of patients at the end of life. A patient tracking list (PTL) had been developed so that when patients were identified as being in the last days or hours of life the care of the dying facilitator would be alerted. The facilitator would then review the patient record, identify any learning for staff relating to end of life care and provide support for medical and nursing staff as required.

The compassion project within the trust was implemented in May 2017 in collaboration with the local hospice. The aim of the project was to promote dignity, respect and compassion at the end of life in an acute hospital setting and consisted of a compassion symbol that was used to identify patients at the end of life. This meant that all staff including clinical and non-clinical could work together to improve the experience of patients and their family at the end of life. The project was funded by a legacy donation from the past Kent & Canterbury Hospital senior matron and local hospice trustee. The Project had received national recognition, and had featured in a number of national publications including the Nursing Times.

End of life comfort care packs had been developed for use by families of those at the end of life who were staying overnight to be with them. The comfort packs included a variety of toiletries.

The palliative care nurse consultant told us they were most proud of the passion of staff to ‘get it right’ and that they felt the trust were moving forward in terms of end of life care, particularly since the employment of end of life care facilitators at each site within the trust. The end of life care facilitators were sponsored by Macmillan Cancer Support for an initial two year period when a business case would be developed for trust board approval to continue to fund the posts.