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**

Medway NHS Foundation Trust operates a single site hospital based in Gillingham. Medway Maritime Hospital, serves a population of more than 400,000 across Medway and Swale districts.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway Maritime Hospital</td>
<td>Windmill Road, Gillingham, Kent</td>
<td>Designated trauma unit, vascular surgery, level 3 neonatal intensive care unit, West Kent urology cancer service (providing surgical care to patients from North and West Kent and Medway)</td>
<td>400,00 people across Medway and Swale</td>
</tr>
</tbody>
</table>

(Source: Acute Routine Provider Information Request (RPIR); Medway NHS Foundation Trust website).

Medway Maritime Hospital was originally a Royal Naval hospital, opened in 1905 by King Edward VII. The NHS acquired the hospital from the Navy in 1961. Buildings were modernised as part of the £1.5m modernisation scheme and the hospital reopened in 1965 as Medway Hospital. In 1999,
the hospital changed its name to Medway Maritime Hospital, following a development programme, which saw the hospital increase in size and services transferred from St Bartholomew’s in Rochester and All Saints in Chatham.

The trust has 655 general and acute beds. Specialities included, day-surgery, general surgery, trauma, orthopaedics, maternity, services for children and young people, critical care, neonatal intensive care, emergency medicine, general medicine and specialist medicine.

The trust has 500,000 patient contacts a year, including 110,000 Emergency Department attendances and 325,000 outpatient attendances a year.

The trust is one of the largest employers in Medway, with more than 4,400 employees, of which 543 are doctors and 1,240 are registered nurses.

Services provided at the trust:
- Urgent and emergency services
- Medical care (including older people's care)
- Therapy Services (Urgent Care)
- Surgery
- Critical care
- Maternity
- Gynaecology
- Services for children and young people
- End of life care
- Diagnostics
- Outpatients

Financial position

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical Data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous financial year (2 years ago) 2015-2016</td>
<td>Last financial year 2016-2017</td>
</tr>
<tr>
<td>Income</td>
<td>£254.8m</td>
<td>£287.7m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£52.5m)</td>
<td>(£331)</td>
</tr>
<tr>
<td>Full costs</td>
<td>£307.3m</td>
<td>(£43.3)</td>
</tr>
<tr>
<td>Budget</td>
<td>(£22.5m)</td>
<td>(£43.9m)</td>
</tr>
</tbody>
</table>

The Trust had been in a deficit position since 2012 and this continued to be the case. The main drivers for the deficit were the imbalance in the case mix whereby profitable elective activity had been displaced by increased non-elective activity, income that the trust was not receiving for a variety of reasons.

The size and shape of the workforce in some staff groups was an outlier when benchmarked to peers, failure to deliver recurrent cost improvement programmes year on year and the need to improve productivity in many areas in line with the Carter and Model Hospital Metrics. However, the trust was maintaining temporary staff costs below the ceiling, a significant shift from agency to bank and effective controls were in place.
2017-18 had been a challenging year for the trust and this had seen the forecast deficit increasing adversely to the original plan. The trust had a number of significant capital projects underway, the largest of which was the redevelopment of the emergency department which will increase capacity. The trust has developed a financial recovery plan to enable them to achieve financial balance by 2020-21. This was a challenging plan which required a significant change in process and culture to deliver at the required pace.

**Is this organisation well-led?**

**Leadership**

We found the senior leadership team had the stability, capability, capacity, and integrity to ensure strategy could be delivered and address risks to performance. However, the systems and processes to support this were not sufficiently embedded to be able to drive improvement at the time of the inspection. It was acknowledged there were many examples of new and sustained improvement.

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

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

The board of directors comprised of five executive directors, seven non-executive directors (including the chair) and five non-voting directors. As an NHS Foundation Trust, they had 25 members of the board of governors and over 11,000 public members.

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

The trust became an NHS Foundation trust in 2006 and 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 chief executive joined the trust in May 2015 and had more than 30 years’ experience across the public health system. Prior to taking up the role as chief executive, they held senior executive roles in government and health services within the Australian health system. This involved gaining experience and knowledge within primary, community and tertiary healthcare settings, working collaboratively across agencies and jurisdictions. They had been named by the Health Service Journal as one of the top 50 NHS chief executives in the country.

The medical director joined the trust in October 2015 as part of the trust’s buddying agreement with another trust. Prior to this they had been: director of education transformation; clinical director for women’s service and deputy acting medical director; director of quality and education for health education south London; dean of the secondary care specialities at the London deanery; London
fellow’s representative for the council of the Royal College of Obstetricians and gynaecologists and was an appointed member of the London clinical senate council.

The director of nursing had been in post since October 2015 and was deputy director of nursing prior to this. The director of nursing had a strong working relationship with the medical director to deliver the trust’s quality strategy. Prior to working at Medway, they were directorate head of nursing for ambulatory care services at another NHS trust and had previous experience in a variety of challenging nursing roles, predominately in acute medicine.

The director of finance and business services had joined the trust in May 2017. Prior to working at the trust, they were director of finance & deputy chief executive at an NHS trust. They have experience in community services, mental health and acute settings.

The executive director of human resources and organisational development was also the deputy chief executive of the trust and joined the organisation in October 2016. Prior to this, they were the deputy director of human resources at another NHS trust and held senior roles in human resources in trusts over the past 20 years.

The executive director of clinical operations, unplanned and integrated care was appointed in April 2016 and had 21 years’ experience across the public health system. They had a background as an anatomical pathology technologist.

The executive director of clinical operations for planned care was appointed in April 2016. Prior to this, they were a general manager and operational director in NHS trusts. They had 20 years in the NHS in operations and operational management.

The director of communications joined the trust in 2016 following more than 20 years’ experience of working for public sector communications. They are a member of the Chartered Institute of Public Relations and the Association for Healthcare Communications and Marketing.

The director of estates and facilities was appointed in March 2018. They worked in the NHS for 17 years and had previously held senior roles in finance, general management, site management and estates and facilities, prior to this they worked in banking and finance.

The trust secretary had been in post since 2017. They had previous posts in the NHS as a trust barrister, head of legal services and had worked for the NHS litigation authority.

The chair was appointed in April 2017 and was previously a chief executive and chairman of financial institutions. They were also a non-executive director of an investment business, a qualified banker and chartered fellow of the Chartered Institute for Securities and Investment. Other activities included: Pro-Chancellor and Chair of Governors at Canterbury Christ Church University, Chairman, Marshalls Charity (Church of England), Chairman and Senior Advisor and Chairman of the Disciplinary Panel, Chartered Institute for Securities & Investment. They were also a member of Henley Business School Strategy Board and acted as a business mentor under the London First Leadership Exchange scheme.

The trust had seven non-executive directors. Their backgrounds included: accountancy, legal, clinical, banking, communications and revalidation of healthcare professionals. In addition to this, they held a variety of positions such as director, executive sponsor, chairman, and had fellowships and membership to a variety of professional bodies.

We spoke with the executive directors and non-executive directors. They had a clear understanding of each other’s roles and responsibilities. The executive team told us they had healthy challenge and debate from the non-executive directors and we observed a board meeting which confirmed this was the case. We saw that that non-executives had read supplied board
papers. However, board papers were lengthy and it was difficult to identify the key issues and points without reading through all the information.

We reviewed all executive and non-executive files and saw the administrative and employment processes to ensure fit and proper persons were employed were in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our review of the executive and non-executive Directors personnel files confirmed the trust was fully compliant with Regulation 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. There were good arrangements for annual appraisals of the executives through the executive performance review process with a separate annual performance review process for non-executive directors. There was evidence of a board development program with support for leadership development.

We looked at a random selection of personnel files (two medical staff, two registered nurses, two administration staff, two estate and facilities staff, to assess the trust’s compliance with their human resources recruitment and selection policy and associated procedures. We found good and clear evidence of fair and equitable employment practices.

We also looked at a small sample of personnel files in relation to staff subject to the trust’s disciplinary policies and procedures and found these to have been undertaken in line with good employment practice.

The board and governors had a development programmes which covered areas such as an induction, risk, finance, community engagement, quality and charity.

The trust had amended its organisational structure at the end of 2017, which became fully implemented at the start of 2018.

The trust had two clinical directorates; unplanned and integrated care and planned care, supported by corporate functions. Each clinical directorate has a dedicated director of clinical operations, deputy medical director and deputy director of nursing. Each directorate had three programmes within it.

The acute medicine programme, acute specialist medicine programme and cancer and clinical support services programmes were within the unplanned and integrated care directorate.

The critical care and perioperative programme, surgical services programme and children’s and women’s health programme were within the planned care directorate.

Each of the six programmes had triumvirate, which consisted of; two clinical co-directors (a nurse and a doctor) and a head of operational performance. Speciality leads, service managers and matrons reported to the triumvirate for each programme.

The executive team undertook regular visits to a variety of areas around the hospital. These were called ‘gemba’ walks’. Gemba is a Japanese word that means “the real place”. In management terms, gemba is the workplace, the place where value is added and the work of the business is done. The gemba walk was about getting managers and leadership out of their offices and into the workplace, walking in the shoes of those on the frontline. In addition to this, the executive team provided feedback to the areas they visited and we saw examples of this. We saw records of the visits and a chart outside the executive offices to indicate which areas of the hospital members of the executive team had recently visited. Staff told us they felt overall, they could contact members of the senior leadership team if they needed to and that they were visible throughout the trust.
The organisational and professional development department offered a range of leadership development programs for all staff to provide the ‘Best of Care’ through the ‘Best of People’. The department had practical and interactive masterclasses available for all staff members and covered a range of topics including; project management, managing teams fairly, achievement review, giving and receiving feedback, personal effectiveness skills, people management for managers, and customer service.

The trust also offered a management leadership program to support the development of those who managed others. In addition, to this they had a ‘coach to lead’ program to help staff apply practical coaching skills to adapt and develop leadership style.

The trust’s workforce strategy included leadership development and looked to embed equality and diversity as part of these development programmes. Existing programmes had been refreshed to reflect this approach, and, as part of the Better, Best, Brilliant programme work streams.

The leadership development series included external guest speakers presenting at Medway to a diverse audience from across the hospital. They had facilitated four sessions in the past year, with approximately 80 attendees at each session. In addition to this, they had facilitated a number of individual events including ‘women in leadership’ and ‘mental health resilience’.

The trust was an active partner of the Medway leadership programme which brought together delegates from a number of local employers across Medway to take part in programmes to improve understanding and relationships between key public sector organisations in Medway. A junior doctor leadership programme (MediLead) empowered doctors new to the trust to talk about their ideas with colleagues. On application to MediLead, each doctor identified a project that they would work on with support of senior doctors, senior nurses and managers, as part of their leadership development.

Three hundred and twenty staff had attended the leadership development series. Below outlines the numbers of staff attending specific groups:

- Women in leadership - approximately 50 participants
- Mental health resilience - approximately 80 participants
- Medway Leadership Programme approximately 40 have been through the programme
- Medilead - approximately 60 participants.

**Board Members**

Of the executive board members at the trust, 62.5% were female. 14.3% of the non-executive board’s members were female. There were no British Minority Ethnicity (BME) members on the board at both executive and non-executive levels.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0</td>
<td>62.5</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0</td>
<td>14.3</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0</td>
<td>40.0</td>
</tr>
</tbody>
</table>

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

**Vision and strategy**
The trust had a clear vision and values, which had been shaped by feedback following engagement with more than 600 members of staff, through surveys, workshops and focus groups. Staff had a clear understanding of the vision and values.

The trust’s vision was to be Better, Best, Brilliant.

They had demonstrated improvement in quality and safety of care had got better and aspired to be the best. This meant providing the highest quality of care for patients, through skilled staff. They wanted to challenge themselves and ask whether they were the best they could be.

The trust’s values were Bold, Every person counts, Sharing and open and Together (BEST).

- Bold-We are inspiring and ambitious
- Every Person Counts-We are respectful and supportive
- Sharing and Open-We are open and speak up
- Together-We are inclusive and responsible

The trust’s vision and values were embedded from the initial job interview, at induction and through to appraisals. Staff we spoke with during the core service inspection knew the trust’s values and felt they delivered services and care in line with them. The appraisal system had recently been modified to bring it in line with the trust’s values.

The trust’s strategy was dated 2016-2020 and had been developed within a board workshop. Consideration had been taken in line with local system changes and the sustainability and transformation plan and the updated objective s were:

- Provide the best of care by embracing new and innovative models supported by technology and learning.
- Improve system integration and leadership
- Enable staff to be their best & give their best
- Create financial sustainability & value in all we do.

The strategy was aligned with the NHS five year forward view. The NHS Five Year Forward View was published in October 2014 and set out a new shared vision for the future of the NHS based around new models of care. This included the need for acute trusts to provide services with community based service providers.

It was underpinned by the recovery plan, estates strategy, engagement strategy and people strategy.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement within the Kent and Medway Sustainability and Transformation Plan.

The trust’s better, best, brilliant strategy had four strategic objectives below:

Objective 1 - Integrated Health Care: We will work collaboratively with our local partners to provide the best of care and the best patient experience.

Objective 2 - Innovation: We will embrace innovation and digital technology to support the best of care.
Objective 3 - Financial Stability: We will deliver financial sustainability and create value in all that we do

Objective 4 - Our People: We will enable our people to give their best and achieve their best

The strategy was produced through board and executive development days to which representatives of the CCG, Medway Council and Healthwatch were invited. The governors, members and the public were consulted in regular meetings, public meetings across Medway and Swale and the Annual General Meeting (AGM) of the trust.

Culture

We found staff satisfaction throughout the trust was mixed. They did not always feel empowered to raise concerns and teams were often working in silos. There were processes for staff to raise concerns, they did not always know what they were and felt no change would happen because of concerns being raised.

The trust recognised work need to be done to improve the culture of the organisation and was developing processes to support staff and promote their positive well-being.

The workforce strategy was underpinned by four pillars, which were linked to the hospital values. These were: BEST Size, BEST Cost, BEST Culture, BEST Future. The trust would prioritize the continuing improvement journey from better, to best, to brilliant and engage the workforce to believe in this with a range of initiatives to embed the values. This would include:

- Further embedding of the freedom to speak up guardians, and workplace listener roles.
- Career planning, talent management and succession planning.
- Staff surveys as an indicator of engagement
- A series of ‘Better, Best, Brilliant’ surveys to actively engage in becoming an open and sharing organisation.

The trust had appointed five freedom to speak-up guardians in line with the principles and role profile produced by the National Guardian Office and following recommendations of the Francis report. All the guardians’ names and contact numbers were disseminated as part of the trust’ ‘Every Person Counts- Raising Concerns (Respect)’ campaign in November 2016.

However, the guardians told us they had faced some barriers in continuing the work they had started due to perceived lack of resources and commitment from the trust.

The guardians did not feel assured that the trust fully understood the responsibilities placed on them and they did not have the time or remit to assess and change the culture of this trust. Following inspection, the trust told us they had met with the guardians to ensure there was support going forward. The guardians felt that staff did not have confidence in coming forward with their concerns and this was reflected in the very low number of concerns raised.

The majority of staff we spoke with prior to and during the core service inspection were not aware of the freedom to speak-up guardians and so did not how or when they could contact them. The trust had workplace listeners who were available to listen to individual staff concerns and signpost them if required.

The trust was developing a promoting professionalism programme to promote behavioural expectations. This involved structured route to address poor behaviour and attitude. This was in an informal way initially, if there was a single concern; the cup of coffee message. However, held individuals to account under the ‘every person counts’ aspect of their values.
Peer partners had been identified and attended training to assist them in holding conversations with their peers to address perceived poor behaviour.

The trust set up an online portal in 2017 to support new starters to Medway. They could access what the expectations of the trust were and know what they could expect from the trust, which included information on the better, best, brilliant programme.

A staff app was introduced at the end of 2017. Over 800 staff had downloaded the app. It acts as a way to communicate with and engage staff in the better, best, brilliant programme and develop the culture at Medway.

As part of the workforce strategy a number of workshops were designed and facilitated for the trust to understand better, how they could engage, support, develop and hear the workforce. This was supported by an ‘unconference’ facilitated by an external facilitator, with an agenda set in real time by the staff who attended. We saw evidence which indicated this was widely communicated and open to staff throughout the trust.

We spoke with the safe working guardian and safe working guardian junior doctors. They all felt supported to do their roles, attended training and introduced themselves at staff inductions. The implementation of electronic rostering, meant shift swaps to be identified and kept track of, staff could access it on their phones and it could be linked to their job plans. They felt consultants were approachable and the organisation, in general was supportive.

The trust managed its approach to equality and inclusion through the Equality Delivery System (EDS2) framework. The Equality Delivery System was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010.

The baseline assessment for EDS2 was conducted in August 2017, with a second assessment scheduled for March 2018. The assessment on average identified there was sufficient evidence to suggest each of the four goals was developing. The trust developed its objectives in line with the outcome of the assessment, which suggested development in some areas.

The trust’s equality objectives for 2017-2020 were:

- Improving equitable health outcomes and patient experience by developing a culturally competent workforce;
- Improving patient experience and access by achieving a better understanding of the diversity of experience, through more effective use community feedback and reviewing how we capture and analyse demographics on patient experience and complaints;
- Achieving workforce stability, enabling the Trust to be an employer of choice, ensuring we have a representative and valued workforce, through equitable recruitment, opportunities for progression, equal pay and job satisfaction across all protected characteristics.

These three objectives covered EDS2 Goals 1 to 3, and all contributed to Goal 4 (inclusive leadership).

The trust had an Inclusion Policy, dated March 2017. The policy set out how the trust was committed to delivering the very highest standards of access and care to patients from diverse
cultures, different age groups and a range of abilities and needs. It detailed committing to provide a working environment free from discrimination, harassment or victimisation, where everyone received fair and equitable treatment, regardless of sex, pregnancy or maternity status, race, disability, religion or belief, sexual orientation, gender reassignment, marital or civil partnership status or age.

Trust had operated three staff networks for: Black and Minority Ethnic (BME) staff, Disabled staff, and Lesbian, Gay, Bisexual/Pansexual, Transgender (LGBT+) staff. However, these networks were not well attended and had not met for several months. The trust was in the process of relaunching its approach to staff equality networking. The new model was an equality network that was to be open to all staff who were interested in advancing, promoting and championing equality, diversity and inclusion. The aim was to develop self-managed, ‘safe space’ networks for staff (e.g. BME, LGBT, Disability, as staff themselves consider relevant), increasing visibility of minority groups. The programme for 2018 was to focus on five points in the year:

- February, LGBT History Month
- March, Women’s History Month, with an event on career progression for International Women’s Day
- 9th May – Staff Networks Day (in conjunction with neighbouring/partner Trusts) and formal relaunch of Medway Foundation Trust Staff Equality Network
- October, Black History Month
- December, Disability History Month

Staff Diversity

As of March 2017, the trust reported a breakdown of staff as follows:

- 80.2% were women.
- The breakdown of staff by age can be seen in the table below:

<table>
<thead>
<tr>
<th>Age band</th>
<th>% of workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 20</td>
<td>0.6</td>
</tr>
<tr>
<td>21-25</td>
<td>7.3</td>
</tr>
<tr>
<td>26-30</td>
<td>13.1</td>
</tr>
<tr>
<td>31-35</td>
<td>11.7</td>
</tr>
<tr>
<td>36-40</td>
<td>12.0</td>
</tr>
<tr>
<td>41-45</td>
<td>12.0</td>
</tr>
<tr>
<td>46-50</td>
<td>13.1</td>
</tr>
<tr>
<td>51-55</td>
<td>13.1</td>
</tr>
<tr>
<td>56-60</td>
<td>10.3</td>
</tr>
<tr>
<td>61-65</td>
<td>5.4</td>
</tr>
<tr>
<td>66-70</td>
<td>1.4</td>
</tr>
<tr>
<td>71+</td>
<td>0.2</td>
</tr>
</tbody>
</table>
- 74.0% of staff disclosed their sexual orientation as heterosexual and 1.4% as lesbian, gay or bisexual with the remainder unknown or chose not to disclose.
- 4.6% of staff disclosed that they consider themselves to have a disability, 69.8% of staff declared that they don’t consider themselves to have a disability with the remainder either unknown or chose not to disclose.
- The breakdown of staff by religion and beliefs can be seen in the table below:

<table>
<thead>
<tr>
<th>Religious Belief</th>
<th>% of workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christianity</td>
<td>46.9</td>
</tr>
<tr>
<td>Not Disclosed</td>
<td>27.5</td>
</tr>
<tr>
<td>Atheism</td>
<td>10.6</td>
</tr>
<tr>
<td>Other</td>
<td>7.1</td>
</tr>
<tr>
<td>Hinduism</td>
<td>2.9</td>
</tr>
<tr>
<td>Islam</td>
<td>2.9</td>
</tr>
<tr>
<td>Sikhism</td>
<td>1.0</td>
</tr>
<tr>
<td>Buddhism</td>
<td>0.9</td>
</tr>
<tr>
<td>Jainism</td>
<td>0.2</td>
</tr>
<tr>
<td>Judaism</td>
<td>0.1</td>
</tr>
<tr>
<td>Unspecified</td>
<td>0.0</td>
</tr>
</tbody>
</table>

(Source: Medway NHS Foundation Trust website - Equality and Inclusion Annual Report 2017)

The trust provided the following breakdowns of staff by ethnic group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Proportion of staff (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>68.3</td>
</tr>
<tr>
<td>White - Irish</td>
<td>1.2</td>
</tr>
<tr>
<td>White - Any other White background</td>
<td>6.0</td>
</tr>
<tr>
<td>Mixed - White &amp; Black Caribbean</td>
<td>0.4</td>
</tr>
<tr>
<td>Mixed - White &amp; Black African</td>
<td>0.4</td>
</tr>
<tr>
<td>Mixed - White &amp; Asian</td>
<td>0.5</td>
</tr>
<tr>
<td>Mixed - Any other mixed background</td>
<td>0.6</td>
</tr>
<tr>
<td>Asian or Asian British - Indian</td>
<td>6.1</td>
</tr>
<tr>
<td>Asian or Asian British - Pakistani</td>
<td>1.5</td>
</tr>
<tr>
<td>Asian or Asian British - Bangladeshi</td>
<td>0.4</td>
</tr>
<tr>
<td>Asian or Asian British - Any other Asian background</td>
<td>3.8</td>
</tr>
<tr>
<td>Black or Black British - Caribbean</td>
<td>0.8</td>
</tr>
<tr>
<td>Black or Black British - African</td>
<td>4.3</td>
</tr>
<tr>
<td>Black or Black British - Any other Black background</td>
<td>0.6</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.6</td>
</tr>
</tbody>
</table>
Any Other Ethnic Group
Not stated

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

NHS Staff Survey 2017 – results better than average of acute trusts

The trust had 11 key findings that exceeded the average when compared to other acute trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average (all acute trusts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td>KF20. % experiencing discrimination at work in last 12 Months</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.77</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.71</td>
<td>3.65</td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.70</td>
<td>3.62</td>
</tr>
<tr>
<td>KF16. % working extra hours</td>
<td>71%</td>
<td>72%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.80</td>
<td>3.74</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 months</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>72%</td>
<td>66%</td>
</tr>
<tr>
<td>KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>26%</td>
<td>28%</td>
</tr>
<tr>
<td>KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>22%</td>
<td>25%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust had seven key findings that were worse than the average when compared to other trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td>KF20. % experiencing discrimination at work in last 12 Months</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.77</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.71</td>
<td>3.65</td>
</tr>
<tr>
<td>KF19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.70</td>
<td>3.62</td>
</tr>
<tr>
<td>KF16. % working extra hours</td>
<td>71%</td>
<td>72%</td>
</tr>
<tr>
<td>KF10. Support from immediate managers</td>
<td>3.80</td>
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</tr>
<tr>
<td>KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>22%</td>
<td>25%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)
KF12. Quality of appraisals | 3.03 | 3.11
KF28. % witnessing potentially harmful errors, near misses or incidents in last month | 33% | 31%
KF15. % satisfied with the opportunities for flexible working patterns | 49% | 51%
KF4. Staff motivation at work | 3.88 | 3.92
KF14. Staff satisfaction with resourcing and support | 3.22 | 3.31
KF2. Staff satisfaction with the quality of work and care they are able to deliver | 3.74 | 3.91
KF32. Effective use of patient / service user feedback | 3.67 | 3.71

(Source: NHS Staff Survey 2017)

**Workforce race equality standard**

Implementing the Workforce Race Equality Standard is a requirement for NHS commissioners and NHS healthcare provider. It ensures employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

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.

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.

In the 2017 survey the total response rate was 40.1% which was lower than both the England average (43.7%) and the minimum recommended response rate of 50%. In the previous and latest survey this trust used a census which sends the survey to all staff in the trust.
In the latest survey the responses from BME staff and white staff were significantly different for KF21 (percentage of staff believing that the trust provides equal opportunities for career progression or promotion) and Q17b (in the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?).

(Source: NHS Staff Survey 2017)

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 consistently below the England average for recommending the trust as a place to receive care from February 2017 to January 2018. In the most recent month 87.0% of patients recommended the trust compared to the England average of 95.5%. The response rate at the trust in January 2018 was 20.6% which was similar to the England average of 22.7%.

(Source: Friends and Family Test)

Sickness absence rates

The trust’s sickness absence levels from October 2016 to September 2017 were lower than the England average. The trust's sickness rate fell from 4.2% in October 2016 to 3.1% in April 2017 before rising again to 3.7% in September 2017.

A trust’s sickness level can be an indicator of culture within an organisation.
General Medical Council – National Training Scheme Survey

In the 2016 General Medical Council Survey the trust performed worse than expected for two indicators (induction and feedback) and the same as expected for the remaining 12 indicators.

The trust had a monthly team and employee programme which recognised staff achievement, with specific focus on BEST. They held annual awards with categories all aligned to the BEST ethos, which included the BEST team and employee of the year awards.

Governance
The arrangements for governance and performance management were not fully embedded. There had been a recent review of governance arrangements, which was still in transition at the time of inspection. The trust acknowledged there was still work to do and that it was an on-going process in response to the changing requirements of the trust.

The governance system had been modified and the plan was to reduce the number of meetings overall. It had resulted in half as many meetings as the previous structure, with the aim to reduce it by another half.

The terms of reference for groups and membership were reviewed annually. The trust wide groups were all chaired by senior members of the medical directors or director of nursing office. The board received a monthly integrated quality performance report and a report from the quality assurance committee.

The trust board received assurance from the executive group, the integrated audit committee, the finance committee, nominations and remuneration committee and the quality assurance committee.

The quality improvement group, clinical council, estates infrastructure an investment group, corporate informatics groups, equality and diversity group, strategic workforce group and performance review group reported to the quality assurance committee.

There were clear lines of accountability from the speciality services to unplanned and integrated care and planned care directorates as indicated in the diagram below:

Ward to board assurance was achieved through a performance management and quality governance framework.

The directorate structures for governing quality ran from ward up to directorate board which reported into the monthly executive led performance review meetings.
Each specialty in either the unplanned and integrated care directorate or in the planned care directorate had a patient safety lead. The patient safety lead reported to the clinical governance lead for each speciality. The clinical governance lead for each specialty reported to the directorate clinical governance leads.

The directorate clinical governance leads reported to the deputy director of nursing and the deputy medical director for each of the directorates, who reported to the executive director of clinical operations for each directorate.

The directorate governance leads co-chaired the directorate governance board with the deputy director of nursing and attended the quality assurance committee, serious incident panel and quality safety group.

Program clinical governance leads chaired program governance meeting and attended: the quality steering group; the patient safety group; the medicines management group; patient experience group; clinical effectiveness group. They organised representatives for the tissue viability group, pressure ulcer group; falls; safe sedation; medical gases; medical equipment and research governance.

The patient safety leads attended programme governance meetings and led on patient safety and attended mortality; end of life; resuscitation; safeguarding; infection control and antimicrobial stewardship meetings.

The executive group received reports from the quality improvement group and other quality groups. The board monitored quality through the work of the quality assurance committee, a subcommittee of the board, and the executive integrated quality & performance report, supplemented by reports taken directly to board. The quality assurance committee received regular monitoring information from its sub groups as well as receiving reports directly on matters where further assurance was required.

Alongside the clinical governance structure, was a nursing assurance framework. The terms of reference for the nursing and midwifery advisory group had been in place since 2016 and had recently been amended to strengthen the purpose of the group and nursing assurance. The group was remained to Nursing and Midwifery Steering Group and a standing agenda item is the review of a nursing score card.

A programme of activities enabled the board and senior managers to test the assurances provided via reports. These activities include executive gemba walkabouts and a programme of unannounced out of hours visits by senior nurses.

This approach was to ensure quality was owned by front line staff and therefore embedded in daily practice and provided a seamless approach to quality monitoring from ward to board.

**Board assurance Framework**

The board assurance framework is a key mechanism which boards should be using to reinforce strategic focus and better management of risk. The board assurance framework brings together in one place all of the relevant information on the risks to the board’s strategic objectives.

The trust had undertaken a review whereby the strategic objectives and associated risks were to be allocated to the most appropriate committee for oversight and assurance to board by way of an update within the key issues report.

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 and accompanying risks. A summary of these is below.

Objective one - our people: We will enable our people to give their best and achieve their best

Objective two – innovation: We will embrace innovation and digital technology to support the best of care

Objective three – integrated health care: We will work collaboratively with our local partners to provide the best of care and the best patient experience

Objective four – financial stability: We will deliver financial sustainability and create value in all that we do

(Source: Routine Provider Information Request (RPIR) P133 1. W5 – Board Assurance Framework (BAF))

The strategic objectives and their associated risks were kept under review as part of the board assurance framework (BAF); the BAF was monitored by the integrated audit committee with onward recommendation to the board. Performance was monitored against key performance indicators agreed within the trust recovery plan.

The strategic risks to the organisation were discussed at a board development session in February 2018, which was facilitated by an external auditor. Each strategic risk was aligned to the most strategic objective.

Management of risk, issues and performance

The organisation had processes to manage current and future performance. We saw there were systems and processes in place to assess, prevent, deter, manage and mitigate risk throughout the organisation. However, we found risk management was reactive, there was no forward look or awareness/acknowledgement of anticipated risks. In addition, it was not always clear to see where risk had been escalated from ward to board.

Risk registers were managed locally and reported through an electronic system which produced a weekly update to the deputy director of compliance and risk; the corporate risk register was updated by the deputy director from this information and reported to the board bi monthly for discussion along with the corporate risk register. A review of reporting risk and responsibility for managing specific strategic risk had resulted in each risk being allocated to the most appropriate board committee. Changes were also being implemented to ensure the board had sight of those risks that were low risk of occurring but with significant consequence.

The director of nursing and medical director were the named executive leads for quality and patient safety. A named non-executive director chaired the quality assurance committee and one for the mortality reviews.

The director of nursing had become a member of the finance committee to ensure quality remained a focus in decision making the nursing and medical director signed off all the quality impact assessments of all the improvement programmes in the trust.
The medicines management group and serious incident group met monthly. The patient safety group, and clinical effectiveness and research group met bimonthly. The patient experience group, safeguarding assurance group and director of infection prevention and control and antimicrobial stewardship met quarterly. All groups reported to the quality steering group.

The patient safety group had terms of reference aligned to the trust’s vision and values. There was a clear line of reporting in to the group and it was well attended by staff.

There had improvement in the safety culture in the organisation. There was 135% increase in the number of reports on the national learning and reporting system, which put the trust in the top quartile in the country. This was due to training staff in root cause analysis and writing reports. The improvement in the investigation methodology and responsiveness to concerns had increased the number of reports.

The proportion of serious incidents to the overall reporting rate had reduced and was close to the national average. The degree of harm to patients through clinical care incidents had decreased and there were fewer serious incidents associated with failure to detect deterioration, commencing on the sepsis pathway in the emergency department.

Staff escalated serious incidents, to the medical director or director of nursing within 48 hours. Never events were escalated immediately to the board.

The trust had introduced multidisciplinary serious incident patient case reviews led by a consultant and / or senior nurse according to the nature of the incident and swarm events for themes or multiple serious incidents from a single cause (e.g. falls to harm / pressure ulcers). The medical director and executive director of nursing circulated themed safety bulletins including learning points in the ‘Theme of the week’.

The simulation suite was being used to recreate situations of serious incidents so learning could be taken from them. The team was running a course for human factors training in for healthcare staff throughout Kent.
We looked at five serious incident investigation reports. They all included detail of the incident and evidence of root cause analysis in the investigation. All met duty of candour requirements.

**Safeguarding training figures**

The safeguarding team implemented separate children’s and adults training strategies implemented in the last year. Whilst training at all levels was a priority and focus within the organisation it was a challenge to maintain compliance figures. The fluidity of the workforce and numbers of temporary staff affected this. Adult safeguarding training was completely reviewed at all levels and audience targets reviewed to ensure staff receive the correct levels of training required. A plan of increased training and bespoke training was made available to staff.

![MFT Safeguarding training figures 2017-18](image)

(Source Additional data request (AR13-2018))

We found during the core service inspections there was improved awareness of safeguarding and support available to staff.

The quality assurance committee received a safeguarding report for adults and children every quarter. It was a single report and included all patients with learning disability and looked after children.

The hospitals standardised mortality ratio (HSM) and summary hospital-level mortality Indicator (SHMI) had been consistently within the national average for the last 18 months. All specialties held morbidity and mortality meetings and the trust had introduced and trained consultants in the use of the Royal College of Physician’s Standard Judgement Framework.

The trust has introduced the new mortality investigation, reporting system and the report for quarter one, and two was presented to board in January.

Recognition and response to deteriorating patients was good and evidenced by national early warning score audits. For example, from January to December 2017 on average, 99% of ambulance patients received a national early warning score. Results of the audits were discussed regularly at morning handover meetings, monthly forums, weekly updates and clinical governance meetings.
There was improvement in staffing levels in the emergency department. We saw staff hold quality rounds two hourly. The emergency department sepsis audit showed a higher than national average identification of patients with sepsis and administration of antibiotics within one hour of attendance.

There were clear lines of governance in the infection control team. The director of infection prevention and control was part of a decontamination meeting group and a water safety meeting group. Both reported to the infection, prevention and control and antimicrobial meeting. The infection, prevention and control group reported to the quality improvement group, which reported to the quality assurance committee.

The director of infection prevention and control also sat on the capital projects group, so they were involved in any building projects to ensure infection control was considered from the start.

A medical devices group and equipment library, provided assurance for the decontamination of reusable medical devices.

The trust took part in all of the national audits with designated consultant leads for each one. We saw there was a register of all local audits. The research and development team was included in clinical effectiveness governance and had regular governance meetings to ensure they were complaint with national research guidance. The trust held a trust wide audit day every six months for presentation of trust wide audits. A prize was awarded once a year to the best audits.

All our doctors in training were expected to participate in quality improvement projects, which were presented to the board in July each year. The clinical effectiveness and research group reported to the quality assurance committee of the board quarterly.

Scorecards were used at every level of performance management and quality governance, presenting outcome measures relating to patient safety, effectiveness and experience. Data was presented in a non-aggregated way to ensure variation was easily identifiable and supports benchmarking.

We saw monthly performance dashboards for each directorate and the key performance indicators were aligned with the five key questions.

Trustwide mandatory training compliance

![Graph showing trustwide mandatory training compliance](Source: Additional data request AR91-2018)
Finances Overview

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£254.8m</td>
<td>£287.7m</td>
<td>£267.2m</td>
<td>£289.9m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(52.5m)</td>
<td>(£42.9m)</td>
<td>(£55.8m)</td>
<td>(£29.2m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£307.3m</td>
<td>£330.6m</td>
<td>£323m</td>
<td>£319m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£22.5m)</td>
<td>(43.9m)</td>
<td>(£37.8m)</td>
<td>(£29.2m)</td>
</tr>
</tbody>
</table>

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

Trust corporate risk register

The trust provided a document detailing their eight highest profile risks. Each of these have a current risk score of 12 or higher.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25/09/2016</td>
<td>CRR-2016-001</td>
<td>Nursing staff shortages may lead to suboptimal care, affecting patient safety processes and clinical outcomes.</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>26/09/2016</td>
<td>CRR-2016-010</td>
<td>Failure to meet national performance standards results in delayed diagnosis and harm to patients, financial penalties and reputation damage.</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>11/09/2016</td>
<td>CRR-2017-004</td>
<td>Because lift 10 may be out of service for approximately 20 weeks, this increases the burden on lift 8 to gain access to level 4. Lift 8 is already vulnerable and has potential to break down. If lift 8 breaks down there is a risk that there would be no access for beds or trolleys to level 4 green zone for patients requiring movement between floors for diagnosis and treatment, or evacuation. There is a risk that the neonatal unit would need to close for access to the network if access to level 4 is denied.</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>09/08/2017</td>
<td>CRR-2017-002</td>
<td>An estates fire risk assessment has identified a number of trust wide risks in relation to fire safety arrangements across the trust. The risks identified are to patient and staff safety, breach of regulations, potential business interruption, reputational and financial risks. The individual risks identified are</td>
<td>15</td>
<td>4</td>
</tr>
</tbody>
</table>
Inability to recruit sufficient numbers of suitably qualified medical staff, may lead to sub optimal care, impacting on patient safety processes and clinical outcomes.

Due to failure to meet operational performance standards and maintain effective patient flow there is a risk of delayed diagnosis, treatment and/or discharge of patients.

Failure to achieve planned financial control total through cost improvement plans and Carter Review efficiencies across the trust affects the financial sustainability and going concern assessment of the trust.

Due to financial constraints, conflicting priorities and the current capacity for innovative change, there is a risk that the trust may not be in a position to embrace innovation and digital technology to support the best level of care for patients and facilitate improved working practices for staff.

(Source: Routine Provider Information Request (RPIR) P113 2. Corporate Risk Register – January 2018)

The trust had a standard operating procedure for risk management. Any member of staff could identify risks and complete a risk description form. That would be escalated to their line manager. The programme board reviewed the risk description forms and made a decision about whether or not it needed to go on the electronic risk register management system. Each programme had a risk register which fed into the directorate register. The directorate register fed in to the trust risk register. Any risks scoring 15 or above would be escalated directly to the directorate senior management team. We saw the risk registers for the programme board and directorate, however it was not always clear to see where risk at ward or department level had been identified and discussed. For example, issues with flooring in the theatres did not appear on risk registers for the programme and directorate. So, it was not clear to understand how this risk would be mitigated.

**Information management**

There were arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems and the trust was ensuring compliance with new legislation.

The trust had been carrying out work focussing on data quality for over two years. Prior to this, the trust had to pause reporting 18 weeks Referral to Treatment Time (RTT), because of poor data quality. The trust had returned to reporting as they had made improvements in recording the 18 weeks RTT pathways with a reduction of more than 16,000 open pathways mainly through validation. In addition, the trust saw an improvement over the last 12 months in the capture of NHS numbers with the performance now at 98.76% overall for all secondary user datasets, which was
still below the target of 99%. However, it was anticipated that the trust would be compliant in 2018/19 as part of the data quality improvement work.

The trust had begun a data assurance programme of work to carry out deep dive reviews on all metrics and data systems across the organisation. This improvement programme was intended to provide the board and external commissioners with greater confidence in the accuracy of the data and information provided.

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

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

The 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.

In 2017 to 2018, the trust achieved attainment level two in relation to the Data Output Quality Standards (Information Governance Toolkit Requirement 507). This indicated secondary uses data quality assurance checks had been completed. The trust achieved a score of 68% satisfactory (Green in the toolkit grading scheme) against the Information Governance Toolkit Version 14.

At the time of inspection, the trust was in the process a “best of breed” solution strategy for electronic patient records and care assessments. They had invested in a new patient administration system electronic order communication, in patient flow management, paperless maternity EPR system and deteriorating patient alerting utilising mobile technology.

The senior information risk owner, the Caldicott guardian and the data protection officer worked together and oversaw compliance to information governance.

They gave examples of information governance incidents, reportable to the information commissioner’s office. The information commissioner’s office is the United Kingdom’s independent body set up to uphold information rights. One included unintended sharing of patient pictures. The incident received a full investigation, all patients and their families were informed and process was changed because of the investigation. Another involved a staff member inappropriately accessing patient information. This resulted in dismissal of the staff member concerned.

The trust had achieved 87% compliance in information governance training, which was below the trust target of 95%. However, the trust had an action plan in place to address the shortfall.

The General Data Protection Regulation (GDPR) (EU) 2016/679 is a regulation in EU law on data protection and privacy for all individuals within the European Union. Organisations are required to demonstrate they are compliant with GDPR, which came into force end May 2018. At the time of inspection, the trust was partially complaint and working with an external organisation to ensure full compliance.

The information management and technology teams ensured there were regular backups of information systems in order to ensure business continuity. Systems were secure and regularly updated in order to withstand a cyber-attack and processes to deal with such a situation were detailed in the significant incident plan, dated September 2017.

Engagement
The trust engaged with people who used services, the public, external partners and staff to develop and deliver high quality service. However, not all staff felt the trust engaged when there was a change in the organisation of services. The trust was in the process of establishing which communications methods were most effective with staff. Following this piece of work, the internal communications plan would be reviewed and adjusted.

The trust engaged with the local community, stakeholders and public, so that they had more information about the trust and a say in the future improvement of services. They achieved this by having a presence at health and community fayres, enabling them to hear patient experience stories first-hand. At each board meeting, the trust invited a patient and their family or carers to recount the story of their care at the trust. This varied between positive and negative experiences.

The trust coordinated and facilitated a focus group with patients with chronic lung disease, who were able to share their complete health care experience with the different providers. The findings of this engagement were to inform service redesign.

The trust governors attended community events, held coffee mornings, attended member events and membership recruitment stands and acted as a bridge between the community and the trust. As the trust had foundation trust status, local people could become members. Member events were held 10 times during 2017 and 2018.

Governors were engaged within the hospital in various ways, as members of board committees, and as representatives e.g. in Patient Led Assessments of Care Environment assessments.

As part of the Sustainability and Transformation Partnership agenda, the trust helped promote and facilitate CCG engagement events. For example, they vascular and stroke services as part of the wider service reviews.

In the past year, the trust had made links schools, youth centres, The Medway Youth Council and Medway Youth Trust to engage young people, as well as hundreds of older people through Kent Active Retirement Association. They also attended meetings with various harder to reach groups within the community and those in ethnic minorities. They also worked to involve patients in service user groups.

The trust produced a bimonthly publication, News@Medway, which contained trust news, provided opportunities for patients and public to be involved in planned service improvements and promoted opportunities for involvement in Sustainability and Transformation Partnership engagement.

The trust website invited patients to give feedback via the website or social media and detailed ways in which they and the local population could get involved. For example, as a volunteer at the hospital. At the time of inspection, the hospital had 430 volunteers working throughout the hospital.

**Overall indicator of staff engagement for Medway NHS Foundation Trust**

The figure below shows how Medway NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. The trust's score of 3.66 was in the lowest (worst) 20% when compared with trusts of a similar type.
Overall staff engagement
This overall indicator of staff engagement has been calculated using the questions that make up key findings 1, 4 and 7. These key findings relate to the following aspects of staff engagement: staff members’ perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how Medway NHS Foundation Trust compares with other acute trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

<table>
<thead>
<tr>
<th>OVERALL STAFF ENGAGEMENT</th>
<th>Change since 2016 survey</th>
<th>Ranking, compared with all acute trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>! Decrease (worse than 16)</td>
<td>! Lowest (worst) 20%</td>
</tr>
<tr>
<td>KF1. Staff motivation at work</td>
<td>! No change</td>
<td>! Below (worse than) average</td>
</tr>
<tr>
<td>KF4. Staff ability to contribute towards improvements at work</td>
<td>! No change</td>
<td>! Lowest (worst) 20%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

The trust carried out the staff, friends and family test quarterly basis, apart from the staff survey quarter and the results which have showed improvements in the response rate, alongside trialling additional methods to improve response rates and methods for completion (trial of iPads).

The results were reported in the directorate performance review meetings and reported to the executive team and board.

Within the results, the number of staff recommending the hospital as a place to work had not changed. The trust dedicated work stream on culture and engagement within the improvement programme (Better, Best, Brilliant).

The trust had plans to engage staff more. In September 2017, they introduced an on line portal designed engage with new members of staff from the moment they received their offer letter of employment. Each new staff member had a login and could access the portal anywhere on any device. The portal walked staff through five steps designed to help orientate them with the trust, learn about the culture and understand job functions across the trust in a timely fashion. Since launch more than 337 new staff members had used the portal.

The trust launched a dedicated app for staff called @MFT, which has been downloaded more than 1,500 times. This had been specially designed by trust staff and provided them with access to a wide range of systems and information, news and updates, important policies and mandatory training.
Junior doctors developed the Forward app while they were at Medway and it provided a secure platform for clinical staff to communicate with one another.

The trust had appointed a head of culture and staff engagement at the time of inspection and had plans to do further work to improve staff engagement.

The chief executive and chair met the five local Members of Parliament quarterly as well as health leads on Medway Council. The chief executive and other executives attended Medway Health Overview and Scrutiny Committee and Health and Wellbeing Board. The trust worked closely with Healthwatch, who had regular stalls within the hospital and carried out enter and view visits.

The trust also engaged regularly with clinical commissioning groups, NHS Improvement and Care Quality Commission.

We spoke with stakeholders who told us they felt engagement with the trust was collaborative and collegiate in style

Learning, continuous improvement and innovation

The trust had systems in place to share learning from incidents and complaints. They had developed a learning strategy and were keen to develop further. However, at the time of inspection, the pace at which this had occurred meant not as much improvement was demonstrated compared with the potential.

The trust had developed a learning strategy in place with three objectives:

- **Objective 1**: Creating capability and growing competence
- **Objective 2**: Promoting Team Based Learning
- **Objective 3**: Encouraging open system thinking and creating a cohesive vision

The better, best, brilliant improvement programme had two overarching outcomes. To create capability, structure and a common language for continuous improvement within the trust so that benefits could be sustained and new benefits created. In addition, to deliver financial and quality improvement for the trust.

New staff received a short briefing on improvement in their induction, and after three months, were invited to a further course. These courses deliver different levels of capability and leadership in core improvement tools. The ‘white belt’ course delivered an introduction to five tools which helped structure both the process of delivering a project, and the content which flowed through that project. Participants learnt the overall improvement methodology and how to run continuous improvement cycles plan, do, study and act. White belt plus included time to work on participants’ projects, and a deeper look at plan, do, study and act. Green belt set participants up to deliver fast, effective projects through three days of training which formed the core of a five to six month programme, which integrated mentoring, group working and verbal examinations. It allowed participants to apply tools to a real-life project that was a trust improvement priority. Finally, blue belt leadership training covered leading change, developing teams and a range of tools to allow senior leaders to support their project leads by providing direction, challenge and expertise.
Alongside the capability building, specific projects were identified and prioritised to enable some projects to reach full implementation. Thirteen projects were underway to deliver savings, productivity improvements and patient experience benefits.

Junior doctors working at the trust developed the green book. This was an app to help junior doctors provide faster, safer treatment for patients with acute illness and provided junior doctors with easy access to up to date advice in acute clinical situations.

The trust had made changes to it discharge processes and worked with local partners in the health economy to reduce its delayed transfer of care rates by 25%.

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

In response to the guidance, the trust developed an action plan, which was monitored by the mortality and morbidity group and reported to the board. The trust had an allocated deputy medical director who chaired the mortality group and an identified non-executive director with responsibility for mortality. In response to the publication of the guidance, the trust implemented Learning from Deaths Policy, which was approved by the trust board, introduced the structure judgement review methodology, introduced a programme of training for consultant staff and developed learning from deaths dashboard, which is published in the public session of the trust board. Progress with implementation of the action plan was overseen by the mortality & morbidity group and reported directly to the trust board.

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

We reviewed five investigation of death files. The review forms were based on the structured judgement framework review. We found learning outcomes were identified and action plans were documented.

**Complaints**

The trust had made a significant to change to the way they responded to complaints, the time in which they did so and the quality of complaints responses.

The chief executive was the responsible officer for complaint and the lead executive was the director of nursing, with oversight from the associate director of quality. The directors of clinical operations were responsible for the corporate day to day complaints management and managed a central complaints team. The trust had a complaints policy and associated procedures, which clearly set out the process for the management of complaints.

Each of the two clinical directorates had a governance manager who had operational responsibility for complaints management within the directorate. They managed a team of three governance facilitators (one per programme) who were responsible for local management of complaints. The directorate and programme roles had responsibilities additional to complaints. Learning from complaints was the responsibility of the directorate teams. One hundred and seventy seven staff
from clinical and non-clinical backgrounds had attended training the management of complaints and root cause analysis.

Directorate programme board and executive led performance review meetings discussed complaints every month. A quarterly trust wide complaints performance report was produced and presented at the patient experience group and the quality improvement group. The quality improvement group reported to the quality assurance committee, which was a board level committee. An annual complaints report was published in the trust annual report.

The trust had information about concerns, compliments and complaints on the website which was accessible to the public. A 'compliments, comments, concerns, complaints' leaflet was available in clinical and non-clinical areas and there were signs in clinical areas detailing how to make a complaint, or raise a concern.

The central complaints team were responsible for receiving and acknowledging complaints and obtaining consent (if required). The central complaints team were also responsible for registering the complaint on the electronic incident reporting system, allocated an initial red, amber, green rating to the complaint and allocated the complaint to the appropriate directorate.

Each directorate was responsible for allocating an appropriate investigating manager to oversee the investigation of the complaint. The investigating manager was responsible for initiating contact with the complainant within three working days of receiving the complaint or upon receiving the consent; the investigating manager was also responsible for obtaining any relevant evidence, retaining and uploading any correspondence, statements and other evidence onto the electronic reporting system. If the complaint covered multiple directorates, one directorate would take the lead to enable one response to was provided to the complainant. The main subject of the complaint indicated which directorate was the lead one.

Statements and comments were gained from relevant staff to assist the investigation. The director of clinical operations or the deputy director of nursing checked the letter to the complainant. The directorate is responsible for sending the completed response to the complainant and for closing the compliant on the electronic system. The directorate was responsible for any follow up actions and learning from the complaint.

The director of clinical operations or deputy director of nursing before they were given to the chief executive for signing reviewed high-level complaints (red rated).

Learning from complaints was shared team meetings, at governance and programme boards, programme quality summits and governance meetings. Trust wide learning was shared via the quarterly and annual reports and presentations at forums, such as the nursing and midwifery quality forum, audit meetings and a weekly theme of the week.

We saw examples of changes made because of complaints:

- Keats Ward introduced a carer’s card which allowed relatives access to the ward at any time, mainly used for palliative or vulnerable adults.
- Nelson Ward introduced an escort policy for patients with learning disabilities being transferred to other hospitals, to ensure a smooth handover of care and a level of continuity for patients.
Lister Ward introduced a process whereby patients presenting on two occasions with the same clinical symptoms would be escalated for senior review.

Lister/Emergency Department introduced a ‘Patient's guide to Ambulatory Care’ that explained the pathway.

The children’s emergency department introduced a process whereby a doctor would review all patients under one year of age and escalate to a more senior doctor when required.

**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</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 working days</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30 working days</td>
<td>85%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>60 working days</td>
<td>85%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months (January 2017 to December 2017)?</td>
<td>915</td>
<td></td>
</tr>
</tbody>
</table>

(Source: *Routine Provider Information Request (RPIR) – P60 Complaints process* )

**Number of complaints made to the trust**

The trust received 723 complaints from January 2017 to December 2017. Medical care received the most complaints with 167 (23.1% of all complaints).

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care (including older people's care)</td>
<td>167</td>
<td>23.1%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>154</td>
<td>21.3%</td>
</tr>
<tr>
<td>Surgery</td>
<td>147</td>
<td>20.3%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>115</td>
<td>15.9%</td>
</tr>
<tr>
<td>Maternity</td>
<td>40</td>
<td>5.5%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>33</td>
<td>4.6%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>26</td>
<td>3.6%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>18</td>
<td>2.5%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>8</td>
<td>1.1%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

The majority of complaints had more than one theme. The most common themes reported in complaints were:

- All aspects of clinical treatment (274 complaints)
- Attitude of staff (145 complaints).
- Communication/information to patients (99 complaints)
The Trust has had seven complaints referred to the parliamentary health services ombudsman of which one was partially upheld, two were not upheld and four remained open. Because of the one complaint, which was upheld, the trust adjusted the junior doctor’s local induction and handbook. In addition, the rota system was changed to ensure middle grade doctors were available all day to perform senior reviews. Learning from this partially upheld complaint was been shared at the audit meeting.

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

Compliments

From January 2017 to December 2017 the trust received a total of 338 compliments recorded. The trust does not have a centralised system in place for receiving and logging compliments, therefore the total compliments is a combination of compliments received by the planned care directorate, chief executive officer (CEO) and the patient advice and liaison service (PALS). A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>125</td>
<td>37.0%</td>
</tr>
<tr>
<td>Other</td>
<td>213</td>
<td>63.0%</td>
</tr>
</tbody>
</table>

The planned care directorate and PALS gave a summary of the main themes of compliments received:

Planned care directorate
- Care and treatment provided to patients and families.
- Kindness of staff.
- Staff going the extra mile offer support, comfort and reassurance for patients when at their most vulnerable.

PALS
- Helpfulness of staff.
- Efficiency of staff.

(Source: Routine Provider Information Request (RPIR) – P62 Compliments)

Improvement and innovation

The trust had made improvements and worked closely with local partners in the health economy. The trust had undertaken huge recruitment drive locally, nationally and internationally, for the first time in late 2017 had more starters than leavers. They had introduced recruitment and retention incentives.

The trust had developed a frailty pathway, the Proactive Assessment Clinic for the Elderly (PACE). PACE is a community based initiative that supports the health needs of patients over 65 years old. The initiative, which had been delivered in partnership between the trust, local council, and local GP services since 2016, had meant elderly local residents could continue to live healthy and independent lives with support from the expanding number community centres opening across Medway. It has also meant that patients who need medical care but did not require emergency care at the hospital can be treated efficiently and with high quality expertise at their nearby centre.
Monthly monitoring had shown a reduction in falls in the community; and the trust was developing a similar model for Chronic Obstructive Pulmonary Disease (COPD).

The trust worked closely with the local clinical commissioning group, community services and social care to ensure patients could be discharged in a timely way. This had meant they had been able to reduce the number of delayed transfers of care (DTOC) from an average of around 25 to single figures. The trust had consistently had one of the lowest DTOC figures in the country and had presented and shared its success at conferences.

A pathway had been developed to reduce attendance at the emergency department. Staff assessed patients and directed them to the primary care ambulatory emergency centre and assessment areas where appropriate. As a result of this change, 25 per cent of patients were being treated away from the emergency department.

The trust had implemented the clinical coordination centre to coordinate the management of admissions and discharges to the hospital. It met three times a day to review the position in the emergency department, number of decisions to admit, ensured movement of patients to the most suitable area, the bed situation and any staffing issues. Additional meetings could be held depending on status of escalation. Managers and clinicians attended it from all the admitting areas, the senior manager on call and the director of clinical operations /director on call. The clinical coordination centre used an electronic bed management system and a focus on early electronic discharge notices as well as an improved process for reducing the wait time for medication to take home. The transport bookings were also under review to avoid unnecessary waits.

The emergency department developed a new way of caring for patients who come to the trust with suspected hip fractures. The patient was guided through the new clinical pathway, from when the ambulance arrived at their home and was ‘fast tracked’ to the imaging department for diagnostic tests. They were admitted straight into an orthopaedic bed. The mortality rates for hip fractures had improved, decreasing from 11.2 per cent to 5.7 per cent (some of the lowest in England), while the waiting time between initial assessment by paramedics and transfer to a specialist ward had also reduced from 379 to 81 minutes.

The trust was chosen to participate in Chole-QuIC, a Royal College of Surgeons programme developed to improve care for acute gallstone disease. Since launching in October 2016, the trust had made huge changes to their practice for treating gallbladders. Results so far have shown an improved eight-day rate and time to surgery and reduced length of stay across all gallstone disease, which had led to cost savings. There was also a reduction in numbers of recurrent attendees.

The breast cancer screening service had been transformed and was providing a greatly enhanced service to patients. The model led to significant improvements in patient safety and better screening outcomes. Due to this intervention, early treatment and diagnosis of cancer had improved, meeting the 31 and 62-day targets.

Since the last inspection, the acute response team (ART) had been developed further and there were two members present in the trust 24 hours a day, seven days a week. They reviewed all patients that had been stepped down from level two or three care and responded to all patients with a rising NEWS score. This has led to a significant reduction in inpatient cardiac arrests with no transfers from the bed base to level two and level three beds in the last four months.

The trust had made changes to processes and pathways across the trust to help reduce and eliminate all avoidable pressure ulcers. The changes made included creating a fully established tissue viability team, developing and making changes to tissue viability paperwork, replacing the Braden risk assessment tool, improving communication between the wards and tissue viability team and including competence-based wound management with all tissue viability training.
There had been a 31 per cent reduction in hospital acquired pressure ulcers between April 2017 and March 2018, compared to April 2016 and March 2017, and a 60 per cent reduction in moderate or severe harm incidents between April 2017 and March 2018 (10 cases) when compared to April 2016 to March 2017 (25 cases). There had been no cases of the hospital acquired pressure ulcers being a factor in the patient’s death in this period.

The trust had worked to reduce the numbers of patient falls in hospital by implementing several strategies and projects. They introduced a Falls Investigation toolkit and ran a falls awareness campaign “May the falls NOT be with you” in May last year. The falls prevention clinical nurse specialist had been invited to speak at several conferences to talk about our successes and share best practice. There was an 11 per cent reduction in falls in April 2017 – March 2018 when compared to the previous year and the trust remained below the national mean rate for falls per 1,000 occupied bed days.

In October 2017, the hospital was selected to be one of 11 sites to trial the national bereavement care pathway, a new pathway developed to improve the quality of care experienced by bereaved parents and families. Since starting the national bereavement care pathway, they had supported 82 families through the pathway. They were about to start on the second wave in which they would support two other trusts to develop their bereavement pathway.

Over the past two years, the trust had closed 53 escalation beds.

Medway NHS Foundation Trust was actively involved in research supported by the National Institute for Health Research (NIHR). During 2016/17 there were a total of 159 research studies conducted at Medway NHS Foundation Trust. For the same period, Medway NHS Foundation Trust participated in 123 NIHR supported studies, including 54 cancer specialty studies.

The trust and its services had been nominated for and received a number of awards:

**NHS70 Parliamentary award nominations**

- Excellence in Urgent and Emergency Care – Fractured Neck of Femur Pathway
- Excellence in Urgent and Emergency Care – Nursing Recruitment
- Excellence in Mental Health Care – Perinatal Mental Health
- Excellence in Primary Care – Frailty Pathway
- Excellence in Cancer Care – Improving Breast Screening
- Care and Compassion Award – Surgical Bereavement Service
- Lifetime Achievement Award – Medical Director

**THE BMJ Award nominations**

- Improving Breast Screening – Cancer Care Team
- Accelerated Fractured Hip – Emergency Team (Highly commended)
- Perinatal Mental Health – Mental Health Team

**HSJ Value award nominations**

- Effect of Triaging of Spinal Referrals - Specialist services
- Emergency Department Workforce Recruitment and Retention – Specialist services (Highly commended)

**HSJ Top Chief Executives list 2018**

Medway Clinical Commissioning Group Community and Patient Partnership wards 2018
- Surgical Bereavement Service – The Learning from Experience award

London 2018 Maternity and Midwifery Festival Awards
- Team Maia – Midwifery Innovation Award

Kent Chartered Institute of Personnel Development Awards 2018
- Human Resources and Organisational Development Team - HR Team of the Year

Lotus Awards Finalists 2018
- Employee Relations Team (winner)
- Recruitment Team (winner)

Healthcare People Management Association Awards
- Human Resources and Organisational Development Team - Vivup Award for Wellbeing - Best Financial Wellbeing Strategy (Highly Commended)
- Recruitment Team - Recruitment Team of the Year (Highly Commended)

Royal College of Midwives Annual Midwifery Awards 2017
- Maternity Team - Johnson’s Award for Excellence in Maternity Care

Kent, Surrey, Sussex Leadership and Innovation Awards 2017
- Dr Sanjay Suman – Excellence in out of hospital care

Royal College of Emergency Medicine Awards 2017
- Emergency Department - Clinical

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>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy – 26/10/2017</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Radiography, General, Ultrasound, Mammography, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Therapeutic Radiology Procedures, Bone Mineral Densitometry (DXA), Radionuclide Imaging (RNI), Patient Archiving and communication system (PACS), Teleradiology – last accredited 17/11/2017</td>
</tr>
</tbody>
</table>
| Clinical Pathology Accreditation  
and its successor Medical Laboratories ISO 15189 | Department of Biochemistry, Department of Haematology & Blood Transfusion, Department of Microbiology |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>Macmillan Cancer Care Unit – Assessed in 2018 with a 5 star rating</td>
</tr>
</tbody>
</table>

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

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

Medway NHS Foundation trust urgent and emergency care department is located in Medway Maritime hospital, Gillingham, Kent. In early 2016, work began to modernise the urgent and emergency care department with the intention of improving capacity and streamlining the service to reduce the time it takes for patients to be seen. The new building was due to open in May 2018. The urgent and emergency care department at Medway Maritime hospital provides a 24-hour, seven day a week service to the local area.

The urgent and emergency care department has a co-located primary care facility (operated by a separate provider) and a separate children’s emergency department. The children’s emergency department is accessible from the main urgent and emergency care department and is secured with swipe card access. Patients are directed on arrival to the most appropriate health care provider.

The urgent and emergency care department has a designated trauma unit, a specialist stroke service, with input from a team specialising in older people’s care and is supported by a seven-day consultant led ambulatory care unit.

The urgent and emergency care department at Medway Maritime hospital has a five-beded resuscitation area, 11 cubicles for major emergencies (majors), 12 majors escalation trolleys, four cubicles for minor injuries (minors), a mental health assessment room and two triage/rapid assessment rooms. There is a majors and a minors waiting area. There is a designated children’s resuscitation bay within the resuscitation area. Total capacity is for 40 patients and when the new building opens, this will increase to 58. There are two triage rooms and five assessment rooms in the children’s emergency department. There is an ambulatory care ward near to the urgent and emergency care department, where staff direct patients from the emergency care department if appropriate. The ambulatory care ward undertakes day case assessments, rapid access clinics; inpatient stays and facilitated early discharge.

Urgent and emergency services were last inspected in 2017 when overall, we rated it as requires improvement. We rated caring, effective and well-led as good, responsive, and safe as requires improvement.

This inspection was announced and we inspected all five key questions. We spoke to 16 patients and carers and over 20 staff from different disciplines, including support and administration staff, nurses, doctors, managers and ambulance staff. We observed daily practice and viewed 23 sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.
Activity and patient throughput

Total number of urgent and emergency care attendances at Medway NHS Foundation trust compared to all acute trusts in England.

There were 121,856 attendances to the urgent and emergency care department between April 2016 to March 2017 at Medway NHS Foundation trust as indicated in the chart above.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission

The percentage of accident and emergency attendances at this trust that resulted in an admission...
admission increased from 2015/16 to 2016/17. Rates were lower than the England average in 2015/16 but similar to the England average in 2016/17.

(Source: NHS England)

Urgent and emergency care attendances by disposal method

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>23,523</td>
</tr>
<tr>
<td>Discharged*</td>
<td>70,194</td>
</tr>
<tr>
<td>Referred^</td>
<td>10,986</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>1,060</td>
</tr>
<tr>
<td>Died in department</td>
<td>102</td>
</tr>
<tr>
<td>Left department#</td>
<td>3,317</td>
</tr>
<tr>
<td>Not known</td>
<td>8,790</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

The service provided mandatory training in key skills to all staff. The majority of staff had received mandatory training. However, training rates for medical staff fell below the trusts set target of 85%

The trust had a programme of mandatory training for staff. Mandatory training subjects included; fire safety, moving and handling, information governance, equality and diversity, learning disability awareness, dementia awareness and infection control. Safeguarding training included information on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Mandatory training was delivered face-to-face and through an online learning management system. Staff were given protected time on their rota to complete mandatory training to help them keep up to date.

Senior staff monitored completion rates for mandatory training of staff against the trust’s minimum 85% target. Training compliance was a standard agenda item on the weekly senior staff department meeting agenda. This meant overall compliance was monitored.

Staff received email notifications when their training was due to expire and their manager booked them onto training courses.
Managers were able to show us up to date training records of all their staff, from these it was easy to identify who was not compliant with their training.

**Mandatory 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 mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical and dental staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>43</td>
<td>49</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>38</td>
<td>46</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>37</td>
<td>49</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>38</td>
<td>51</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>38</td>
<td>51</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>34</td>
<td>48</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>29</td>
<td>47</td>
<td>62%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>30</td>
<td>49</td>
<td>61%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the training target in eight out of the nine modules for medical staff in urgent and emergency care. Only 30 out of 49 staff had up to date adult basic life support training equating to 61% of all eligible medical and dental staff.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and midwifery staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>76</td>
<td>77</td>
<td>99%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>73</td>
<td>77</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>71</td>
<td>76</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>68</td>
<td>79</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>66</td>
<td>79</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>62</td>
<td>78</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>61</td>
<td>78</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>52</td>
<td>76</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>50</td>
<td>78</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met the training target in five out of 10 eligible training modules for qualified nursing and
midwifery staff in urgent and emergency care. The lowest training compliance rate was for Prevent Level 2 training with 64% compliance.

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

More up to date data was provided to the inspectors during the inspection in relation to mandatory training compliance. This data showed 91% of administration staff, 73% of medical staff, 85% of adult nursing staff and 85% of paediatric staff were compliant with mandatory training. This meant only medical staff were failing to meet the trust target of 85%. This showed an improvement in mandatory training compliance since our last inspection.

Training compliance was displayed on a noticeboard within the department. This meant staff could see if the department was meeting the trust target.

A mental health consultant provided training for nurses and junior doctors, which included information on the potential needs of patients with a mental health illness, learning difficulty, autism or living with dementia. This was scheduled in advance as part of the weekly teaching programme. An agenda from the November 2017 clinical governance meeting also included training on this.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

**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. Seventy-six percent of staff in urgent and emergency care had completed safeguarding training from April 2017 to October 2017.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for medical and dental staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>32</td>
<td>49</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the target for safeguarding adult’s level 2 training for medical and dental staff in urgent and emergency care.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for qualified nursing and midwifery staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for qualified nursing and midwifery staff in urgent and emergency care is shown below:
<table>
<thead>
<tr>
<th>Safeguarding Adults (Level 2)</th>
<th>58</th>
<th>76</th>
<th>76%</th>
<th>85%</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>1</td>
<td>2</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the target for the two eligible safeguarding courses for qualified nursing and midwifery staff in urgent and emergency care.

(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 1 and higher levels of training were then completed, based on the level of responsibility each member of staff had.

At the time of our last inspection, medical staff had not completed level 2 or 3 adult safeguarding training. This was not in line with the Adult Safeguarding Levels and Competencies for healthcare professionals Intercollegiate Document 2016.

During this inspection, we found safeguarding training was in line with Safeguarding Children’s Standards produced by the Royal College of Emergency Medicine’s. For example, all medical and nursing staff had, as a minimum, level 2 child protection training.

The department had systems and processes in place to safeguard adults and children from abuse or harm. 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.

Safeguarding information was displayed in the department’s staff room and training areas to provide staff with guidance and access to additional advice from the local safeguarding team and safeguarding telephone contact numbers if required.

Electronic patient records contained an ‘alert’ to identify children or adults that had been previously identified as vulnerable or who may be at risk. This enabled staff to identify patients likely to be at risk from abuse or neglect and use appropriate strategies to promote their health and wellbeing. The service maintained a ‘paper based alert folder’, which was stored securely and contained additional information regarding the safeguarding concern. We reviewed this folder, which confirmed this.

Safeguarding referrals were completed electronically via the trust’s intranet. Staff demonstrated the on-line system for making referrals to the local authority. An incident form was also completed in conjunction with raising a safeguarding alert. A staff member told us they had raised a safeguarding alert and incident form and had received feedback. This meant staff that raised the alert were informed of the outcome of the alert.

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 was guidance and pro formas available.

There was a child protection information resource folder within the department, this included where to access relevant guidance, changes in national guidelines and legislation. This ensured staff were kept up to date with child protection guidance and legislation.

The department 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 highlighted their name on records to confirm the check had been completed.

Staff were aware of the Mental Health Act holding power and could access the mental health liaison and safeguarding team for urgent advice. Junior doctors received training for a mental health consultant on holding power. 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.

If a patient was assessed to be at risk of suicide or self-harm, increased observation was carried out. In addition, security guards could be present if required. Urgent referrals to mental health liaison for consultation and assessment were made as soon as a risk was identified. During our inspection, we observed a handover of a patient between staff, which included the frequency of observations.

Data supplied to us by the trust showed between January 2017 and March 2018, 100% had a documented handover within the patient’s records. This showed staff were handing over all the relevant information and documenting the details of this.

There was a trust policy on the rapid tranquilisation of patients, which staff could access electronically. Mental health patients were assessed and assigned a category based on the level of risk to themselves and others. If patients were categorised as red (the highest level of risk) the police were called to support staff in the restraint of the patient if required.

**Cleanliness, infection control and hygiene**

The urgent and emergency care department had effective systems and processes in place to maintain cleanliness and control infection.

All areas were visibly clean, staff kept corridors and waiting areas free from clutter and storage areas were clean and tidy with stock, which was positioned off the floor to reduce the risk of cross contamination and enable effective cleaning to take place. For example, we saw intravenous (into vein) fluids were kept on a rack off the floor.

Staff and visitors had access to hand hygiene facilities. Hand sanitising dispensers were located at regular intervals throughout all areas and we saw staff and visitors using them.

All clinical staff had their arms bare below the elbow, in line with trust policy and national guidance to prevent the spread of infection.

Staff had access to personal protective equipment such as aprons and gloves. Staff demonstrated the correct use of personal protective equipment and disposed of gloves and aprons in the correct clinical waste bins.

Systems and processes were in place to treat patients with infectious diseases for example, flu. There were four single cubicle isolation rooms that could be used to prevent the spread of infection. These were given a thorough clean after they were used.

Staff segregated and labelled clinical waste and domestic waste bins correctly. This meant staff could clearly identify the appropriate receptacle to dispose of waste.

Sharps (needles) bins were located in all clinical areas. We checked 12 sharps bins and saw 10 were correctly assembled and labelled; two bins were not in the temporary closure position. This meant the contents could spill out if the container was moved. All sharps bins were within a safe fill limit therefore reducing the risk of needle stick injury.
Staff employed by the trust provided cleaning services. The same housekeepers worked in the department to provide cleaning services. Dedicated housekeeper cover was available 24 hours per day Monday to Sunday. This provided continuity of cleaning and ensured a good relationship between the housekeeper’s staff and emergency department staff. Staff we spoke to knew the names of the housekeeping staff responsible for the cleaning of the department and were embedded as part of the emergency department team.

The housekeeper supervisor and the matron undertook weekly audits. These were undertaken with the cleaning staff, which ensured immediate feedback was given and action was taken. In a cleaning audit undertaken in March 2018, the department scored 98% this exceeded the trust target of 90%. This was an improvement since our last inspection when overall compliance was 74% in November 2016, which was worse than the trust target of 90%. During the inspection, we reviewed cleaning schedules and cleaning audits, which were fully completed.

A Patient-Led Assessment of the Care Environment audit undertaken in 2017 scored cleanliness in the department, as 93%, this was worse than the national average of 98%.

The national blood culture contamination rate is between 3% and 4%. The emergency department in 2016-17 overall rate was 8%. Blood cultures are an important investigation to help tailor effective management for patients with severe sepsis. Frequent contaminated samples increases laboratory workload and can delay or cause incorrect changes to patient management. We saw an action plan had been developed to try and reduce the blood contamination rate. Actions included reinforcement of aseptic non-touch technique. Aseptic technique means using practices and procedures to prevent contamination from germs. We observed staff using a non-touch technique during our inspection, which was undertaken correctly. More recent data showed a variable blood contamination rate. January and March 2018 showed a rate of over 10%, February 6% and November and December 2017 just under 8%. All months were still worse than the national average rate.

During our inspection, we observed staff following appropriate hand hygiene practices. This included staff washing their hands prior to and after patient contact to prevent the spread of infection. This was in line with the National Institute of Health and Care Excellence Quality Statement 3. We observed that hand hygiene practices had improved since our last inspection when there was mixed compliance with infection control practices during busy times.

Data supplied to us by the trust showed between September 2017 and March 2018 there was 100% compliance in hand hygiene practices.

The toys within the children’s emergency department were part of a scheduled daily clean; we saw records, which confirmed daily cleaning was undertaken.

Decontamination products were stored securely and were risk assessed using the control of substances hazardous to health (COSHH) guidelines.

We saw staff inserting vascular access (inserting a small tube into a vein) minimised the risk of infection by completing specified procedures during insertion. For example, we saw staff cleaned the skin before inserting the device. This was in line with the National Institute for Health and Care Excellence guideline QS61. A proforma was completed by the staff member, which confirmed the specified procedures had been undertaken. A similar proforma was used for the insertion of urinary catheters.

Staff undertook infection prevention level 2 as part of their mandatory training. Compliance with this training was below the trust target of 85% for both nurses (76%) and medical staff (79%). This meant staff may not be up to date on infection control and prevention policies and processes.
The hospital had a designated infection prevention and control (IPC) team, in line with the recommendation of criterion one of the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of Healthcare associated infections and related guidance. The team included the designated lead for infection control, qualified infection control nurses, and a consultant microbiologist with infection control responsibilities.

Environment and equipment

The service had suitable premises and equipment and looked after them well. However, emergency equipment was not consistently checked to ensure it was safe for use.

Although some areas were not the ideal environment, these were being addressed with the new building, which would provide a more modern environment.

A new building, which would increase capacity and aid access and flow, was due to open in May 2018. Included in the new building plan was a staff rest/welfare area as space was limited in the current building. Staff told us they were looking forward to a larger staff area, which was away from the main department allowing breaks to be taken away from the main department.

A Patient-Led Assessments of the Care Environment audit undertaken in 2017 scored the condition, appearance and condition in the department, as 56%, this was worse than the national average of 94%.

The urgent and emergency care department at Medway Maritime hospital had a five-bedded resuscitation area, 11 cubicles for major emergencies (majors), 12 majors escalation trolleys, four cubicles for minor injuries (minors), a mental health assessment room and two triage/rapid assessment rooms. There was a majors and a minors waiting area. There was a designated paediatric resuscitation bay within the resuscitation area. Total capacity was for 40 patients when the new building opens this will increase to 58. There are two triage rooms and five assessment rooms in the children’s emergency department.

There was an ambulatory care ward near to the urgent and emergency care department, where staff moved patients from the emergency care department, if appropriate. The urgent and emergency care department had co-located primary care facility (operated by a separate provider). Patients that were directed by a nurse and required input from a general practitioner were transferred to the primary care facility.

The electronics and medical engineering department managed a programme of planned maintenance of the department’s equipment and provided support to staff. An effective monitoring system enabled staff to plan equipment maintenance in advance. We checked 13 pieces of equipment during our inspection all of which had undergone servicing and electrical safety check within the last 12 months. Staff we spoke to understood the reporting and escalation procedures for faulty equipment.

There was a fully equipped paediatric resuscitation bay and resuscitation trolley with all sizes of equipment. This and the other adult resuscitation bays were checked on a daily basis to ensure they were ready for use and we saw records, which confirmed this.

During our last inspection, we saw documented daily safety checks of resuscitation trolleys were not fully completed, there were days, where checks were missing. During this inspection, we checked all the resuscitation trolleys and identified the same issue. Equipment on top of the trolley, for example, the defibrillator and suction were meant to be checked daily and the entire contents of the trolley checked weekly. All resuscitation trolleys were tagged with a tamper evident tag and the number of the tags recorded in the records. This meant it was obvious to staff if the
trolley had been opened and a check could be undertaken to ensure all equipment was in the
trolley and available for use.

The trolleys in the paediatric and minors area had fully completed daily and weekly checks.
However, the resuscitation trolleys in the majors and majors escalation were missing daily checks.
For example, the resuscitation trolley in the majors area was missing daily checks on 04 April, 22
March, 24 February, 13, 14 and 15 March 2018. This meant there was not an effective process,
which ensured emergency equipment was checked on a daily basis to ensure it was available and
safe to use. Weekly checking records were complete with no missing gaps, which meant all
equipment had been checked and was safe and available for use. We checked 25 items on the
resuscitation trolley in the majors department and all were in date.

There was audio and visual separation of the children’s waiting room and treatment room. This
was in line with the Royal College of Paediatric and Child Health: Standards for Children and
Young People in Emergency Care Settings 2012.

The children’s department could be accessed by the main urgent and emergency care
department. We saw clear signage to direct relatives and patients to this area. All paediatric areas
were secure with restricted access by swipe card for staff only.

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
heavy weight furniture, panic buttons and no ligature points.

Self-presenting patients arrived to the main urgent and emergency care department and were
booked in at the reception desk. Reception staff had direct oversight of all patients within the
waiting area; protective screens covered the reception staff.

There was adequate seating in waiting areas to accommodate those presenting to the department.

There was no key coded or swipe access doors to access other areas within the urgent and
emergency care department, the main waiting room all doors were unlocked. This meant
unauthorised personnel could access all areas.

As highlighted in previous inspections, we saw the resuscitation area was very cramped; however,
the new building, which included a larger resuscitation area, was due to open in May 2018.

During our last inspection, we saw there was a fire door propped open in the majors escalation
area. The fire door was external and led to a raised concrete area with steps. This meant there
was a potential risk that patients who may not be able to assess danger could injure themselves if
they went through the open door. We saw this door was open during this inspection despite
notices on the door advising that they should not be opened. This showed the process
implemented after the last inspection to ensure the doors were kept shut was not effective.

We asked the trust to provide evidence that weekly fire safety logs within the urgency and
emergency care department were undertaken. The trust did not supply this information because
they were not currently undertaken. Records reviewed showed only one check had been
undertaken in the previous 12 months. This meant there were no assurances that fire exits and fire
doors, firefighting equipment checks, and emergency lighting functioned. This was consistent with
our findings at our previous inspection, which meant the trust had failed to address the issue and
take action. The matron explained that this issue had recently been identified and they planned to
undertake the weekly fire safety checks to ensure they were completed.

The x-ray department was located adjacent to both the paediatric and adult departments enabling
easy patient and staff access to these facilities.
The emergency nurse practitioner area was located adjacent to the emergency department. All equipment and consumables within this area were in date, and up to date with servicing and therefore safe for use.

All equipment and consumables that we checked within the paediatric department were in date, and up to date with servicing and therefore safe to be used.

Children with mental health conditions were placed within the children’s emergency department in high visibility areas, to ensure oversight from staff.

We observe equipment was easy to locate, clearly organised, labelled and sufficient to meet the needs of patients.

There were sepsis (infection) and tissue viability (skin and soft tissue wounds) trolleys within the department. This meant all the equipment required to treat these two conditions was available in a trolley, which could be wheeled to the patient making the equipment easily accessible.

The department was close to car parks and had a drop off area for police and ambulances.

Assessing and responding to patient risk

Emergency Department Survey 2016

The trust scored about the same as other trusts for the five emergency department survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.3</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>6.7</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>6.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.4</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 worse than the overall England median in six out of 12 months from January 2017 to December 2017. The trust’s performance was generally worse than the England average from January to July 2017 but performance then improved with the trust time initial assessment being below the England average from August to October 2017. The trust did not provide data for this metric for November and December 2017.

Data provided to us by the trust during the inspection showed in March 2018 the median time from arrival to initial assessment was 16 minutes for patients arriving by ambulance. The same data provided showed the median time from arrival to initial assessment was 19 minutes for walk
Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Medway Maritime hospital

From February 2017 to January 2018, there was a varied trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Medway Maritime hospital. From April to October 2017 there was a lower proportion of ambulance journey turnaround times over 30 minutes followed by an increase from November 2017 with the highest proportion of 68% over 30 minutes reported in January 2018.

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Medway Maritime hospital
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 January 2017 to December 2017, the trust reported 812 “black breaches”. The majority of the “black breaches” occurred in the winter months with 65% reported in just four out of the 12-month period (January to March 2017 and December 2017). In the other eight months (April to November 2017), there was an average of 36 “black breaches” reported per month.

The department had a patient triage, assessment, and streaming processes in place. Since our last inspection, the service had introduced a system of streaming adult patients. Adult patients booked in at reception and were then immediately reviewed by a senior nurse who directed the patient to the most appropriate service. Adult patients with minor illnesses or injuries were either transferred to the primary care suite of the minors area for assessment and treatment. Adult patients with more severe illnesses or injuries were then triaged by a nurse and treated within the majors area. Streaming of adult patients allowed staff to prioritise the most clinically unwell patients upon arrival to the department.

Paediatric patients were not streamed by a nurse and were directed straight to the children’s emergency department for triage after booking in at reception. Data supplied to us by the trust showed that in February 2018 the triage time was three minutes.

There were two triage rooms that were staffed by two senior nurses and an associate practitioner, patients were seen and treated in order of clinical priority. A nurse triaged all patients and a colour category assigned depending on their condition. These categories were red, indicates high priority treatment required such as massive blood loss, yellow, indicates medium priority such as an isolated leg fracture, and green indicated walking patients with abrasions or sprains.
Between the hours of 10am and 10pm, an emergency nurse practitioner used a rapid assessment and treat model, to assess patients. Rapid assessment and treatment of patients enabled staff to detect critical illness or injury in a timely manner. This enabled them to assess and treat patients more quickly.

The adult waiting areas had separate male, female and disabled toilets. We identified potential ligature points in the toilets, which could be used by mental health patients. The risk was mitigated as mental health patients were always escorted to the toilet and a member of staff waited outside the toilet.

An emergency buzzer was located at the reception desk so that staff could summon assistance in the event of an emergency.

We saw there was a missing patient protocol for liaison staff. The protocol outlined was action staff should take if a patient was referred to liaison psychiatry and left the department without being seen or who went missing during or falling assessment. The protocol was completed with a description of the patient for every patient who attended with a mental health illness. This meant a description could be given to the police if necessary.

Every patient had 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 saw completed safety checklists in all the notes we reviewed. Safety checklists have been shown to improve standardisation and demonstrated improvements in patient safety and care.

Reception staff in the urgent and emergency care department followed an escalation process if they were concerned about a patient. This escalation process was displayed in their reception area and staff could describe the process of escalation. Staff alerted the streaming nurse, triage nurse or called the nurse in charge if they were concerned about a patient. Staff gave us examples of when they had implemented the escalation process. For example, when a patient was suffering from severe chest pain. This process ensured patients who were acutely unwell that booked in received treatment quickly. Reception staff described the use of the emergency buzzer in the reception and that clinical staff always responded immediately.

Emergency ambulance crews pre-alerted the emergency department by telephone when on route with a critically unwell patient. Patients arriving by ambulance as a priority (blue light call) were accepted and assessed immediately in the resuscitation area. The resuscitation area was located next to the ambulance arrival area. During our inspection, we observed patients arriving by ambulance. Patients were accepted and assessed immediately by the receiving clinicians within the resuscitation area.

The service was using the National Early Warning Score system for the monitoring of vital signs in adult patients on wards to highlight early signs of deterioration of a patient’s conditions. The National Early Warning System score prompted staff to take further action. For example, increasing the frequency of monitoring vital signs and informing medical staff so they could review patients and escalate treatment if required. We checked 17 adult patient records and saw all of the early warning score charts were fully completed and scores calculated correctly and action taken when required.

Data supplied to us by the trust showed between June 2017 and March 2018 (with the exception of November 2017 (91%)) suggested 100% of patients arriving by ambulance had an early warning score documented. The same data shows with the exception of August 2017 (75%) and
February 2018 (67%) 100% of walk in patients had a national early warning score calculated. The same data showed 96% overall compliance in February 2018 with undertaking vital signs, calculating a National Early Warning and documenting the score. The same data showed 100% of Early Warning Scores which required escalation and action to be taken had documented evidence this had taken place. This meant staff were monitoring patients for any signs of deterioration and taking correct action when prompted by the score.

The children’s emergency department used a paediatric early warning score. We reviewed six sets of medical records and saw that a paediatric early warning score was documented on arrival in all records.

All staff within the paediatric emergency department were registered children nurses (RCNs). This meant there was always a paediatric-trained nurse available.

Every patient who attended had an adult or paediatric initial assessment and plan of care document completed. The document included details of the presenting complaint, initial assessment of vital signs on arrival, triage colour, national early warning scores, allergies, plan of care and investigations required. The document contained important patient information in one place, which meant staff could access the information easily.

When demand in the department was high, patients awaited ambulance handover in non-treatment areas. The area was visible to clinicians and regularly overseen by clinical staff. To mitigate risk, the nurse in charge allocated staff to regularly review patients waiting for initial assessment for signs of deterioration. During our inspection, we saw staff checked patients at regular intervals, this meant that clinical deterioration could be identified and escalated in a timely manner.

The service used an Acute Sepsis Screening and Treatment Tool for adults and paediatrics, which was based on Sepsis Six. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce deaths and serious illness associated with sepsis. The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis.

Staff had access to a sepsis policy and pathway within the department. We reviewed the policy and found it to be in date and reflected national guidance. For guidance, departmental paperwork contained a sepsis tool to ensure that staff identified patients with sepsis in a timely manner. During our last inspection, we identified varied compliance with sepsis recognition and management. During this inspection, the management of sepsis was at the forefront of the care delivered by all the staff we talked to. This meant that staff had the insight and knowledge to better manage sepsis outcomes for patients. For example, patients identified during triage as possible sepsis were fast-tracked through to the majors department and the nurse in charge informed. We observed this during our inspection. This meant patients with sepsis were assessed and treated quickly.

We reviewed the patient records of three adult patients with sepsis and found all aspects of the Sepsis Six had been completed. We did not observe any paediatric patients attending with sepsis.

An effective audit programme monitored the management and treatment of all patients with sepsis. If during the audit process it was identified that the patient did not receive treatment in line with Sepsis Six an incident form was completed and an investigation undertaken. Staff involved in the treatment of the patient were sent a generic letter, which highlighted the gaps in care and treatment. This meant staff were made aware and could learn and ensure the same lapses in sepsis management were not repeated. Staff told us that they thought sepsis management had improved since our last inspection. For example, the introduction of staff with a lead role in sepsis management. This meant that the lead staff were leading the changes and embedding the practices in sepsis management.
Staff used body maps to document injuries to patients; this helped with assessment of injuries or in cases of unexplained bruising or injuries where there was a safeguarding concern. The body maps were all used to document and pressure areas or pressure ulcers a patient had. This meant a record of a patient’s pressure areas where recorded when they first admitted, and any new areas were easily identified.

The six paediatric patient records we reviewed showed that they were all seen within 15 minutes for initial assessment. This meant children were assessed quickly to ensure care and treatment was given quickly.

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 used to provide support to families.

There was access to mental health liaison twenty-four hours seven days a week. This meant there was specialist support and advice available for patients attending the department with mental health needs.

Patients suffering from a mental health illness who attend the urgent and emergency department were assessed with a specific risk assessment tool. This ensured staff placed the patient in the most appropriate location within the department and assessed whether a registered mental health nurse was required. During our inspection, we saw staff identified a patient required a mental health nurse to support them. This was communicated to the matron by the nurse in charge who organised one promptly. This showed staff recognised when additional support was required for patients to keep them safe.

Three hospitals in Kent 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 at risk of neutropenic sepsis (a life-threatening complication of anticancer treatment), were provided with alert cards to present on arrival to the emergency department. This demonstrated staff started treatment in a timely manner.

The service used an escalation policy to initiate a response from the site management team during periods of high patient demand. Escalation procedures were determined by a number of factors including patient acuity (how clinically unwell patients were), numbers of patients within the department and ambulances that were delayed in handover. During our last inspection, senior staff were not able to describe the escalation processes. During this inspection, senior staff described escalation processes that were in line with trust policy.

During our inspection, the senior management team were assisting staff to manage flow in the emergency department. Regular updates were provided to the site team throughout the day at meetings that took place three times a day at the clinical control centre. This meant the site management team and senior staff had oversight of the department. We saw a list of actions was agreed during the clinical control centre meetings and an update on these was provided at the next meeting. In addition, regular communication took place between the local NHS ambulance trust and the service to advise and discuss the pressures the department was experiencing. This meant that ambulance diversions to other hospitals could be arranged if required.

We reviewed patients who were in the major escalation area and majors waiting area and all met the criteria to be placed in these areas. For example, no patients had a national early warning score of more than four. This meant patients were being cared for in areas that were able to
support their needs.

The nurse in charge undertook two-hourly safety rounds; they reviewed the records of randomly selected patients and checked there was a recent national early warning score and a treatment plan.

The consultant in charge of the department led board rounds three times a day. These were attended by all members of the multi-disciplinary team. All patients were reviewed; investigation results checked, ensured a treatment plan was in place and if necessary referred to a specialist team. This ensured patients were monitored and any changes were highlighted. In addition, it also meant the doctor in charge had oversight of all the patients within the department and could prioritise accordingly.

Patients underwent a falls risk assessment, this identified if the patient was at risk of having a fall whilst in the department. The assessment included a review of their medicines, footwear, mobilisation aids and blood pressure. The comprehensive assessment was designed to identify any cause for falling and whether the equipment and footwear was suitable. Patients who were identified as high risk worse a yellow patient identification wristband, which acted as a visual alert to staff that the patient needed supervision of assistance to mobilise.

**Nurse staffing**

The trust reported their registered nursing staff numbers as below for December 2017. The trust had a nursing fill rate of 94%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>106.1</td>
<td>99.4</td>
</tr>
</tbody>
</table>

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

During our inspection, we found that the numbers and skill mix of staff was suitable for the needs of the emergency department. Senior staff allocated nurses between various clinical areas dependent on demand and patient acuity. Senior departmental staff maintained oversight of staffing within the emergency department. The department used an information board to show the number of nursing staff on duty.

A team of 99 nurses, who were supported by a team of associate practitioners, led nursing care in the urgent and emergency care department. A team on clinical support workers provided support to clinical staff and provided patients and relatives with refreshments.

Each shift in the adult urgent and emergency departments was staffed by 12 band six or seven nurses, eight band five nurses, four associate practitioners and five clinical support workers. We reviewed the roster, which confirmed this.

In the children’s emergency department between 8am and 8:30pm there was one paediatric band six nurse, one paediatric band five nurse and a clinical support worker, in addition to this, there were two other paediatric band fives, who worked between 10 am until 10:30pm and 4pm and midnight. On a night shift in the children’s emergency department, there was one paediatric band five nurse and one paediatric band six nurse. We reviewed the roster, which confirmed this.

On each shift there was a nurse in charge and a co-ordinator, we saw there were clearly defined roles and responsibilities of each. The nurse in charge was responsible for the quality and safety
of care delivered and the co-ordinator was responsible for flow through the department. These staff were clearly identified by a yellow badge.

In April 2016 there were 70 nurses in post as of February 2018 there was 150 in post. This reflected a recruitment campaign to fill existing roles and the creation of new specialist roles amongst the nursing group.

During our inspection, we saw that there were always two nurses based within the resuscitation room to meet the needs of patients. This was an improvement in comparison to our previous inspection, when there were times when only one nurse was present.

In September 2015 there was only one associate practitioner in post as of April 2018 there was 15. This showed a significant investment and recruitment into the role.

The children’s emergency department had a senior nurse available at all times. All nurses within this area were registered children’s nurses and overseen by a lead nurse.

Training records for agency nurses included oversight of mandatory training and competencies were checked and overseen prior to commencement of work within the department. Agency and bank nurses were required to sign in and out of a daily diary. This ensured it was possible to have oversight of who was on each shift.

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.

Staffing was reviewed twice a day at handovers in the department and three times a day at the clinical control centre meetings. If the department was short staffed, the staffing across the whole hospital was reviewed and additional staff sought from other areas in order to support the department.

Seasonal variations and increased demand was managed by the department’s escalation plan and the trust’s business continuity plans.

**Vacancy rates**

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

The trust reported an annual vacancy rate from January 2017 to December 2017 of 0% for qualified nursing and midwifery staff in urgent and emergency care. This was below the trust’s target of 12%.

(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.

The trust reported an annual turnover rate from January 2017 to December 2017 of 15% for qualified nursing and midwifery staff in urgent and emergency care. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate, which is the data that has
been provided by the trust.

(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.

The trust reported an annual sickness rate from January 2017 to December 2017 of 4% for qualified nursing and midwifery staff in urgent and emergency care. This was equal to the trust target of 4%.

(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 January 2017 to December 2017, the trust reported a bank and agency fill rate of 28% in urgent and emergency care with a further 9% of shifts remaining unfilled. A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>268 (2.5%)</td>
<td>2,334 (22.0%)</td>
<td>462 (4%)</td>
<td>10,587</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>5,654 (24.2%)</td>
<td>1,359 (5.8%)</td>
<td>2,555 (11%)</td>
<td>23,360</td>
</tr>
</tbody>
</table>

Nursing assistant shifts were mainly filled by bank staff whilst qualified nursing shifts were mainly filled by agency staff.

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

We asked the trust why there was still a significant number of shifts covered by bank and agency if almost fully established for nurses. The trust explained whilst nurses underwent training to perform specialist roles agency and bank staff were required to cover these shifts. In addition, additional nurses in excess of the establishment were used for example to staff the majors waiting area.

Medical staffing

The trust reported their medical staffing numbers as below for December 2017. The trust had a medical staffing over-establishment of 40%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental - Hospital</td>
<td>41.0</td>
<td>57.2</td>
</tr>
</tbody>
</table>

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

The service employed 6.7 whole time equivalent consultants (including the children's emergency department).
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.

Although the trust reported, an over-establishment in medical staffing, this was due to additional middle grades employed to supplement the consultant vacancies. At the time of the inspection, there were three consultant vacancies, which meant the Royal College of Emergency Medicine guidelines for consultant cover was not being met.

We asked the trust why they were unable to meet the consultant cover of 16 hours a day. The trust told us that they could not enforce that the three to four locum consultants the service used, to provide 16 hours of cover daily on a regular basis. There was a business case that had a three-year programme to increase the establishment of ten full time consultants. These posts were advertised but the trust was unsuccessful in recruiting any consultants.

The consultant vacancies were not highlighted as a risk on the risk register that was provided to us by the trust. However, during the inspection, we saw posters, which identified the emergency department’s top five risks, and medical staffing was the fifth risk. The poster detailed actions to mitigate the risk, which included three permanent locum consultants and a recruitment strategy, was being designed.

On weekdays, consultants were typically present from 8am to 11.30pm and on weekends from 12pm to 8pm. A consultant was on call at all other times. Overnight cover in the department was provided by a senior specialty doctor, trainee and middle grade doctor with support from additional specialty middle grade doctors.

There was paediatric consultant cover 24 hours a day, seven days a week. The consultant in charge of the adult department was also responsible for the children’s department. Outside the hours, the consultant was on site, cover was provided via an on-call consultant. The service had two emergency medicines dual accredited (adult and paediatric) consultants who provided support and supervision to the middle grade paediatric doctors. There were nine full-time middle grade doctors who provided cover 24 hours a day, seven days a week. We reviewed the medical rota, which confirmed this. There was a clinical consultant lead for the children’s emergency department and a deputy lead who was a middle grade doctor.

There was a dedicated supernumerary consultant in charge of every shift and led the handovers, safety rounds and board rounds. The consultant in charge wore two yellow badges, which meant it was easy to identify the consultant in charge.

A handover was undertaken at the end of each shift to the oncoming team, this included a brief summary of each patient in the department and any who were acutely unwell and patients who required review. This ensured the oncoming team had oversight of the patients within the department.

**Vacancy rates**

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

The trust reported an annual over-establishment from January 2017 to December 2017 of 39% for medical and dental staff in urgent and emergency care. This signified that the trust had more staff in place than they have budgeted for; therefore, the target vacancy rate was being met. The
over-establishment was due to additional middle grade doctors.

(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.

The trust reported an annual turnover rate from January 2017 to December 2017 of 30% for medical and dental staff in urgent and emergency care. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals,) there is no set target for the overall turnover rate, which is the data that has been provided by the trust.

(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.

The trust reported an annual sickness rate from January 2017 to December 2017 of 1% for medical and dental staff in urgent and emergency care. This was below the trust target of 4%.

(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.

The trust was unable to provide the number of shifts available per month due to data being collected manually, therefore bank and locum agency fill rates could not be calculated. This meant the trust may not have oversight of monthly bank and locum agency fill rates.

From January 2017 to December 2017 1,733 shifts were filled by agency staff, 882 shifts were filled by bank staff and 602 shifts remained unfilled.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>277</td>
<td>89</td>
<td>1</td>
<td>367</td>
</tr>
<tr>
<td>Middle grade</td>
<td>1,377</td>
<td>684</td>
<td>495</td>
<td>2,556</td>
</tr>
<tr>
<td>SHO</td>
<td>79</td>
<td>109</td>
<td>103</td>
<td>291</td>
</tr>
<tr>
<td>SPR</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

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

**Staffing skill mix**

As of October 2017, the proportion of consultant staff reported to be working at the trust was
lower than the England average and the proportion of junior (foundation year 1-2) staff was similar.

**Staffing skill mix for the 43 whole time equivalent staff working in Urgent and Emergency Care at Medway NHS Foundation Trust.**

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>This Trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>15%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career(^)</td>
<td>40%</td>
<td>14%</td>
</tr>
<tr>
<td>Registrar group(^)</td>
<td>25%</td>
<td>34%</td>
</tr>
<tr>
<td>Junior*(^)</td>
<td>20%</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**

The department used paper records for patient notes and assessments and an electronic system for tracking lengths of stay, x-rays and tests. A paper based casualty card was used to record any treatments and procedures undertaken whilst the patient was in the department. The same one was used for adults and paediatrics.

There was an emergency department specific document, which included specific risk assessment documents such as infection control, pressure ulcers, nutrition and hydration and falls. This document also included observations such as blood pressure, heart rate, respiratory rate, and temperature to be recorded.

We reviewed 16 adult patient records; patient files were signed, dated and legible. Pressure area assessments were complete, where applicable, and early warning scores and pain scores were recorded.

We reviewed six sets of paediatric records none had been fully completed. Common themes of missing information included; child’s weight, pain score, no signature or name of staff member writing in notes, no date or time of entry in notes and no evidence of discharge. In addition, some forms were not fully completed or sections marked as not applicable. This meant that staff did not always complete records in a way that promoted patient’s safety and wellbeing. We raised this issue with the senior management team who thought this could be because new documentation had been introduced and staff were unfamiliar with it. The senior management team were going to discuss this with the paediatric staff and ensure they were familiar with the new paperwork.

Data supplied to us by the trust showed that on average 85% of medical records were in chronological order (following the order in which they occurred), and all documentation had been fully completed, signed and dated. The same data showed with the exception of June 2017 (60%)
and February 2018 (90%), 100% of nursing records were in chronological order, and all documentation had been fully completed, signed and dated.

We reviewed two sets of records relating to patients who had accessed the emergency department and who had a mental health concern or condition. We found that mental health risk assessments were appropriately completed and patients referred to mental health services where appropriate. There was a flagging system on the computer system within the emergency department to alert staff to patients attending with mental health conditions.

Medical records contained appropriate details for patients with mental health, learning disability and dementia needs alongside physical health needs.

A member of the administration team explained how all the paper casualty cards were reviewed for the previous 24 hours to ensure they were fully completed and the times recorded matched those on the electronic system. Once this was complete, they were scanned into the electronic system, they were kept for 24 hours in case the patient returned to the department, this enabled them to be found quickly and easily. After 24 hours, they were stored in a locked office. They were kept in the department in the locked office until all audit data had been obtained and then the paper casualty card was shredded. Any other associated paper work, for example medicine charts, was returned to the medical records department for filing.

Administration staff said they rarely had to request a patient’s full medical records, but if required they could request these electronically. This meant there was access to the patient’s full medical records if needed.

Staff could access patient records from previous attendances electronically if required. For example, if a doctor wanted to look at the patient’s electrocardiogram (heart tracing) from a previous attendance. This meant information regarding previous attendances was accessible quickly.

Discharge summaries were generated and sent to the patient’s general practitioner electronically. This meant the patient’s general practitioner was informed of the patient’s attendance and could follow up if required.

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. The electronic patient system also had a box for free text, which staff could document any important information for example if the patient had suspected sepsis.

**Medicines**

The trust had a medicines management policy in place. Stock was effectively overseen and ordered in conjunction with the trust’s pharmacy team. A pharmacy technician checked medicine stock levels daily in the morning and replenished the stock in the afternoon.

Staff securely stored controlled drugs within both the adult and children’s emergency department in wall-mounted cupboards, in line with legislation. Controlled drugs are medicines liable for misuse that required special management. We checked three randomly selected controlled drugs and found that documented quantities for medicines, matched actual stock levels. A member of authorised staff from both the paediatric and adult emergency department held the keys to the controlled drugs cupboards to enable timely access to medicines.

Non-controlled medicines were stored in areas that were restricted by key code access. We found all areas to be well organised and medication was clearly labelled to ensure that staff could locate
medicines in a timely manner. We checked seven randomly selected medicines and all were in their original packaging and in date.

Data supplied to us by the trust showed between July 2017 and December 2017 there was 428 reported medicine errors. One-hundred and ninety-eight (46%) of these occurred within the Acute and Continuing care directorate. Twenty-five of the incidents occurred within the emergency department of these, five resulted in low harm, one moderate harm and 19 resulted in no harm. The most common reason assigned to the errors was an error in the administration or supply of the medicine.

An electronic medicine dispensing system had been purchased for the new building, this operated securely on staff thumbprint access.

We observed staff checked each patient’s names, date of birth and allergies prior to the administration of medicines. We reviewed nine medication administration records and noted that all records documented allergies if applicable, or stated ‘no known allergies’ if none had been reported. This alerted staff to the patient’s allergies.

There was a variety of adult and paediatric patient group directives used within the department, which were within date. 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 nurse’s own assessment, without necessarily referring back to a doctor for a prescription. Doctors assessed staff before they could issue patient group directives; this ensured they had the skills and knowledge.

Medicines used to treat sepsis were available via a patient group directive. This meant medicines could be given immediately to patients for the treatment of sepsis.

There was 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.

Prescribing guidelines were developed in line with best practice (National Institute for Health and Care Excellence (NICE) and NHS Protect).

There was a medicine fridge within the resuscitation area, which stored medicines for use within the adult areas. We saw some boxes of medicines were frozen to the back of the fridge, which indicated changes in fridge temperature. We reviewed the fridge temperature monitoring records and found lack of daily checks and a lack of documented action when the fridge temperature were outside the safe temperature range. For example, there were no documented temperature checks for five days in January, three days in February and three days in March 2018. This did not provide assurance the department stored refrigerated medicines within the correct temperature range to maintain their function and safety. Some medicines must be stored between specific temperatures for them to remain safe and effective for use. We raised this issue with the trust who said they would take immediate action. During our last inspection, we also found a lack of daily fridge temperature checks. This meant the department had failed to ensure an effective system was in place to monitor daily fridge temperatures. All staff in the Emergency Department had been emailed to advise of the concerns regarding fridge temperature checks and the importance of these checks.

Since the inspection, we have seen a completed daily temperature monitoring audit, which showed the temperature of the fridge was being monitored. The leadership team informed us that the matron would undertake daily checks for two weeks and then weekly checks to ensure the checking process was embedded. Staff will be informed of the monitoring process in the weekly departmental newsletter and monthly staff forums.
The trust undertook a medicines audit in August 2017, the purpose of this audit was to ensure that the trust was compliant with CQC standards around medicines management. Overall compliance for the urgency and emergency care department was escalation area 88%, majors 92%, resuscitation area 43%, minors 74% and paediatric department 74%. Clinical areas were allocated a green status if 85% or more standards had been achieved. Only the escalation area and majors achieved a green status. We observed good compliance with medicine management except for the lack of daily fridge temperature checks.

We saw medical gas cylinders were correctly stored and the correct signage was in place in line with legislation.

**Incidents**

Between April 2017 and March 2018, urgent and emergency care services reported 1725 incidents. Seven-hundred and nine incidents occurred within the majors area, 58 in the paediatric department, 209 in the escalation area, 42 in the minors area, 306 in the resuscitation area, 130 in majors waiting areas and 251 in other areas. Of these incidents 73% resulted in no harm, 23% in low harm, 3% in moderate harm and 1% in severe harm. The highest number of reported incidents (240) related to implementation of care. The majority of incidents in this category related to grade one or two pressure ulcers which patients were admitted with as opposed to acquired in the hospital. Of those recorded under the category of accident 18 incidents related to patient falls within the emergency department.

Staff recognised incidents and knew how to report them, an electronic system was used for reporting incidents. Staff understood their responsibilities to raise concerns and report incidents. Members of staff we spoke with were able to tell us how incidents were reported and that information was shared with staff so they could learn from previous incidents. For example, a staff member told us when they had raised a safeguarding concern and had received feedback and assurance that action was taken.

One of the matrons for the urgent and emergency department had oversight of all incidents that were reported. Staff attended daily ‘safety huddles’ to share information on incidents in a timely manner amongst staff.

Any incidents that were graded with a high severity score of three, four or five were presented at the weekly incident review meeting. The purpose of this meeting was to assess the risk and adjust the severity of risk if required. For example, an incident maybe downgraded or upgraded and declared a serious incident. It was the responsibility of the matron head of nursing in conjunction with the lead medical consultant to ensure incidents were discussed at the weekly meeting.

Incident feedback and learning was shared through a weekly email to all staff and we saw examples of this.

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 considered. 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 because of unsafe clinical practice. We saw in the monthly meeting minutes that the meetings were used to improve patient care. We saw there was a multi-agency approach to mortality and morbidity meetings with discussions and learning shared for example with the local ambulance trust and primary care provider.

We reviewed two investigation reports following serious incidents within the department. Both investigations contained a root cause analysis of each incident, lessons learnt and methods for sharing learning amongst relevant staff. In addition, we reviewed that action plans in relation to each incident each action had a person identified for the action and a date to be completed.

The emergency department had access to a major incident store, which contained equipment in the event of a declared major incident or chemical, biological, radiological and nuclear (CBRN) attack. This area contained appropriate equipment including but not limited to; personal protective equipment, tents and radios.

**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 January 2017 to December 2017, the trust reported one incident classified as a never event for urgent and emergency care. This was an overdose of insulin due to abbreviations or incorrect device.

The never event occurred within the majors area of the department on the 10 November 2017. We reviewed the root cause analysis of the incident and saw evidence that the duty of candour regulation had been applied. A family member had been informed at the time of the incident and been kept informed of the investigation, investigation outcome and learning from the incident. We saw a comprehensive investigation had been undertaken, using the trust’s serious Incident Level 2 Investigation Report template. The root cause of the incident had been identified and a number of recommendations implemented. We saw there was a comprehensive action plan to implement the recommendations, with allocated staff for implementing the recommendations and clear timelines. We saw evidence that some of the recommendations had been undertaken and there was a plan for all recommendations to be implemented. For example, we saw that insulin preparation and administration was included within the Emergency Care Essentials Programme, which was three-day standard course. All staff now undertake this course within three months of commencing employment with the urgent and emergency care department.

(Source: NHS Improvement - STEIS)

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 44 serious incidents (SIs) in urgent and emergency care, which met the reporting criteria set by NHS England from January 2017 to December 2017. This includes the never event described above.

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 11 (25% of total incidents).
- Adverse media coverage or public concern about the organisation or the wider NHS with nine (21% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with nine (21% of total incidents).
- Treatment delay meeting SI criteria with six (14% of total incidents).

(Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017))

Safety thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from December 2016 to December 2017 within urgent and emergency care.

Any patient who was going to be in the department for more than four hours or admitted to a ward had a venous thromboembolism assessment undertaken. This was in line with The National Institute for Health and Care Excellence guideline QS3; we saw completed assessments within patient records.

(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment
The department provided care, which was evidence based and in line with national guidance, such as the national Institute for Health and Care Excellence and the Royal College of Emergency medicine standards. Trust policies and procedures were available to view electronically. Staff we spoke with knew how to locate policies and procedures.

There were specific pathways demonstrating adherence to national guidance for example sepsis and fractured hips amongst others.

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. Data was collected to improve the timely recognition and treatment of patients with serious infections such as sepsis.

One of the consultants had developed a paediatric patient safety leaflet for viral wheeze. We saw meeting minutes from 05 April 2018 where this had been ratified by Emergency Department Clinical Governance Meeting. The leaflet was based on evidence based practice and gave information to parents and carers on managing a viral induced wheeze in children.

During our last inspection, we observed varied compliance to national guidance in relation to sepsis recognition and management. During this inspection, we reviewed three records of patients attending with sepsis and saw all had received treatment in line with national guidelines. This showed an improvement since our last inspection and the department had implemented an effective process for the recognition and management of sepsis.

We reviewed adult advanced life support algorithms, which showed they were based on relevant guidelines produced by the Resuscitation Council. Guidance for massive blood loss referred to the National Institute for Health and Care Excellence guidelines.

Data supplied to us showed between October 2017 and December 2017 98% of patients had a sepsis screen and between January 2018 and March 2018 97% of patients had a sepsis screen undertaken. This showed an improvement from data between July 2017 and September 2017 when 89% of patients had a sepsis screen. The same data showed between October 2017 and December 2017 88% of patients received intravenous antibiotics within one hour, this improved between January 2018 and March 2018 when 91% of patients received antibiotics. We saw audit data findings were shared with staff; they were displayed on staff noticeboards and discussed at clinical governance days.

The department participated in local and the Royal College of Emergency Medicine audits. Audit findings were displayed on a noticeboard within the department. This meant staff were kept informed of audit findings and areas of compliance and where improvement was required.

Departmental meeting minutes showed that National Institute for Health and Care Excellence guidelines were discussed this enabled changes to guidance could be applied to systems and processes within the department.

Emergency nurse practitioners worked in accordance with national best practice guidance. For example, they followed National Institute for Health and Care Excellence Head injury: assessment and early management Clinical guideline (CG176). We saw this guideline was displayed within the department and was available for staff to access on the trust internet.

We saw there were a variety of paediatric guidelines and policies in use within the paediatric department, which reflected evidence based, practiced. For example, management of acute asthma, head injuries, meningitis and acute kidney injury. We saw staff adhering to the head injury policy during our inspection.
We saw General Paediatric Governance meeting minutes, which confirmed paediatric guidelines and compliance with guidelines, was discussed at this meeting. This meant policies and guidelines were reviewed to ensure they were up to date and were being adhered to.

Old people who were frail or vulnerable who attended were referred for a comprehensive assessment of their physical, mental and social health needs. For example, they could be referred to the frailty team for assessment.

**Nutrition and hydration**

**Emergency Department Survey 2016**

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

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

Clinical support workers offered patients and relatives, food, hot and cold drinks throughout their stay in the emergency department where it was clinically safe to do so. Clinical support workers undertook two-hourly refreshment rounds, this ensured patients and relatives were offered regular refreshments. Clinical support workers reported good access to a variety of food, which was available from the hospital kitchen. Clinical support workers could call the kitchen with a request and go and collect it.

There was a vending machine in the main waiting area. This offered hot and cold drinks and a selection of snacks such as biscuits, crisps and confectionery. During our inspection the vending machines were stocked and in use. There was also a water fountain in the main waiting area.

The hospital also had a large canteen, and shop all close to the department.

All the patients we spoke to said they had been offered an adequate amount of food or drink.

**Pain relief**

The department assessed and recorded a pain score for patients arriving in the department as part of their initial assessment in line with the Faculty of Pain Medicines Core Standards for Pain Management.

The national early warning chart was used to document the patient’s pain score after initial pain assessment; we reviewed five records, which confirmed this.

The department used pictorial charts for patients that were unable to verbalise that they were in pain.

We spoke with three patients who told us their pain was being adequately managed and that pain relief had been administered in a timely manner. We reviewed nine sets of medication administration records which demonstrated appropriate pain relief had been prescribed and administered in a timely manner where clinically indicated.

We reviewed five medical records for children that presented to the paediatric emergency department. We saw that pain had been assessed and documented upon arrival in the department and triage. This was in line with the Royal College of Emergency Medicines guidance on the management of pain in children.
Data supplied to us showed between June 2017 and March 2018 95% of patients who had broken their hip had a documented pain score.

Data supplied to us by the trust showed between June 2017 and March 2018 on average 82% of patients had a pain score recorded within their records. This data showed that improvement was required to ensure every patient had a documented pain score. Documenting a pain score is important to know if pain relief medicine has been affected, a pain score should be recorded prior to any pain relief medicines and after to monitor if the pain score had reduced.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.0 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 7.4 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.

(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 (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 would lead on audit completion and compliance. In total urgent and emergency care, services were undertaking 45 local audits; we saw there was oversight of these, which ensured that progress was monitored.

There were nursing audits undertaken by the department that fed in to monitoring patient outcomes, such as a pain audit and national early warning score audits.

The department had a specific fractured neck of femur (broken hip) pathway, which enabled this group of patients to be treated efficiently, which was based on best practice. The pathway was audited for compliance and patient outcomes. Data from this audit demonstrated a significant improvement in mortality rates since the implementation of the pathway. Data showed in April 2013 the mortality rate was 11%, when the pathway was introduced in April 2016 it reduced to 9% and in March 2018 it was 3%. This showed the pathway had meant a reduction in mortality and patients were less likely to die because of breaking their hip.

Data supplied to us by the trust showed on average patients who had broken their hip spent 89 minutes within the emergency department. This meant patient who had broken their hip did not have long waits in the department and were fast tracked to the ward where their needs could be met.

The urgent and emergency care department was part of the South-East London, Kent and Medway Trauma Network. This is a group of hospitals, which make up the regional trauma system to serve the population. These hospitals receive trauma patients and are designated as either major trauma centres or trauma units. Major trauma centres have resources available 24 hours a day to manage severely injured patients, while trauma units are responsible for the local management of patients with less severe injuries. Medway hospital was a trauma unit, the service
collected data, which was submitted to the network to monitor its performance and benchmark against other hospitals.

The most recent data (October 2017 and December 2017) from the trauma network showed that 67% of patients received a computerised tomography scan within 60 minutes of arrival in the department in line with national guidelines. This was better than the national median average of 53%. This meant patients were getting the scan they needed in a timely way. Data also showed 100% of patients received Tranexamic acid (medication used to treat heavy bleeding) within two hours of the incident to patients who received blood products within six hours of the incident. This was better than the national median average of 64%. This meant patients who had bled heavily were receiving the correct medicine in line with national guidance.

Data supplied to us by the trust showed between February 2017 and March 2018 100% of patients with high risk sounding chest pain received aspirin within 60 minutes of arrival. This was in line with national guidance.

We saw audit data findings were shared with staff; they were displayed on staff noticeboards and discussed at clinical governance days.

**Royal College of Emergency Medicine Audit: Moderate and Acute Severe Asthma 2016/17**

In the 2016/17 moderate and acute severe asthma report, Medway Maritime hospital did not meet any of the national aspirational standards.

The hospital performed better than other trusts (in the top quartile) in three standards:

- **Standard 4 (fundamental):** Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Hospital: 90%; UK: 77%.

- **Standard 5a (fundamental):** If not already given before arrival to the emergency department, steroids should be given within 60 minutes of arrival (acute severe) as follows:
  - Adults 16 years and over: 40-50mg prednisolone orally or 100mg hydrocortisone intravenously (into a vein)
  - children 6-15 years: 30-40mg prednisolone orally or 4mg/kg hydrocortisone intravenously
  - children 2-5 years: 20mg prednisolone orally or 4mg/kg hydrocortisone intravenously
  - hospital: 56.0%; UK: 19%

- **Standard 5a (fundamental):** If not already given before arrival to the emergency department, steroids should be given within four hours of arrival (moderate) as follows:
  - adults 16 years and over: 40-50mg prednisolone orally or 100mg hydrocortisone intravenously
  - children 6-15 years: 30-40mg prednisolone orally or 4mg/kg hydrocortisone intravenously
  - children 2-5 years: 20mg prednisolone orally or 4mg/kg hydrocortisone intravenously
  - hospital: 50.0%; UK: 28%

The hospital performed similar to other trusts (within the middle 50% of results) in four standards:

- **Standard 1a (fundamental):** Oxygen should be given on arrival to maintain oxygen saturations of between 94-98%. Hospital: 20.0%; UK: 19%.

- **Standard 2a (fundamental):** As per Royal College of Emergency Medicine standards, vital signs should be measured and recorded on arrival at the department. Hospital: 31%; UK: 26%.
• Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the department. Hospital: 15%; UK: 25%.

• 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: 41%; UK: 52%.

(Source: Royal College of Emergency Medicine)

Royal College of Emergency Medicine Audit: Consultant sign-off 2016/17

In the 2016/17 consultant sign-off audit, Medway Maritime hospital did not meet any of the national aspirational standards.

The hospital performed worse than other trusts (in the bottom quartile) in three standards:

• Standard 2 (developmental): Consultant reviewed – fever in children under 1 year of age. Hospital: 0.0%; UK: 8%.

• Standard 3 (fundamental): Consultant reviewed – patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. Hospital: 3%; UK: 12%.

• Standard 4 (developmental): Consultant reviewed – abdominal pain in patients aged 70 years and over. Hospital: 0.0%; UK: 10%.

The hospital performed similar to other trusts (within the middle 50% of results) in one standard:

• Standard 1 (developmental): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over. Hospital: 5%; UK: 11%.

(Source: Royal College of Emergency Medicine)

Royal College of Emergency Medicine Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 severe sepsis and septic shock audit, Medway Maritime hospital did not meet any of the national aspirational standards.

The hospital performed better than other trusts (in the top quartile) in five standards:

• Standard 4: Serum lactate measured within one hour of arrival. Hospital: 88.0%; UK: 66.0%.

• Standard 5: Blood cultures obtained within one hour of arrival. Hospital: 82.0%; UK: 45%.

• Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Hospital: 62.0%; UK: 43%.

• Standard 7: Antibiotics administered: Within one hour of arrival. Hospital: 62.0%; UK: 44%.

• Standard 8: Urine output measurement/fluid balance chart instituted within four hours of
arrival. Hospital: 71%; UK: 18%.

The hospital performed better similar to other trusts (within the middle 50% of results) in three standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness and capillary blood glucose recorded on arrival. Hospital: 90.0%; UK: 69%.

- Standard 2: Review by a senior medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Hospital: 74.0%; UK: 65%.

- Standard 3: O2 was initiated to maintain oxygen saturation levels of more than 94% (unless there is a documented reason not to) within one hour of arrival. Hospital: 40%; UK: 30.4%.

(Source: Royal College of Emergency Medicine)

More recent data supplied to us showed between October 2017, December 2017, 98% of patients had a sepsis screen, and between January 2018 and March 2018 97% of patients had a sepsis screen undertaken. This showed an improvement from data between July 2017 and September 2017 when 89% of patients had a sepsis screen. The same data showed between October 2017 and December 2017 88% of patients received intravenous antibiotics within one hour, this improved between January 2018 and March 2018 when 91% of patients received antibiotics. The trust’s sepsis rate was 1.08, which was similar to the national average.

A local audit on the management of paracetamol overdoses was undertaken between 01 August 2016 and 31 August 2017. Data from this audit showed the quantity and time of the paracetamol overdoses documented in 88% and 98% respectively, of the case notes reviewed. Of those requiring N-acetylcysteine, it was correctly prescribed in 98% of cases. N-acetylcysteine is a medication that is used for the treatment of paracetamol overdoses. In all of the case notes reviewed, there was clear documentation as to whether overdose was single ingestion or staggered. The time that bloods were taken was documented in 96% of cases, which allowed for an accurate assessment of the paracetamol level.

Royal College of Emergency Medicine Audit: Vital signs in children 2015/16

In the 2015/16 vital signs in children audit, Medway Maritime hospital did not meet any of the national aspirational standards.

The hospital performed better than other trusts (in the top quartile) in four standards:

- Standard 1a (fundamental). All children attending the department with a medical illness should have a set of vital signs (consisting of temperature, respiratory rate, heart rate, oxygen saturation, consciousness level) recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. Hospital: 91.0%; England: 38%.

- Standard 1b (developmental). All children attending the department with a medical illness should have a set of vital signs (consisting of capillary refill time) recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. Hospital: 87.0%; England: 22%.

- 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: 32%; England: 4%.

- Standard 3 (developmental). There should be explicit evidence in the patient notes that the clinician recognised the abnormal vital signs and documented these (if present). Hospital: 86%; England: 70%.

The hospital performed similar to other trusts (within the middle 50% of results) in two standards:

- Standard 4 (fundamental). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Hospital: 80.0%; England: 73%.

- 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 (in emergency medicine or paediatrics, or equivalent non-training grade doctor). Hospital: 77%; England: 60.0%.

(Source: Royal College of Emergency Medicine)

Unplanned re-attendance rate within seven days

From January 2017 to December 2017, the trust’s unplanned re-attendance rate to the department within seven days was consistently worse than the national standard of 5% and worse than the England average in all twelve months.

A much higher re-attendance rate was reported by the trust in October 2017 (49%). NHS Digital noted that the trust submitted some or all of its October activity to both the new Emergency Care Data Set, (CDS 011) and the standard data (CDS 010). This had resulted in unusually high values and may account for the high figure reported by the trust in October 2017.

Unplanned re-attendance rate within seven days - Medway NHS Foundation Trust

(Source: NHS Digital - A&E quality)

Competent staff

Appraisal rates

From April 2017 to December 2017 76% of staff within urgent and emergency care at the trust
had received an appraisal compared to a trust target of 85%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target (%)</th>
<th>Appraisal completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>2</td>
<td>2</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>51</td>
<td>42</td>
<td>85%</td>
<td>82%</td>
</tr>
<tr>
<td>Other Non-Medical Staff</td>
<td>35</td>
<td>27</td>
<td>85%</td>
<td>77%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>36</td>
<td>26</td>
<td>85%</td>
<td>72%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>78</td>
<td>56</td>
<td>85%</td>
<td>72%</td>
</tr>
</tbody>
</table>

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

Appraisal data supplied to us during the inspection showed improved compliance. Ninety percent of urgent and emergency care doctors, 98% of nurses and 100% of reception staff had a completed appraisal. This showed an improvement since our last inspection.

The department had assessed the learning needs of staff by means of appraisal. Staff we spoke with told us the appraisal process was meaningful. We reviewed three appraisals and saw they were in line with the trust’s values, identified learning needs and included objectives met in the previous 12 months and objectives for the next 12 months.

The department had a practice development nurse one day a week to provide support in the development and education of staff. In addition, the consultant nurse and matron provided training and teaching for staff.

The department maintained oversight of when nurses were due to revalidate with the Nursing and Midwifery Council. At the time of our inspection, all nurses in the department were up to date with revalidation. Records we reviewed demonstrated clear oversight of when future revalidation was due, the human resource department checked personal identification numbers (PINs) on a monthly basis.

The human resources department and the consultant lead oversaw medical staff revalidation. Staff had access to support and resources relating to revalidation for guidance.

Since our last inspection, the associated practitioner role had become embedded with 16 now working within the urgent and emergency care department. Associate practitioners undertook a year’s advanced diploma training and were assessed by qualified staff performing competency-based tasks. We observed associate practitioners supported qualified staff, which meant they could make better use of their professional skills, and improve patient outcomes. One member of staff told us that “the associate practitioners were invaluable”

The department had a comprehensive structured programme for the delivery of training for nursing, medical staff and extended roles such as associated practitioners. For example, associate practitioners started initially in the taking and recording of vital signs and the importance of these.

Since our last inspection, the department had introduced advanced clinical practitioners who were currently undergoing training. Advanced clinical practitioners support existing and more established roles and help to improve clinical continuity, provide more patient-focused care and enhance the multi-professional team. We saw there was a structured learning and competency
based training programme in place.

Since our last inspection, a specific resuscitation team working in the resuscitation department had been implemented. Staff had received training and undertaken competency assessments in two new roles, a trauma practitioner and a resuscitation practitioner. Staff who had undertaken this role specific training worked in the resuscitation department and were supported by a junior nurse.

There was always a member of staff who had completed advanced paediatric life support training on each shift within the children’s department. This meant there was always someone with the correct skills and training to care for children.

Clinical governance study days were held every four months which included teaching on a variety of subjects for example, sepsis management safeguarding training, pain management and vital signs in children. Staff were given protected time to attend at least two of these days a year. Feedback from staff about these was positive for example comments included “I am more open to completing incident forms now” and “innovative, inclusive and stimulating”.

There was an education noticeboard within the department, which contained details of what courses and study days were available and who to contact if staff wanted to undertake these.

The urgent and emergency care department was part of a regional training collaborative. This meant different hospitals in the area took turns in providing in house training days. This minimised training costs to the department and provided training opportunities to staff.

The department had links with universities and staff were able to obtain funding to complete accredited courses. Training and development in the department was encouraged for all staff at all levels. Since our last inspection, 20 nurses had obtained an accredited qualification in emergency care.

We saw there was an extensive induction and preceptorship programme for newly qualified nurses and each nurse was allocated a mentor. The training programme was comprehensive and covered areas including: bereavement, life support (basic, intermediate and advanced), sudden death, record keeping, the Mental Capacity Act and Deprivation of Liberty Safeguards, resuscitation, fluids, early warning scores (adult, paediatric and maternity) and infection control and prevention. The practice development facilitator and the staff member’s mentor would then work with them to ensure they felt confident and comfortable working in the department.

We spoke with one agency nurse who told us that they had received an induction prior to starting work in the department. They said the induction programme was fragmented, based on this staff feedback the induction had been changed to a week-long block. Induction included intravenous training, various competencies, safeguarding and computer system training.

Locum doctors completed an induction pack prior to starting work in the department. Induction included access to computer systems, reporting of incidents, policies and local antibiotic protocols. This meant they were familiar with the department’s processes and policies. Locum doctors also had access to teaching and training.

Junior doctors were positive about the learning and teaching opportunities within the department. They had access to scheduled teaching sessions.

There were link nurses for various areas, there were both adult and paediatric nurses for each role. For example, safeguarding, child protection, dementia, organ donation, mental health,
infection prevention and end of life care. Link nurses acted as a resource for staff and could provide support and advice. In addition, they attended specific meetings for their area and could provide updates to staff.

We observed staff had the skills to sensitively manage difficult behaviours that patients displayed. For example, a member of staff efficiently and sensitively cared for a patient with dementia.

**Multidisciplinary working**

Staff generally demonstrated effective multidisciplinary team working. We saw that communication took place between a range of healthcare professionals to improve patient care and outcomes.

Wards and staff communicated well with each other from both the adult and paediatric emergency department. Joint team working occurred when critically unwell paediatrics were bought in to the adult emergency department resuscitation room.

A dedicated play specialist provided support to children attending the paediatric department.

The paediatric department had worked cohesively with local General Practitioners and clinical commissioning groups to improve asthma care in children in the local area. For example, if a patient attended the department they received an asthma pack designed to improve management of asthma. This was an action from the action plan developed after the Royal College of Emergency Medicine audit into management of asthma in children identified room for improvement. This showed the department had undertaken actions based on audit findings to improve the management of asthma in children.

Consultants and nurses attended meetings that were facilitated by the dementia team. This meant these staff could feedback any changes to policy or guidance to staff working in urgent and emergency care department.

Staff who worked within mental health liaison spent a day working with a specialist dementia nurse as part of their induction. This meant they were aware of the service provided by the dementia team and what resources were available.

We observed ineffective multidisciplinary working between the emergency department and the specialist medical team. There was not an effective process, which ensured patients were assessed in a timely manner. We observed patients who were receiving treatment in the majors waiting area as they were waiting for a review by the medical team. We observed some patients had been waiting more than 20 hours to be reviewed by a senior member of the medical team, spending the night on a chair.

We observed the specialist surgical team had an effective multidisciplinary approach, which ensured patients were reviewed and treated promptly. A senior member of the surgical team held a bleep and was contacted by emergency department staff when a patient with a surgical condition attended. The staff member would “triage” the patient and direct them to the correct department or ward, for example the surgical assessment unit.

Staff had access to the critical care outreach team they could contact them for advice and request reviews on critically unwell patients.

A multidisciplinary team cared for patients who had broken their hip. Ambulance crew staff contacted an associate practitioner by telephone if they were bringing a patient in with a suspected broken hip. This meant the associate practitioner could prepare for the arrival of the patient, for example alert x-ray staff to minimise time waiting for an x-ray.
The emergency department had access to a frailty team. When the new building opened there would be a dedicated frailty bay for patients aged over 75. This meant the patient could be reviewed promptly by a frailty specialist and admission to hospital avoided if possible.

During our inspection, we observed a member of the frailty team caring for a patient who was confused. The staff member could contact the patient’s General Practitioner and social services to obtain more information about the patient.

The department worked closely with other emergency departments within the area to form the emergency care training collaborative group.

Clinical control hub meetings were undertaken at least three times a day. The purpose of this meeting was to discuss patient discharges, admissions, staffing, infection control and extra resources required. We attended one of these meetings, which was run efficiently, and had clear actions for staff to take away and action.

A hospital intervention team made up of physiotherapists, occupational therapists and nurses 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 a contact list to assist staff in making referrals.

A paediatric mental health liaison service saw all children under the age of 16 and adolescents with mental health needs.

We observed excellent multidisciplinary working within the department, friendly interaction between all grades of staff and the culture was non-hierarchical. We observed a doctor and an associate specialist discussing the care and treatment of a patient.

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

A variety of specialist nurses provided support to patients in the department, for example, stroke and cardiac specialist nurses.

Board rounds were undertaken three times a day, which gave the multidisciplinary team the opportunity to meet and discuss any issues, and we observed one of these during our inspection.

Ambulance crew told us they had a good relationship with staff within the department. A member of ambulance crew said, “It was one of their favourite hospitals to bring patients to as staff respected their professional opinion”.

Staff worked cohesively with those that provided primary care services, we saw evidence of open communication between the two staff groups.

Patients who were depressed and had been risk assessed as low risk were referred to the primary care department or signposted to external support agencies.

The department’s alert folder included multi agency collaborative working. For example, we saw an end of life care plan for a patient, which included input from the local ambulance service, patient’s General Practitioner and the patient’s specialist. This meant the wishes of the patient would be considered if they attended the urgent and emergency care department and staff knew
how to treat the patient. Patients with alerts were tagged on the patient record system; this would prompt staff to refer to the alert folder.

All staff we spoke with were clear in reporting processes to local services such as hostels, substance misuse and alcohol liaison services. Patients were encouraged to self-refer to substance misuse and alcohol liaison services but could be referred by staff if required.

**Seven-day services**

The adult and paediatric emergency department at Medway maritime hospital was open 24 hours a day, seven days a week in line with the National Health Service seven days a week Priority Clinical Standard six.

The emergency department had consultant presence between the hours of 8am and 11pm with on-call cover outside of these times. Consultant cover did not meet the minimum 16 hours a day cover required by the Royal College of Emergency Medicine.

The department had access a range of imaging services. X-ray and computerised tomography scanners were available 24 hours a day, seven days a week, facilitated by a team of radiographers. An outside provider interpreted results and fed back to staff within indicated timeframes.

The trust provided mental health nurse cover was provided 24 hours a day, seven days a week for adults.

Learning disability support, dementia support nurses and frailty assessment team were available Monday to Friday, 9am to 5pm.

Hospital chaplaincy services were available 24 hours a day, seven days a week.

**Health promotion**

Staff provided information to patients on how to manage their condition and promote a healthy lifestyle. For example, we saw a poster in the department informing visitors who suffered from lung disease of a vaccination available to protect them against a type of pneumonia.

The department had banners, posters and leaflets on display. In the waiting areas, there were contact details of a variety of support groups and advisory organisations for example, patients, drug and alcohol misuse and smoking cessation.

Information around diet and health was available on the hospital’s public website. Information included dietary advice, aspects of healthy living, diabetes and children’s health.

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

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

The trust provides training in Mental Capacity Act level 2, which included Deprivation of Liberty Safeguards training. The trust reported that from April 2017 to December 2017 Mental Capacity Act training had been completed by 73% of staff in within urgent and emergency care, which did not meet the trust target of 85%.

A breakdown by nursing and medical staff is shown in the table below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental - hospital</td>
<td>32</td>
<td>51</td>
<td>63%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery</td>
<td>62</td>
<td>80</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

The trust supplied additional training data, which showed medical staff compliance was 68% in April 2018. The trust told us that poor compliance was being addressed by the clinical lead for service. Medical staff that had not completed training had been identified and were given a deadline of the end of May 2018 to complete the training. The majority of those not compliant with training were new to the team.

Nursing staff were 80% compliant (adult nursing staff) and 84% compliant (paediatric nursing staff). The matron had set up an additional training session for Mental Capacity Act, Deprivation of Liberty and Level 3 Safeguarding and in May 2018 to bring nursing staff up to 85% compliant.

The Mental Capacity Act 2005 is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for their self. The Deprivation of Liberty Safeguards is part of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

The trust had a Deprivation of Liberty Safeguards policy, which was in date. The policy was in line with Department of Health (Code of Deprivation of Liberty Safeguards Practice 2009).

Dementia and learning disability speciality nurses were available to offer advice and guidance on the Mental Capacity Act and Deprivation of Liberty Safeguards if required.

Staff had good awareness of The Deprivation of Liberty Safeguards processes and knew whom to contact if they required advice.

We saw the 4 A’s test was used within the department. The 4 A’s test is a quick and effective routine delirium screening tool that was developed to increase rates of detection of delirium and cognitive impairment in acute general hospitals. We saw one patient had a completed assessment during our inspection, which was fully completed.

The service used a delirium care pathway, which set out guidance on the detection and management of delirium in adult patients.

There was a policy in place to provide guidance to staff for patients detained under Section 136 of the Mental Health Act, including the assessment of capacity.

During our inspection, we observed that staff verbally asked for patient consent when performing examinations and treatments such as taking blood or performing an electrocardiogram.

We saw the patients consent to treatment was written within their patient record. This confirmed that the treatment had been discussed with the patient and they had consented to the treatment.
Staff demonstrated an understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, about children over 16 years and the Children Acts 1989 and 2004.

**Is the service caring?**

**Compassionate care**

Staff ensured the privacy and dignity of patients was maintained with the use of curtains, blankets, and portable screens. However, we did observe patients trying to sleep on chairs in the majors waiting area. Feedback from patients waiting in this area included a lack of communication or explanation of what they were waiting for.

A Patient-Led Assessment of the Care Environment audit undertaken in 2017 scored privacy, dignity and wellbeing in the department, as 75%, this was worse than the national average of 83%.

Staff spoke with patients in a reassuring manner and offered information on waiting times on a regular basis.

We observed an episode of compassionate care when staff were caring for a patient with dementia who did not want to enter the majors escalation area. We saw a staff member gently encouraging the patient into the department where they got a chair and asked the patient where they would like to sit. Staff placed the patient by the staff station away from the main area and made the patient a cup of tea. Staff talked gently and softly to the patient and provided reassurance that they were safe.

The majority of patients we spoke to were positive about the care they had received and felt safe whilst in the department. Negative comments included poor communication with the patient and long waits for a specialist review.

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 introduced themselves when speaking to patients.

We observed the mental health liaison team showing compassion whilst undertaking their assessment of patients.

One patient commented to us “I am surprised from what the emergency department was like to how it was now”.

**Friends and Family test performance**

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

Trust performance improved from 79% in January 2017 to 85% in May 2017 before declining slightly from June to December 2017.

**A&E Friends and Family Test Performance - Medway NHS Foundation Trust**
Emotional support

Staff provided emotional support to patients to minimise their distress.

There was support available for the bereaved from the multi-faith chaplaincy service. We were given examples when staff had accessed the multi-faith chaplaincy to provide support for patients and their relatives.

There was a room for relatives to use if needed, it provided access to hot drinks and spiritual and religious materials were available. Staff took time to talk to patients and understand their needs.

We observed staff supporting patients emotionally and providing assurance to those who were anxious and distressed.

We saw a variety of stickers and certificates were available for children such as ‘I was brave today’ stickers.

De-briefs were undertaken for staff if they had been involved in a distressing or difficult patient interactions, deaths or experiences. This provided support and a forum for ask questions or voice anything they were concerned about.

Staff provided immediate signposting to support services, including emergency counselling services, for the relatives of babies who died from sudden infant death syndrome.

We saw there was an infant bereavement box supplied by a charity, which contained items, which may have provided comfort and memories for bereaved parents. The box contained a teddy bear, paint to make footprints of the baby, and a box to place some of the baby’s hair in.

If a sudden infant death occurred, the parents were allocated a co-coordinator who notified the baby’s General Practitioner, Health Visitor and Social Worker. This meant the parents did not have to inform multiple people of the child’s death.

We observed there was parity of care between those patients who attended the department with a physical health need and those with a mental health need. We saw all patients received the same level of care regardless of the reason for their attendance.

There were leaflets and information about supports groups for patients with mental health or people living with dementia that had been recently diagnosed. There was information available about anxiety and useful coping strategies. There was a patient information leaflet about the liaison psychiatry service.
Comments from patients about the care they received included “brilliant, attend to you quickly” and “efficient and professional attitude about children”.

**Understanding and involvement of patients and those close to them**

The trust provided hospital car parking concessions for patients and visitors. This set out groups of patients who could apply for reduced hospital car parking. For example, visitors or carers of the intensive care unit, high dependency unit and children wards could claim a concessionary rate.

The trust provided a variety of information leaflets /booklets for relatives and carers we saw these were readily available. For example, information for relatives and / or carer of a patient with delirium these were designed to help better understanding of the condition.

Clinical supports workers told us they tried to go the extra mile to get patients and relatives the food they wanted. For example, if someone wanted a ham salad they would request a salad and a ham sandwich and put the ham from the sandwich with the salad. In addition, sandwiches were available in the department throughout the day and out of hours.

The trust gave carers a card, which entitled them to visit then outside the normal visiting hours.

We spoke with two patients and one relative who told us they were not kept updated about their condition, treatment plans, and prognosis.

Patients and relatives of paediatric patients told us staff had explained treatments and care in a way that their child could understand. We observed staff communicating in a way that people could understand and was appropriate and respectful.

The frailty team and hospital intervention 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 worse than other trusts in four of the 24 questions relevant to caring and about the same as other trusts in the remaining 20 questions.

<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>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.2</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.5</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>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.7</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>7.5</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>8.6</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>6.3</td>
<td>Worse than 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>6.1</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>8.5</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>9.6</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>4.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.2</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>6.3</td>
<td>Worse than 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>
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.

Since our last inspection in 2016, building work for an additional building to expand the emergency department had continued and was due to open in May 2018. The additional building would ensure the environment was fit for purpose and to assist with demand and flow through the department. For example, there would be a dedicated frailty bay for the assessment and treatment of patients over the age of 75 in order to meet the needs of local people.

The children’s emergency department was compliant with the Royal College of Emergency Medicine Standards for Children and Young People in Emergency Care Settings 2012. For example, service planners, commissioners and providers work together to provide safe urgent care for children in a geographical network, taking local needs into account. The department had worked with other stakeholders to improve asthma care for children in the local area.

The waiting area had been designed with adequate seating and patients were offered a chair to use when booking in to the department.

The service recognised that demand and flow throughout the department was a key issue. The adult emergency department had recently introduced a new streaming process to improve flow by ensuring patients were treated in the most appropriate setting.

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.

Community mental health teams, community learning disability teams and child and adolescent mental health services were copied into the patient’s discharge correspondence. This ensured all agencies involved in the patient’s care were kept informed of care and treatment provided by the emergency department.

The department had a viewing room for recently deceased patients as recommended by The Royal College of Emergency Medicine guidelines.

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

The department had link nurses that were used as a resource when caring for patients with individual needs, for example, there were link nurses for: sepsis, dementia, diabetes, end of life, learning disability, and mental health. There were nurses from both adults and paediatrics.

Staff undertook and documented ‘intentional roundings’ for patients to ensure they could reach their call bell and had food and drink when needed.

There was dementia resource and information board for staff. This included information on recognising the condition and best practice guidance for effective and compassionate communication.

Patients had access to shower facilities within the majors escalation area and basic personal care items were available.
Meeting people’s individual needs

Emergency Department Survey 2016

The trust scored worse than other trusts for one of the three emergency department survey questions relevant to the responsive domain. The trust scored similar to other trusts for the remaining two 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>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.5</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>8.5</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>

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

The service took account of patients’ individual 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.

If people with a learning disability, dementia or mental health need required extra support or supervision whilst in the department additional, additional staff were requested we saw an example of this during the inspection.

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 hearing loop was not available at the time of our last inspection. A relatives’ room was available for private conversations.

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. Staff members also acted as interpreters the hospital switchboard kept a list of staff who spoke other languages and their contact details. This meant if an interpreter was required urgently, a member of staff in the hospital could interpret.

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.

The service used a communication book, 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.
Equipment was available for bariatric (high body mass index) patients all trolleys took up to the weight of 25 stone. 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. The room provided comfortable seating, and facilities to make hot drinks.

There was a dementia/delirium resource box available within the department. The box contained items to support patients with dementia or delirium.

A butterfly symbol was added to patient records and to their wristband that helped clinical staff identify immediately if they were living dementia.

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 children’s emergency department had a dedicated waiting area, which had been thoughtfully designed with young people in mind. This area contained appropriate toys for young patients. This waiting room was overseen by nursing and reception staff that were based in this area.

**Access and flow**

During the last inspection, we observed the flow of adult patients through the department required improvement. Adult patients experienced significant delays whilst awaiting specialist review especially from the medical teams or to be placed on a ward. We observed the same during this inspection, adult patients experienced significant delays whilst awaiting review by the specialist medical team.

Since our last inspection, there had been a changed in the decision to admit process. Emergency department doctors were no long able to make the decision to admit for adults, this had to be undertaken by a middle grade or consultant specialist doctor.

Staff told us how this had resulted in adult patients waiting many hours to be reviewed, discharged or admitted to hospital.

Data supplied to us by the trust showed the average time from referral to a specialist team and the decision to admit (adult patients only). On 31 March 2018 it was 134 minutes in the day and 102 minutes at night, 30 March 2018 it was 180 minutes in the day and 93 minutes at night, 29 March 2018 it was 159 minutes in the days and 175 minutes at night and 28 March 2018 239 minutes in the day and 156 minutes at night March. This data showed that patients were spending extended periods within the majors waiting area either receiving treatment or awaiting review by a specialist team.

During our inspection, we observed multiple patients receiving treatment, trying to sleep or waiting within the majors waiting area. We observed one patient had been in the majors waiting area for over 20 hours and another for 14 hours awaiting specialist review. This meant patients had spent the night in the majors waiting room sat on an uncomfortable chair. There was also the risk that patients could deteriorate whilst awaiting specialist review. It was also not in line with the trust’s internal professional standards included a 30 minute standard speciality assessment from referral.

We raised our concerns with the trust senior leadership team who explained a number of actions agreed at the morning clinical control centre meeting intended to alleviate the issue.
Staff explained how often by the time the patient was reviewed by a specialist team they had completed their treatment and were ready to be discharged home.

During our last inspection, the trust had just launched a new medical model, which facilitated prompt referral reallocation to a specialist assessment areas and medical triage. Staff told us how the model was no longer working, as senior triage of patients did not occur. We saw evidence, which confirmed concerns, and audit data findings had been escalated but remained unresolved.

The failure in assessment of referred patients to specialist teams especially medicine was the sixth highest risk on the urgent and emergency care risk register that the trust provided CQC. However, during the inspection we saw posters displayed which identified the top five risks and failure in assessment of referred patients to specialist teams was the top risk. The risk register provided to us by the trust showed the control measures put in place to mitigate the risk had not been reviewed since June 2017. This meant the control measures in place may not mitigate the risk. In addition, because of the one trust risk register and one poster displayed in the department the severity of the risk might not correctly understood.

A lack of flow through inpatient areas resulted in the department being regularly overcrowded. Overcrowding within the urgent and emergency care department was the seventh highest risk on the risk register provided to us by the trust. However, during the inspection we saw posters displayed which identified the top five risks and overcrowding in the department was the third highest risk. The risk register provided to us by the trust detailed the actions to mitigate the risk. This included clinical criteria for patients cared for in the majors waiting area, privacy screens to maintain patient privacy and following the trust's cohorting policy. During our inspection, we reviewed the patient records of four patients within the majors waiting area and found they all met the clinical criteria for placement in the majors waiting area. We did not see privacy screens being used during our inspection in the majors waiting area. This meant patient's in this area may have their dignity compromised. This also meant the actions recorded on the risk register to mitigate the risk were not working in practice.

Staff explained how they had ‘boarded’ and ‘lodged’ patients within the department. Lodged patients were to be admitted to the hospital under a specialist team but there was no ward bed available and boarded patients were in excess to the capacity of the department.

From our observations and discussions with patients and staff, patients were triaged and assessed quickly. There were boards in the waiting areas that clearly stated waiting times, this meant patients were kept informed of how long they expected to wait.

Clinical control centre meetings took place three times a day. We observed that they were attended by multidisciplinary staff and senior managers including the executive director of clinical operations. Waiting times were reviewed and breaches and potential breaches discussed.

Data supplied to us showed in January 2018 27% of all attendances were streamed to the primary care provider, 25% in February 2018 and 26% in March 2018. This meant the streaming process allowed those with minor injuries or illness to be treated in the most appropriate service.

The service monitored patient attendances to assess if they required treatment from a urgent and emergency care department. Data showed that in January 2018 30% of patient attendances could of seen their own GP.

**Median time from arrival to treatment (all patients)**
The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard in three out of the 12 months from January 2017 to December 2017.

There was no time to treatment figures reported for the trust from January to March 2017. From April to September 2017 the trust performed better than the standard but from October 2017 performance continuously deteriorated with the most recent month showing a median time to treatment of 83 minutes.

Ambulance – Time to treatment from January 2017 to December 2017 at Medway 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 emergency department.

The trust did not meet the standard in any of the 12 months from February 2017 to January 2018.

The trust had not been able to demonstrate consistent improvement over time. From February to June 2017, performance improved before the performance deteriorated from July to September 2017. Following two further months of improvement, the performance deteriorated again to similar levels as February 2017. This is likely to reflect winter pressures.

Four hour target performance - Medway NHS Foundation Trust
Since the change in process in January 2018 when only a middle grade or consultant speciality doctor could make the decision to admit a patient, performance in the four hour target had got worse. Data supplied to us by the trust showed between August 2017 and December 2017 performance ranged between 83% (December 2017) and 90% (November 2017). Between January 2018 February 2018, March 2018 performance was 77%, 78% and 75% respectively.

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

From February 2017 to January 2018 Medway NHS Foundation Trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average. Performance against this metric showed a general trend of improvement over the period (with poorer performance recorded in September and December 2017) but the percentage of patients waiting more than four hours from the decision to admit until being admitted continued to be much higher than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Medway 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, 22 patients waited more than 12 hours from the decision to admit until being admitted. The highest number of patients waiting over 12 hours was in January 2018 with 15 patients.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients over four hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb-17</td>
<td>1170</td>
<td>2</td>
</tr>
<tr>
<td>Mar-17</td>
<td>1397</td>
<td>3</td>
</tr>
<tr>
<td>Apr-17</td>
<td>944</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>692</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>447</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>529</td>
<td>1</td>
</tr>
<tr>
<td>Aug-17</td>
<td>681</td>
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<tr>
<td>Sep-17</td>
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<td>1</td>
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<tr>
<td>Oct-17</td>
<td>671</td>
<td>0</td>
</tr>
<tr>
<td>Nov-17</td>
<td>603</td>
<td>0</td>
</tr>
<tr>
<td>Dec-17</td>
<td>1221</td>
<td>0</td>
</tr>
<tr>
<td>Jan-18</td>
<td>799</td>
<td>15</td>
</tr>
</tbody>
</table>

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

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

Performance against this metric showed a stable trend until November 2017 when performance improved with just 0.5% of patients leaving the department before being seen for treatment in November 2017 and 0.7% in December 2017. This was better than the England average of 2.5% in November 2017 and 3.5% in December 2017.

Percentage of patient that left the trust without being seen - Medway NHS Foundation Trust
Median total time in A&E per patient (all patients)

From January 2017 to December 2017, the trust’s monthly median total time in the urgent and emergency care department for all patients was consistently lower than the England average. Performance against this metric showed a trend of improvement with the lowest median total time in the urgent and emergency care department reported in May 2017 (113 minutes), followed by an increase in median total time with the trust reporting a median of 142 minutes in the latest month (December 2017).

Median total time in A&E per patient - Medway NHS Foundation Trust

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

Learning from complaints and concerns

Summary of complaints

From January 2017 to December 2017, there were 115 complaints about urgent and emergency
care services. At the time of reporting 96 of these complaints had been closed. The trust took an average of 49 days to close these complaints. The trust has a target to close complaints within 30 days and complex complaints within 60 days. Only 28% of complaints were closed within 30 days and 67% of all complaints were closed within 60 days. This was an improvement since our previous inspection when the average time taken for the service to respond to a complaint was 62 days.

The majority of complaints had more than one theme. The most common themes of complaints were:

- All aspects of clinical treatment – 60
- Failure to diagnose – 22
- Attitude of staff – 21
- Lack of general nursing care and attention – 13
- Appointments – 10
- Communication/information to patients – 10
- Delay/cancellation - 10
- Delay to diagnose – nine

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

Complaints could be made via telephoning or emailing the trust the Patient Advocacy and Liaison Service. There was a trust wide policy for the management of complaints. The department displayed complaint information informing patients and visitors on how to make a complaint. The emergency department waiting room had feedback post boxes and comments cards that were available for completion at the time of visiting the department.

Departmental meeting minutes confirmed that feedback from complaints was discussed at meetings to inform staff of changes in procedure following complaints. Managers shared specific complaints outcomes to staff along with evidence of the sharing of learning. Information about complaints was also shared in the staff weekly newsletter.

We were given an example of learning from complaints during our inspection. A patient with complex health complained because they were had chronic pain in their arms and taking blood caused distress and pain. The matron met with the patients and the created a care plan for the patient, which meant the patient received pain relief whilst undergoing blood tests. This was added as an alert on the patients electronic health record so every time they attended staff knew the care plan in place. In addition, the patient was given a card, which they kept with them, which explained the care plan.

Staff displayed patient feedback and actions in the department for patients and visitors to see. This demonstrated the department was listening to patients feedback on how staff could improve services. There was a “you said, we did” noticeboard in the department, which contained feedback from patients and what action the service had taken.

There were monthly ‘meet the matron’ events, which also gave patients and relatives the opportunity to discuss concerns and complaints.

We reviewed three complaints two of which were not closed within 30 days, in line with trust policy. 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 understood the response.
Each complaint response signposted the complainant to the NHS Complaints Advocacy Service, which is a free, and independent service that can help people to make a complaint about a National Health Service (NHS). Responses also 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. Staff had a good knowledge of hospital complaints procedures and addressed minor issues or informal complaints from patients or relatives at the time they occurred.

### Is the service well-led?

#### Leadership

The trust management structure had changed since our last inspection.

The department came under the Unplanned and Integrated Care Directorate, which had three subdivisions; Specialist Medicine Programme Board, Acute Medicine Programme and Cancer and Clinical Support Service. The directorate was managed by an Executive Director of Clinical Operations, a Deputy Medical Director and a Deputy Director of Nursing. The urgent and emergency care department was within the Acute Medicine Programme which was operated by a triumvirate management system, with a Head of Operational Performance, a Clinical Co-Director (Doctor) and a Clinical Co-Director (Nursing) who worked together to run the programme. A service manager, matron, a consultant nurse, a Quality and Safety Lead, an Audit Lead Quality and a Governance Advisor supported the triumvirate (a group of three people who are in control of an activity or organisation) management team. The department's matron, service manager and consultant nurse reported to the leadership team. A team of senior nurses, nurses associate practitioners, clinical support workers and emergency nurse practitioners supported the service. Band seven nurses were allocated a team of staff to mentor and support.

At the time of our inspection, the role of Head of Operational Performance was vacant. Within the Acute Medicine Programme was; the emergency department, acute medical unit, ambulatory care, therapies, the discharge team, hospital at home team, care of the elderly/frailty, stroke team and the site practitioners. Staff told us they were unsure of the rationale of changing the trust management structure and the size of the Acute Medical Programme was considered to be too large to be managed by the triumvirate leadership team.

Senior leaders within the urgent and emergency care service understood and could tell us the challenges that the department faced. All senior staff were passionate about delivering high quality care to patients, whilst supporting and leading staff other operational staff to achieve this.

Leaders raised concerns regarding the use of the majors waiting area to ‘board’ patients whilst awaiting a speciality review or admission. Leaders felt patients received sub optimal care and a poor patient experience if cared for in this area for a prolonged period of time. Leaders had raised concerns to the trust leadership team and felt their concerns had not been recognised. In addition, leaders felt it had become acceptable to 'lodge' or 'board' patients within the department but this was not permitted elsewhere in the hospital.

The department’s clinical lead regularly liaised with mental health services to ensure support to vulnerable patients groups. The department understood the need to ensure equality in the care for mental health patients and patients with physical health needs.
At the start of each shift, staff were allocated to specific areas in the department. Senior nursing staff maintained regular oversight of demand in the department throughout the shift to best place staff in areas of high demand.

The trust’s management structure was clearly displayed in staff restroom areas. Staff knew that the trust management structure had recently changed but were unsure why it had changed. All staff we spoke with knew who the local leadership team were and how to access them.

All staff we spoke with described the local leadership team as, supportive and visible within the department. During our inspection, we saw the local leadership team maintaining a visible presence and assisting at times of high demand. The local leadership team were located within the department, which allowed them to have oversight of all areas. They had introduced a clearer escalation process, which aimed to provide a consistent approach in times of pressure.

All staff told us clearly about their lines of reporting to the leadership team and told us they felt valued, supported and respected in their roles and staff morale was good.

Consultant leadership in the department was committed and demonstrated clinical ownership of the patients in the department. Consultants had oversight of the department and had an awareness of who was the most unwell or had the potential to deteriorate.

The permanent locum doctors who worked in the department were appreciated by staff and provided stability for the gaps in the doctors rota. However, temporary workers felt the trust was not proactive enough to encourage them to take up a permanent position in the department. Doctors in training felt well supported by senior clinicians and felt they could approach them for advice and support.

The mental health liaison team had the expertise to lead the mental health service within the department.

In the 2017 staff, survey staff rated support from immediate line managers as 3.68 on a scale of one to five. One being unsupportive managers and five being supportive managers. This was equal to the 2017 national average for acute trusts.

During this inspection, we identified some issues that were also identified at the last inspection. These included; inconsistent daily checks of emergency equipment, daily monitoring of fridge temperatures, weekly fire safety checks, open door in the escalation area and not meeting the trust target for compliance with mandatory training. This meant the processes and systems put in place following the last inspection had not been effective.

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. At this inspection, we found consultant cover within the department still did not meet these requirements

We asked the trust why they were unable to meet the consultant cover of 16 hours a day. The trust told us that they could not commit the three-four locum consultants to provide 16 hours of cover daily on a regular basis. There was a business case that had a three year programme to bring the establishment of ten full time consultants. These posts were advertised but the trust was unsuccessful in recruiting any consultants.

Staff told us that they were often short of or had run out of stationary items. For example, during our inspection reception staff were printing on pink paper as the white paper had run out. We raised this issue with the local management team who told us there was high scrutiny on stationary orders as the trust were reviewing their expenditure on stationary.
Vision and strategy

In the summer of 2016, building work began to refurbishment the majors area of the department, this was due to open in May 2018. Staff and managers were passionate about the refurbishment and had a clear vision and strategy on how this would operate in order to improve patient experience. For example, a dedicated frailty bay for the assessment and treatment of patients aged over 75.

Staff described a vision of providing high quality care to patients in a modern bigger department that met the needs of the local population.

Staff had a good awareness of the urgent care improvement programme. Progress of the programme was monitored at departmental and directorate meetings. There was a noticeboard within the department, which showed progress made to date changes. At the time of the inspection, the improvement plan was 83% completed.

The trust had an overarching vision and values, which had the acronym of BEST. This stood for bold, every person counts, sharing and open, together. We saw values were incorporated into staff induction, recruitment and the appraisal process. The values were displayed throughout the department on posters. Staff described the values to us and said they had become more embedded since our last inspection.

Urgent and emergency care services had a clinical and operational strategic view for the Acute Medicine Programme. This was based on Urgent and Emergency Care in Medway Kent and Medway Sustainability and Transformation Plan. It included local and national priorities and objectives and included other local stakeholders.

There was also a vision, values and transformational approach which said “We want to maintain momentum, continue to improve and become ‘brilliant’”. Better, best, brilliant focussed on 13 programmes – all of which were designed to have a significant impact on the care provided to patients.

The service had an Emergency Care strategy and 2018/19 operational focus strategy. This focussed on bringing together a range of local urgent care services to ensure patients access the most appropriate service for their needs.

Staff were able to describe the principles of the strategies to us and felt they all had a shared vision and were kept informed of any changes, which affected them.

The strategies and plans were monitored on a regular basis through a variety of methods including performance meetings and through external stakeholder meetings.

Culture

Staff were proud of the care they provided, despite increasing demand on the department. Comments from staff included “there is a refreshing attitude, moving away from compartmentalization” and “great teamwork between all grades”.

Staff said that there had been some improvements and some areas of deterioration since our last inspection. Areas of improvement included better triage processes, streaming of patients better staffing including middle grade doctors, nurses and associate practitioners.

Staff told us that flow and capacity through the department was worse than during our last inspection, often there were times when the department was full. Staff told us that using the
majors waiting area for patients awaiting specialist review or admission had become normalised practice.

Staff told us that there was a culture where patients within the department were only seen as the responsibility of the service and not the wider organisation. It was felt this had an impact on the clinical care, patients experience and impacted flow in the department. Staff told us that using the majors waiting room to ‘board’ or ‘lodge’ patients was done to delay the decision to admit and allow extra time to avoid a 12 hour breach. Staff told us that patients were often suddenly transferred when they were about to breach the 12 hour target. This meant staff were unable to take a full set of observations, document these and give a comprehensive handover in line with trust policy.

We observed staff working well together and helping each other in an open, friendly but professional manner. Different disciplines worked alongside each other and showed respect for each other’s opinions.

Discussions with staff revealed their enthusiasm and motivation for working in the department. However, staff were frustrated at the constant use of the majors waiting room to ‘board’ and ‘lodge’ patients as the restrictions of the environment meant it impacted the quality of care they could provide to patients.

There was a strong culture of openness and transparency, leaders actively encouraged staff to raise concerns. One staff member commented, “there is a strong emphasis on patient safety”.

Staff we spoke to were aware of the role of the trust’s Freedom to Speak Up Guardians was, and how they would access them if required however, staff did not know their names.

Some staff described a micro-management culture from senior leaders within the trust. Staff described a culture of avoiding a 12 hour breach at all costs although it was acceptable to the senior management team for patients to wait for many hours within the department awaiting review or admission.

The culture was positive and inclusive at local level but this did not extend to the wider organisation. This was mainly due to lack of support from the trust senior leadership team in tackling the long delays patients experienced within the department awaiting review or admission.

**Governance**

Emergency Department Clinical Governance meetings took place on a monthly basis. We reviewed meeting minutes from April 2018, which demonstrated regular discussion had taken place around key areas such as incidents, patient safety alerts, audits, complaints and the risk register. Emergency Department Clinical Governance meetings minutes demonstrated that there had been a good representation of staff from the emergency department.

There were measures in place for risks to be escalated to the trust board. The Unplanned and Integrated Care - Directorate Management Board Meetings were held monthly which reported into to the trust committee on patient safety.

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.

The department held quarterly governance days which were open to all staff, typically staff attended two of these a year. We reviewed the agenda for these days and saw they included a variety of subjects, which included; paediatric safeguarding, sepsis management and simulation sessions. Staff were positive about these days and one staff member told us “it made me more open to reporting and learning”.

Management of risk, issues and performance

During the inspection, we saw the top five risks were displayed within the department. However, these risks were not the same or were graded differently to the risk register that the trust provided us with. This meant that risks might not be fully understood and that the trust risk register had not been reviewed and updated to reflect the changes and there was no oversight of the risk register.

All the risks on the risk registrar provided to us had been reviewed within the last 12 months. However, some of the actions put in place to mitigate the risk had not been recently updated. This meant the actions had not been reviewed to ensure they were still enabling the risk to be mitigated.

During our inspection, we only found that weekly and monthly fire safety checks had not been undertaken. This meant essential checks were not being undertaken for example checking firefighting equipment was available and fit for use. This was consistent with our findings in our previous inspection. We raised this issue with the local leadership team who explained that there had been confusion regarding who was responsible for undertaking the checks. The matron had now assumed responsibility for ensuring these checks were undertaken and we saw a folder had been produced to record these checks.

Staff were able to report clinical incidents anonymously, this meant if a staff member wanted to raise a concern but wanted their identity to be confidential they could.

Senior nursing and medical staff met weekly we saw each meeting had meeting minutes and included a separate action log for actions arising from the meeting. This meant any actions arising from the meeting had a staff member responsible for ensuring the action was undertaken. We reviewed three meeting minutes and saw they followed a set agenda and included key topics such as incidents, policy updates, requirement and audits.

Unplanned and Integrated Care - Directorate Management Board Meetings took place on a monthly basis. We reviewed three sets of meeting minutes from January 2018 and March 2018, which demonstrated a broad attendance of medical, nursing, and support staff from the emergency department.

We saw Royal College of Emergency medicine patient safety alerts were displayed within the department. This meant staff were alerted to these.

There was a structured education pathway for all nurses and associate practitioners. This meant staff had the relevant training and skills to undertake their role.

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.

The consultant vacancies were not highlighted as a risk on the risk register that was provided to us by the trust. However, during the inspection, we saw posters, which identified the emergency department’s top five risks, and medical staffing was the fifth risk. This meant there was an inconsistent approach to identifying and recording risks.

The department carried out local audits to monitor quality and patient safety. Audits included patient records, environmental cleanliness, hand hygiene and sepsis.
Staff could describe the escalation process for times of increased demand; this was an improvement since our last inspection.

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

We saw patients remained in the majors waiting area for extended periods of time. This meant there was a risk that patients could deteriorate whilst in this area. The risk was mitigated by dedicated staff in the area and clinical inclusion criteria, in addition, this was in place for the majors escalation area. This meant only suitable patients who were not acutely unwell were placed in these areas. We reviewed patient records of patients within these areas and saw they met the clinical criteria. For example, no patient had an early warning score of more than three. However, one of the patient records we reviewed stated that the patient should be attached to a cardiac monitor and was not. This meant the patient’s heart was not being monitored in accordance with the doctor’s instructions.

Potential risks were taken into account when planning services or improvements to improve efficiency. For example, the opening of the new building had been delayed to install water sprinklers.

**Information management**

Staff were able to access patient information using an electronic system and paper records.

Staff had access to policies through the trust’s intranet. We saw that staff could access policies in a timely manner.

All staff had access to information technology systems to track patients through journey in the emergency department. The trust used electronic flagging system to identify patients who were vulnerable or those who were living with complex needs.

Staff locked and secured computer terminals when not in use.

There was an information screen in the majors area of the department, which displayed non-identifiable patient information. This meant that staff had oversight of patients within the department, whilst confidentiality was being maintained.

During our inspection, we did not see any occasion when patient records with confidential information were left unattended. Notes from patients who had been discharged were kept securely at all times.

**Engagement**

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

The trust interacted on social media via a variety of social media networks. 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 were able to have a tour of the new building, which were undertaken weekly. This meant they could visualise the new building and how it was designed. The new building included a new staff area, which was outside of the immediate clinical area. This was to replace a staff room, which was not big enough for the amount of staff using it, and it was in the middle of the clinical area. The new staff area provided a modern larger environment away from the clinical area where staff could have their breaks.
Staff had direct access to physiotherapists and could refer themselves if they required physiotherapy. This meant staff received physiotherapy quickly if needed to treat an injury or health condition.

The department had staff outings for staff to attend for example, there was a summer picnic every year, which all staff were invited to.

Staff were given a discount card, which gave them a discount at some local shops near the hospital.

The department had undertaken collaborative work with the clinical commissioning groups to set up the patient streaming service. The department and the clinical commissioning groups worked together to understand what the needs of the local population were and what services were available both inside the hospital and within the local community. This meant patients could be directed to the most appropriate service. For example, if a patient attended the department and they needed an emergency dentist staff were able to direct them to one. Local General Practitioners were also involved in setting up the patient streaming process so it was understood what services they provided and where any possible service provision gaps were.

The department worked closely with the local Healthwatch group, they attended the monthly ‘meet the matron events’ which were attended by patients and relatives. These events gave the matron and Healthwatch the opportunity to get feedback from patients and relatives and improve the service. Healthwatch were also involved in reviewing various policies used within urgent and emergency care services. This meant Healthwatch reviewed them from a service users perspective and provided feedback on whether they met the needs of service users.

Healthwatch also had input into the new building design. This meant there was appropriate consultation with independent patient advocacy groups to capture and improve patient experience and.

The leadership team received a weekly email from NHS choices. This included feedback that patients had left regarding their experience in the urgent and emergency care department in the previous week. NHS choices included a star rating; zero being a poor experience and five being the most positive experience, ratings were also included in the weekly email. Medway Maritime hospital has a rating of three and a half stars based on 323 reviews.

The department worked collaboratively with the local ambulance service in developing the fractured hip pathway. This involved providing ambulance staff additional training in recognising and managing a broken hip. Ambulance rang a dedicated mobile held by an associate practitioner and alerted them when they were bringing in a patient with a suspected broken hip. This meant arrangements could be made to ensure the patient spent the least amount of time within the department.

CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. This meant that a proportion of the income depends on achieving quality improvement and innovation goals, agreed between the Trust and its commissioners. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients, a principle fully supported at all levels of the hospital.

The department worked with local stakeholders such as General Practitioners 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.

Since our last inspection, patients could now complete the friends and family test by text message or on the trust’s website. A paper copy could still be completed and we saw these were available in the department. This meant patients could provide feedback on whether they would recommend the service in a variety of methods, which suited their needs or convenience.

Staff received a weekly email from the leadership team. We reviewed three of these and saw they included a variety of information, which included, changes to standard operating procedures, progress on the new building and how to access mandatory training. This, which ensured staff, were kept up to date with any changes.

The department undertook multi-agency de briefing sessions. These were held for staff if they had been involved in a distressing event with a patient. For example, we saw the local ambulance trust were involved in a de-briefing session. Counselling was available for staff if required.

The trust used an electronic software system, which staff could download onto their mobile phone. The software system allowed access to booking mandatory training, booking bank shifts, accessing the staff rota and hospital news. This meant staff could access information remotely.

The department had worked with NHS digital to implement the child protection - information sharing project (CP-IS). This is an electronic database designed to help health and social care staff share information securely to better protect society’s most vulnerable children. We saw staff using the database during our inspection.

Different staff groups used downloaded messenger applications on their mobile phones. This allowed them to send messages to each other and aided effective communication.

The department had a variety of different staff group forums for example the associate practitioners. One of the leadership team chaired these forums. This allowed staff groups to communicate and raise any concerns to the leadership team. We saw forum meeting minutes, which confirmed they were undertaken.

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

Service users and people in the local area could apply to be a member of Medway Maritime NHS foundation trust. Membership allowed local communities to have ownership of the trust and contribute to its future development.

The trust had annual celebrating excellence awards. The awards recognised staff members who went the extra mile to improve the experience patients had when they visited the hospital.

In the 2017 staff survey 87% of staff agreed that their role made a difference to patients and service users, this was equal to the national 2017 average for acute trusts.

Learning, continuous improvement and innovation

The department were nominated for three national awards. The pathway for patients with broken hips had been nominated of a Health Journal Society award and a Parliamentary award. The staff recruitment strategy had been nominated for a Health Journal award.
Staff in the paediatric department had worked with other health agencies to improve asthma care in children in the local community. This included inhaler check clinics and information for parents and carers looking after children with asthma.

The service had developed a specific pathway for patients who had broken their hip. This meant a multi-disciplinary team worked together and ensured patients were assessed and treated as quickly as possible. An associate practitioner facilitated the pathway.

The department was part of an education collaborative. Emergency departments within the South East region had joined together to provide education, each department offered a different educational course and staff from all hospitals attended.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at Medway NHS Foundation Trust provides care and treatment for acute medicine, acute specialist medicine (gastroenterology, respiratory, cardiology, and endocrinology), elderly care medicine and planned services (dermatology, neurology, and rheumatology). In addition, they offer haematology and acute oncological services. They also offer domiciliary non-invasive ventilation and sleep services. There are 318 medical inpatient beds located across 14 wards.

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

The trust had 31,661 medical admissions from November 2016 to October 2017. Emergency admissions accounted for 62% of all admissions (19,626), 1.2% were elective (384) and 36.8% were day case (11,651).

Admissions for the top three medical specialties were:

- General medicine (17,913)
- Gastroenterology (4,447)
- Clinical haematology (1,835)

(Source: Hospital Episode Statistics)

During the inspection, we visited 10 areas:

- Cardiac care unit
- Medical assessment unit
- Medical infusions suite
- Endoscopy (Joint Advisory Group on Gastrointestinal Endoscopy Accreditation)
- Lawrence ward - oncology
- Milton ward, Harvey ward and Tennyson ward - care of the elderly
- Keats ward and Will Adams ward - gastroenterology

We looked at 29 patient records including 24 drug charts. We spoke with 12 patients and three visitors, and a number of staff who worked in medical care. Staff interviews included volunteers, housekeeping staff, clinical engineers, technicians, consultants, doctors, physician associates, nurses, student nurses, and care support workers.

Is the service safe?

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

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

Mandatory training
The trust had increased its target for mandatory training since the previous inspection from 80% to 85%.

Information provided to us prior to inspection showed mandatory training was below the trust target. However, an update from the trust at March 2018, showed compliance to mandatory training was 81% for the unplanned and integrated care directorate. This remained below the trust target of 85%.

Staff completed online mandatory training modules through the Medway online learning environment. Staff had individual logins and could access the system remotely. Mandatory training modules were colour coded; green for complete or red for incomplete. Staff received email alerts when training was due for completion and could view available mandatory training dates. This meant individual staff had oversight of their mandatory training status.

The trust had a statutory and mandatory training policy, due for review December 2020. This clearly outlined permanent staff needed to complete statutory and mandatory training within two weeks of employment. It also stated temporary staff such as bank and agency staff could only work on site if they had completed the necessary training. This ensured all staff had received training to enable them to carry out their role.

Staff completed online sepsis management training yearly. Data showed 58% compliance to sepsis training for the unplanned and integrated care directorate. This was worse than the trust target of 85%. However, staff we spoke with had a good knowledge of sepsis management and we evidence staff complied with the trust’s sepsis screening guidance.

**Mandatory 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 mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical and dental staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>122</td>
<td>163</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>103</td>
<td>153</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>105</td>
<td>162</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>105</td>
<td>164</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>97</td>
<td>161</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>95</td>
<td>162</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>4</td>
<td>7</td>
<td>57%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>82</td>
<td>162</td>
<td>51%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>78</td>
<td>165</td>
<td>47%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>0</td>
<td>1</td>
<td>0%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the training target in any of the ten modules for medical staff in medical care. Only 78 out of 165 staff had up to date PREVENT level 2 training equating to 47% of all
eligible medical and dental staff and 82 out of 162 eligible staff (51%) had up to date adult basic life support training.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and midwifery staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>287</td>
<td>312</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>270</td>
<td>308</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>271</td>
<td>310</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>268</td>
<td>310</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>248</td>
<td>311</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>245</td>
<td>310</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>227</td>
<td>300</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>189</td>
<td>280</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>201</td>
<td>307</td>
<td>65%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>2</td>
<td>9</td>
<td>22%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met the training target in four out of 10 eligible training modules for qualified nursing and midwifery staff in medical care. Only two out of nine staff had up to date resuscitation training equating to 2% of all eligible nursing staff.

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

Safeguarding

Staff understood how to protect patients from abuse and report abuse. However, staff were not trained to the recommended safeguarding levels. Between January and December 2017, medical teams made 69 adult and no children and young people safeguarding referrals. Data from the trust showed the staff compliance rate for safeguarding training in medical care was much worse than the trust target. This meant not all staff had received training to enable them to identify abuse and report it correctly.

There were 52 children aged 17 or under treated on medical wards between January and December 2017. However, staff did not have the correct level of safeguarding training. ‘Safeguarding children and young people: roles and competences for health care staff Intercollegiate Document, Third edition: March 2014’ states: ‘All staff working in health care settings should be trained to level one. All non-clinical and clinical staff that have any contact with children, young people and/or parents/carers, Level two. All clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns needs to be trained to level three.’ Across medical care, we saw that no one had safeguarding training in children at level three or above.

Staff we spoke with had a good understanding of the trust’s safeguarding policies. Staff completed paper referral forms and faxed these to the trust safeguarding team. They could also escalate any safeguarding concerns at daily safety huddles. Staff reported they telephoned the trust safeguarding teams for advice and found them to be very helpful.
Staff told us they received feedback from safeguarding referrals from the safeguarding team and the senior sister. These discussions were held in private with the staff involved in the care of the patient.

In notes we looked at, it was clear staff in medical care services took responsibility to report safeguarding concerns. The adult safeguarding team had spoken to patients upon receiving referrals. They documented their conversations with patients and instructions for the ward staff in the patients’ notes. This meant information on the progress of the referral and subsequent actions were accessible to all staff.

There were arrangements in place to safeguard women or children with, or at risk of, female genital mutilation. There had been no cases of female genital mutilation reported by the medical care services. Health and social care providers have a statutory duty to report female genital mutilation in line with the Department of Health guidelines.

There was a standard operating procedure and contact flowchart in place for the escalation of patients with mental health disorders. Staff could refer patients to the liaison psychiatry team who reviewed the patient daily. We saw evidence of this within the patient records we reviewed.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. Sixty nine percent of staff in medical care had completed safeguarding training from April 2017 to October 2017.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for medical and dental staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>98</td>
<td>165</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>84</td>
<td>156</td>
<td>54%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the target for the two eligible safeguarding courses for medical and dental staff in medical care.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for qualified nursing and midwifery staff in medical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>213</td>
<td>278</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>218</td>
<td>292</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the target for the two eligible safeguarding courses for qualified nursing and midwifery staff in medical care.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
Cleanliness, infection control and hygiene

Overall, the service controlled infection risk well. Most staff kept followed infection prevention and control processes in line with trust policy and best practice. However, we saw audit results for infection prevention and control showed varying levels of compliance.

All staff received training in infection prevention and control as part of their induction and at yearly refresher training. Topics covered included hand hygiene, needle stick injury, sepsis, and aseptic non-touch technique. Data showed 59% of medical and dental staff completed the training, which was worse than the provider’s target of 85%. Data showed 79% of nursing and midwifery staff completed the training, which was below than the provider’s target of 85%.

Staff wore personal protective equipment to reduce the spread of infection when required. This refers to protective clothing, gloves, aprons, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. We saw staff in several areas use personal protective equipment.

Patients with known infections were nursed in side rooms. We observed staff transfer a patient with an infectious disease from a side room to a negative pressure room to prevent contaminated air from escaping the room. Negative pressure isolation rooms are used as they allow air to flow into an isolation room, but not out of the room, which prevents contaminated air from leaving the room and reduces the risk of cross infection.

We saw all side rooms had a sign to show what process staff should use when entering the room. A colour-coded system clearly indicated to staff what type of personal protective equipment was needed and if a patient was especially at risk of infection.

Overall, staff demonstrated good hand hygiene. We observed all staff members wash their hands or use hand sanitiser before and after patient contact, which was in line with the World Health Organisation’s guidance on hand hygiene, which demonstrates five moments when healthcare professionals should wash their hands to reduce the spread of infection.

There were sufficient numbers of hand washing sinks available, in line with Health Building Note: 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. Information near the hand washing sinks displayed the ‘five moments for hand hygiene’. Hand sanitisers were available at the entrance and throughout each department. All hand sanitisers we inspected worked and were in date. This ensured staff and visitors had access to alcohol based hand rub to clean their hands.

Matrons for each department carried out monthly hand hygiene audits. We saw the audit results for March 2018 and found six out of ten areas met the trust target of 100%, two areas scored less than the trust target and two areas did not complete the audit. This indicated compliance to hand hygiene was not consistently carried out or monitored across all areas.

Records for all areas we visited showed housekeeping staff flushed all water outlets within bathrooms and toilets daily to prevent legionella bacteria. These bacteria can cause Legionnaires’ disease, which is a potentially fatal type of pneumonia. This was in line with Health and Safety Executive guidance.

Housekeeping staff we spoke with understood their role in reducing the risk of infection. The trust employed senior housekeepers who oversaw the housekeeping staff on a daily basis and provided coaching or assistance as necessary. One housekeeper explained her cleaning duties to us. They reported they changed the mop heads between bays or side rooms to reduce to spread of infection. They placed mop heads used in side rooms into red bags to identify an infection risk and sent the bags to the laundry service for washing.
The trust performed monthly housekeeping audits for each department. The departments displayed their results at the entrance to the department. We saw the audit results for March 2018 and found six out of nine areas we visited had met the National Standards of Cleanliness target of 95%. This demonstrated compliance to cleaning was inconsistent across the areas. We found high and low dust on top of cupboards and bedframes in Tennyson ward. We informed the housekeeper who took immediate action. But this indicated the processes described to us were not always being followed.

Six out of eight commodes we inspected were clean and staff put ‘I am clean’ labels on the commodes once they had cleaned them. The other two were dirty. The use of stickers ensured staff knew which commodes were ready for patient use. In Will Adams ward, an allocated checker would check the cleanliness of the commodes hourly and recorded this check in a logbook within the sluice. The infection prevention and control team carried out monthly commode audits. We saw the audit results for March 2018 and found all areas achieved the trust’s target of 100%. This demonstrated there were high standards of cleaning commodes across all areas.

All items of equipment we reviewed appeared clean.

The infection prevention control team carried out monthly saving lives compliance audits. The audit results for March 2018 showed compliance varied across the areas we inspected. Compliance levels varied between 60% and 100%. This demonstrated staff compliance to infection control practices was inconsistent. Saving lives audits look at the insertion and ongoing care of invasive devices such as, peripheral vascular cannulas (A peripheral vascular cannula, is a tube that is inserted into a vein and used to administer fluids and medication).

We saw staff documented the insertion of vascular access devices in the patient records. However, daily monitoring of these devices for signs of infection was inconsistent. This is not in line with the National Institute for Health and Care Excellence (NICE) quality statement 5, which states, ‘Peripheral vascular catheter insertion sites should be inspected during every shift at a minimum’. This check ensures any infection or inflammation at the insertion site is identified quickly.

The service decontaminated flexible endoscopes in line with the Health Technical Memorandum 01-06. Endoscope technicians talked us through the cleaning process, which demonstrated a clear one-way flow for dirty endoscopes. This minimised the risk of cross contamination.

The infection prevention and control team carried out an audit in endoscopy in November 2016. The results were rated red, amber, or green. Three out of four areas achieved a green rating indicating compliance. There was one amber rating for the ventilation system, which needed updating. The endoscopy unit achieved accreditation by the Joint Advisory Group on Gastrointestinal Endoscopy following a site visit in October 2017.

Staff screened patients for meticillin-resistant Staphylococcus aureus (MRSA) on admission then weekly. We saw in the bedside records evidence of MRSA screening in line with national guidance; however, staff did not always record the result. Staff recorded the MRSA status of patients on the front of the drug chart and we saw MRSA care plans in place in the bedside records. The performance review scorecard for November 2017 showed nine out of 11 medical areas met the trust target of 95% compliance with MRSA screening on admission. This indicated screening was not consistently occurring.

The infection prevention and control team conducted an audit between April 2016 and March 2017 for staff compliance to MRSA screening on admission and found 97% compliance. This was slightly below the trust target of 100%. They also audited compliance to weekly screening and found 91% compliance. This was also below the trust target of 100%.
All patients we spoke with told us the standard of cleaning within the hospital was excellent and had much improved. One patient said, ‘cleaning is very good, she is thorough’ and another said, ‘They give a thorough clean every day’. However, one patient said, ‘Cleanliness is quiet efficient but they always come at the wrong time when it’s full of people.’ Patients told us staff always washed their hands or wore an apron and gloves before carrying out any personal care. One patient said, ‘after touching any patient they go straight to washing their hands’.

The performance review scorecard for November 2017 showed there were no reports of clostridium difficile.

Environment and equipment

We found the design and layout of wards varied, some areas required refurbishment and required extra storage space. Staff had access to equipment they needed, either on the ward or via an equipment library. Equipment was available and serviced although there were some delays with getting faults dealt with.

Wards and departments were secure. Entry telephone systems were in use, to ensure visitors could not access the ward unless a member of staff had let them in.

Stock and equipment rooms were locked, with keypad access and only authorised staff knew the code. Stockrooms were well organised and there was no equipment on stored on the floor.

The wards varied in design, some had bays with four to six beds, and others were open plan. Due to the design of Will Adams ward, staff told us patients found it difficult to sleep and staff found it difficult to move around the beds to provide patient care. We saw the patient’s quiet room needed decluttering and decorating. However, managers informed us there was a business case in place to refurbish and redecorate the ward.

The corridor on Will Adams ward and the cardiac care unit was cluttered with equipment. Staff on the cardiac care unit explained they moved equipment out of the pacing room as this was in use but did not have an alternative area in which to store the equipment. There had been two staff falls within the unit and the reason given, was because of cluttered areas. Equipment in the corridor could cause a trip hazard or could prevent staff and patients being able to evacuate the department safely in a fire.

Emergency equipment was located on all departments. The resuscitation trolleys contained all the required equipment including a defibrillator, to manage a medical emergency such as a cardiac arrest. We reviewed the daily and weekly checks for the trolleys on three wards for March 2018. We found two daily check omissions on Will Adams, one daily check omission on Milton ward and two omissions on Lawrence ward. This meant staff working on these days did not have assurance the crash trolley and emergency equipment was ready for use. We found no omissions for the weekly checks. We checked ten consumable items within one crash trolley and found these to be in date.

Staff correctly assembled sharp boxes and completed the tracking label on the front. However, on Tennyson ward we saw staff did not use the temporary close function on the sharp box lids between uses. In addition, staff did not place these of reach of vulnerable patients or visiting children. This meant there was a risk of needle stick injury for staff, patients and visitors to the ward. This was not in line with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

We saw that overall waste was separated and disposed of in different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01: Safe Management of health care waste and control of substance hazardous to
health (COSHH), health, and safety at work regulations. However, we saw items such as gloves were placed in the domestic waste bin. Items such as gloves and aprons should be disposed of in the clinical waste stream, as they are worn when there is a risk of contamination.

All departments had fire extinguishers placed in easily accessible places. We checked five fire extinguishers and found these to have had a service test within the past 12 months, which meant they were fit for purpose.

Each area had a medical equipment folder, which contained equipment competency paperwork for staff. We saw this documentation was incomplete and not all staff had received training on the equipment such as hoists, blood glucose monitor and suctioning equipment. A matron told us it was a work in progress, but all staff received basic training on essential equipment at induction. It was the responsibility of the practice development nurse or the ward manager to sign off the competencies for specialist equipment such as a bladder scanner. This meant managers did not have assurance all staff were competent in using equipment.

Staff in the cardiac care unit and Lawrence ward told us they thought they did not have enough room to deliver patient care due to the amount of equipment in patient bays/rooms. They explained these areas did not have adequate storage facilities for equipment. For example, in the cardiac care unit staff kept the portable echocardiography machine by the fire extinguishers where the visitor chairs were stored. This meant the visitor chairs were now in the patients’ bay, which limited the space in the bays.

Staff reported facilities and estates were slow to respond to their concerns. Staff in the cardiac care unit reported they escalated multiple concerns about water dripping into electronic equipment. This occurred for six months without any action taken by the facilities and estates department. This was resolved following the visit of the chief executive office to the unit.

Staff could report faulty equipment to the medical equipment library on weekdays and some Saturdays. Ward staff placed faulty equipment at a designated collection point on the ward and staff from the medical equipment library would collect. If the piece of equipment was essential, the medical equipment library could lend equipment to the ward whilst technicians fixed the faulty equipment. This meant there were always adequate supplies of equipment on the ward.

The medical equipment library could track when servicing and maintenance of equipment was due. It kept a central inventory system of every piece of equipment in the trust. The trust labelled equipment with yellow ‘NSD’ (next service due) so staff had a visual aid to see if equipment was fit for use. We saw the two drug fridges on Lawrence ward were overdue an electrical safety test by one month. The ward escalated this to the medical equipment library who performed the electrical safety test the same day. All other equipment we checked had a service within the past 12 months.

Staff obtained pressure-relieving equipment for patients at risk of developing pressure ulcers. Staff ordered pressure-relieving equipment over the telephone and porters would collect the necessary equipment from the equipment cupboard. We saw patients identified as at risk of developing pressure ulcers had high specification foam or air mattress on their bed. These mattresses can prevent the development or the deterioration of pressure ulcers.

Assessing and responding to patient risk

We found staff responded well to the deteriorating patient and there was effective sepsis management. Patients received timely consultant review on admission and staff completed comprehensive risk assessments for the prevention for falls and pressure ulcers.

Patient moves per admission
The trust provided information on patient moves per admission for the five wards with the highest number of non-clinical ward moves, three of which were medical wards. The wards included were Keats, Nelson and Wakeley. From January 2017 to December 2017 81.2% of individuals on these three wards did not move wards during their admission, and 18.8% moved once or more.

(Source: Trust Routine Provider Information Request (RPIR) P51 – Bed moves)

One patient we spoke with reported staff moved him six times during their admission. They reported this made them disorientated and caused them to fall. The falls team told us they had identified a link between transferring patients out of hours and patient falls. Staff received training on falls risks during their induction.

Staff identified and treated sepsis in line with best practice. Sepsis is a life-threatening condition that arises when the body’s response to infection causes injury to its own tissues and organs. Staff used a sepsis screening and action tool to identify patients with suspected sepsis. If a patient had any of the ‘red flags’ present such as a heart rate above 130 beat per minute, staff put the patient onto the sepsis six pathway.

The sepsis six pathway states patients must receive treatment within one hour of identification this included blood cultures, administration of antibiotics and fluids. In patient records, we saw staff recognised sepsis quickly and escalated their concerns immediately. This ensured patients with sepsis were treated in a timely manner. Staff escalated patients thought to have sepsis to the critical care outreach team or the acute response team for further assessment. Staff told us these teams were very responsive to their calls.

Staff monitored patient physiological parameters such as pulse and temperature in line with National Institute for Health and Care Excellence guidance CG50 Acutely Ill Patients in Hospital. We checked observation charts and saw staff carried out physiological monitoring at recommended frequencies.

Staff used the National Early Warning System (NEWS) to identify acutely ill patients. Six physiological findings such as pulse and temperature, and one observation were checked and a NEWS score calculated. A high score could indicate deterioration in a patient’s condition. Staff calculated these scores consistently and accurately. We tracked several instances of increased scoring, indicating a potential deterioration, and saw clear documentation of where escalation protocols were followed. In the patient notes we reviewed, we saw 100% of patients had their vital signs recorded and NEWS score calculate correctly. This meant staff could identify a change in a patient’s condition quickly.

On Will Adams ward, we saw the consultant reviewed the acutely unwell patients and new patients first during the ward round. In the patient notes we reviewed, we saw a doctor had seen 94% of patients within 12 hours of admission. This ensured patients had a medical management plan in place at the start of their admission, which prevented delays in diagnosis and treatment. There were on site access to high dependency departments if patients had critical care needs.

Staff completed comprehensive venous thromboembolism (VTE) risk assessments for all patients. VTE is a condition where a blood clot forms in a vein. In the patient notes we reviewed, we saw 94% of patients had a risk assessment completed. This meant patients with a high risk of VTE were identified on admission and a management plan commenced.

Staff used a nationally recognised tool to assess the risk of each patient developing pressure ulcers. Staff implemented a specific care plan for patients at high risk of pressure ulcers, which included daily visual skin assessments and regular repositioning. The performance review scorecard for November 2017 showed no medical areas had reported patients with a grade 3 or 4 pressure ulcer. This demonstrated interventions by staff did prevent further deterioration of
We saw ward staff highlighted patients with a high risk of falls and development of pressure ulcers verbally at handover and documented this on the handover sheets. This ensured all staff were aware of the specific care plans in place for these patients. The performance review scorecard for November 2017 showed there had been two patient falls resulting in moderate or severe harm across 11 medical areas. This demonstrated interventions by staff did prevent patient falls.

Staff had access to psychiatry services 24 hours a day, seven days a week. Staff referred patients to the service in line with guidance and we saw the service typically saw patients on the same day as the referral or the next day depending on the urgency of the referral.

Nurse staffing

The trust planned and reviewed nursing staffing levels throughout the day. Staff followed escalation processes when their area was short staffed. However, staff felt nursing staffing levels did not always meet the standard in order to keep patients safe and compliance to the ratio of actual to planned nursing hours was inconsistent.

The trust reported their registered nursing staff numbers as below for December 2017. The trust had a nursing fill rate of 91.0%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>431.2</td>
<td>392.2</td>
</tr>
</tbody>
</table>

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

Vacancy rates

The trust reported an annual vacancy rate from January 2017 to December 2017 of 3.6% for qualified nursing and midwifery staff in medical care. This was below the trust’s target of 12%.

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

Turnover rates

The trust reported an annual turnover rate from January 2017 to December 2017 of 16.5% for qualified nursing and midwifery staff in medical care. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate which is the data that has been provided by the trust.

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

Sickness rates

The trust reported an annual sickness rate from January 2017 to December 2017 of 3.3% for qualified nursing and midwifery staff in medical care. This was below the trust target of 4%.

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

Bank and agency staff usage

From January 2017 to December 2017, the trust reported a bank and agency fill rate of 24.0% in medical care with a further 9.4% of shifts remaining unfilled. A breakdown by staff type is shown below:
<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>1,556 (2.9%)</td>
<td>13,972 (26.3%)</td>
<td>3,887 (7.3%)</td>
<td>53,230</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>10,084 (13.8%)</td>
<td>4,732 (6.5%)</td>
<td>7,990 (10.9%)</td>
<td>73,252</td>
</tr>
</tbody>
</table>

Bank staff mainly filled nursing assistant shifts whilst agency staff mainly filled qualified nursing shifts.

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

Will Adams ward had 26 patients and were short staffed by one registered nurse and one registered mental health nurse during the day shift. There was full staffing for the night shift. Ward management advertised the two day shifts to the nursing agency and had escalated this to the matron. However, the shifts remained unfilled. One patient required a registered mental health nurse day and night, but only seven out of eleven previous shifts had been filled. Staff reported they often were short staffed, which they felt was unsafe. We saw the staff shortage had a direct impact on the provision of patient care and an increased pressure on the staff during our inspection.

Milton ward had 26 patients and were short staffed by two registered nurses during the day shift. Therefore, the ward manager worked clinically to provide cover. The ward was fully staffed for the night shift. Staff told us ward management allocated them to the same patients if they worked two consecutive shifts. This ensured continuity of care for the patients.

Lawrence ward had 18 patients and were fully staffed for the day and night shift. Staff reported the senior sisters were very clinical and worked weekends to cover staff shortages. Staff on this ward were not often moved as they had specialist skills such as chemotherapy administration required for the cohort of patients on the ward. Ward management reported they had six vacancies due to internal promotions, emigration and staff rotation, which were advertised the following week after the inspection.

Tennyson ward were short staffed by one care support worker, however the ward manager worked on the ward to fill this gap. Staff reported the ward was normally fully staff but felt frustrated and disheartened when management asked them to work elsewhere to fill staffing gaps. Ward management told us they believed this explained poor registered nurse retention rates.

Keats ward reported a nurse vacancy rate of 9.3%. Staff reported there was a recruitment drive from overseas and the senior sister worked clinically when there were staff shortages.

The medical infusion suite met its planned staffing levels daily and staff thought their planned staffing levels met the needs of the service.

The trust reported it had maintained appropriate nurse to patient ratios in the cardiac care unit by the implementation of a twilight post. However, staff on the unit reported bank and agency were not always able to fill this position and when it was filled, the nurse was often moved to another area. This made it difficult for the staff to take a break during their shift.

The ambulatory care unit allocated one registered nurse per bay for each shift. There were four bays in total. However, they reported bank and agency staff covered 12 registered nurses vacancies. The unit was recruiting for advanced nurse practitioners at the time of our inspection.

Staff told us they felt elderly care were always short staffed. They reported only substantive staff worked during the day but night shifts were often worked by bank and agency staff. The performance review scorecard for November 2017 showed six out of ten medical areas did not
meet compliance to the ratio of actual to planned nursing hours. This meant these areas did not have the correct number of nurses working to ensure safe care. The trust reported matrons worked extended hours into the evening to support the wards. Student nurses told us poor nursing levels directly affected the support available to them during their placement.

The trust used a systematic approach to nurse staffing levels to ensure that patients received the nursing care they needed. Departments used an electronic rostering system, which used default staffing levels to allocate nursing staff for each shift. Senior sisters discussed and reviewed planned staffing levels at their weekly meetings.

Senior nurses inputted actual staffing levels and patient acuity levels for each day using an electronic system. Senior nurses used this system to escalate concerns regarding staffing levels. Matrons reviewed the system and moved staff to areas of greatest concern. In November 2017, we saw medical care services had escalated nursing staffing levels 300 times. The highest number of escalations were on Keats ward, Milton ward and Tennyson ward. This demonstrated staff were confident to report staffing concerns.

Each area we visited during the inspection displayed their planned and actual nursing staff levels for the day and night. They also had a board, which displayed staff photographs, staff name and designation. This showed transparency to patients and visitors.

Medical staffing

Overall, we judged there was sufficient medical staffing with the correct skill mix to meet the needs of the patients on a day-to-day basis. There were suitable arrangements in place for medical support out of hours.

The trust reported their medical staffing numbers as below for December 2017. The trust had a medical staffing over-establishment of 8.9%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental - Hospital</td>
<td>148.0</td>
<td>161.1</td>
</tr>
</tbody>
</table>

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

Vacancy rates

The trust reported an annual over-establishment from January 2017 to December 2017 of 8.3% for medical and dental staff in medical care. This signified that the trust had more staff in place than they have budgeted for, therefore the target vacancy rate was being met.

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

Turnover rates

The trust reported an annual turnover rate from January 2017 to December 2017 of 44.3% for medical and dental staff in medical care. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate, which is the data that has been provided by the trust.

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

Sickness rates

The trust reported an annual sickness rate from January 2017 to December 2017 of 0.7% for medical and dental staff in medical care. This was below the trust target of 4%.
Bank and locum staff usage

The trust was unable to provide the number of shifts available per month due to data being collected manually, therefore bank and locum agency fill rates could not be calculated.

From January 2017 to December 2017 1,733 shifts were filled by agency staff, 882 shifts were filled by bank staff and 602 shifts remained unfilled.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>2,594</td>
<td>250</td>
<td>22</td>
<td>2,866</td>
</tr>
<tr>
<td>Middle grade</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>SHO</td>
<td>2,311</td>
<td>245</td>
<td>443</td>
<td>2,999</td>
</tr>
<tr>
<td>SPR</td>
<td>716</td>
<td>132</td>
<td>177</td>
<td>1025</td>
</tr>
</tbody>
</table>

Staffing skill mix

In October 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was similar.

Staffing skill mix for the 166 whole time equivalent staff working in medicine at Medway NHS Foundation Trust

<table>
<thead>
<tr>
<th>Staff type</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>39%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>19%</td>
<td>22%</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 (01/10/2017 - 31/10/2017)

Specially consultants such as cardiologists, gastroenterologists and geriatricians worked across the directorate. This ensured patients were seen and reviewed by consultants with relevant skills and expertise in their condition.
The trust told us they had recruited four consultants, four middle grade doctors and five physician associates in medical care in the past three months. The middle grade doctors were scheduled to join the registrar rota in April 2018 but this was delayed. The physician associates were due to start in June 2018.

Most areas reported good medical staffing levels, which was reflective of the data received by the trust. However, we noted Milton ward did not have any registrar or senior house officer cover at the time of our inspection. Staff told us the registrar position would be filled in October 2018. We saw medical staff escalated this and management arranged for senior house office cover for the following day. However, the lack of medical staffing on this ward directly impacted on the workload of the consultant who saw seven sets of patient relatives in one day. The consultant reported paperwork was completed out of hours rather than in allocated time.

Consultants led a ward round daily with the support of a registrar, junior doctors and associate practitioners. The medical team also reviewed all patients awaiting transfer to the speciality wards daily. Nursing staff reported good visibility of consultants and doctors on the wards.

Staff had access to consultant advice out of hours. On weekdays, there was an on call medical consultant on site from 5pm to 9pm and thereafter on call from home until 8am. At weekends, two consultants provided on call services from 8am to 8pm. Another consultant provided emergency reviews and discharged patients from the wards.

Staff in ambulatory care had access to consultant advice out of hours. For ambulatory care there was an on call acute physician providing consultant cover up to 9pm on weekdays and between 8am and 6pm on weekends.

Staff had access to a paediatric registrar 24 hours a day, seven days a week for medical emergencies involving children. There was paediatric consultant cover weekdays between 8.30am and 6pm and at weekends between 9am and 1.30pm. However, consultant non-resident advice was available at all other times with the consultant being able to return to the hospital within 30 minutes.

**Records**

Patients had individual patient care records in place that were accessible to relevant staff. However, we found some examples of confidentiality breaches and incomplete records such as discharge letters, drug charts and do not attempt cardiopulmonary resuscitation forms.

We looked at 29 sets of patient records, which were multi-disciplinary. Doctors, nurses, therapists and specialities such as the infection prevent and control team contributed to a single document. All admission notes we reviewed were legible and complete. This meant patients received coordinated care with clear and accurate information exchanged between relevant health care professionals.

Most patient records were well maintained although we saw two patient records had loose papers. All patient records were easy to navigate as staff filed them in date order and contained the patient’s details on every page.

Patient medical records were stored in open trolleys at the nursing station, which were in constant sight of staff. This maintained security and prevented unauthorised access of patient records. Computers at nursing station were out of view from patients and visitors to maintain patient confidentiality. However, on Tennyson ward we saw staff left the list of patients on the ward open on the mobile computer and there were scraps of patient identifiable information left on the table by the computer. This meant patient details were visible.
Doctors produced electronic discharge letters when patients were discharged from the wards. Patients received a copy of the discharge letter and an electronic copy was sent to their GP. However, staff in the cardiac care unit reported patients are often discharged without their letters and there were 15 outstanding discharge letters from the past two months. This meant patients and GPs may not have records about their treatment whilst in hospital and their plan for follow up post discharge. The staff reported this incident had been reported formally but managers had taken no action to date.

Staff did not always document the date, time and their designation in the patient records. For example, we saw a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) with no time and medical ward rounds without a time, date, staff designation or bleep number. This is not in line with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. Some staff used stamps to identify themselves within the medical records; however, this practice was not consistent.

All records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received. For example we saw care plans in line with the Royal College of Nursing: Management of Pressure Ulcers: All individuals assessed as having a grade 1-2 pressure ulcer should have a documented positioning and repositioning regime. This meant any healthcare professional reviewing the notes could understand the diagnosis; interventions and treatment the patient needed or had undergone.

Doctors signed and dated test results such as blood tests and electrocardiograms. This indicated to other healthcare professionals, the doctor had reviewed and acted upon the results if necessary.

Patients with mental health disorders had clear management and care plans recorded in their records. For example, when a member of the mental health liaison team reviewed a patient the mental health assessment, care plan and risk assessment was documented and accessible to all staff on the ward. We saw documentation by the mental health liaison included what to do if the patient attempted to discharge him or herself or refused treatment. There were also nursing care plans in place for behaviour.

Data from the trust showed on average there were 80 inpatients living with dementia admitted in the trust at any one time. The electronic patient information system flagged patients living with dementia. Staff also identified these patients by the use of the ‘Butterfly Scheme’ whereby a butterfly sticker is put on their medical records. Staff were aware of the butterfly scheme and told us patients could opt out of the scheme. We saw the butterfly scheme in use during our inspection.

Patients living with dementia did not have clear management or care plans recorded in their records. The trust used ‘This Is Me’ passports. These passports contained information about the individual to help health care professionals met their dementia needs. However, these passports were not completed in the two applicable notes we reviewed and it was not clear if staff had discussed these with the family.

Data from the trust showed on average there were two inpatients with learning disabilities admitted in the trust at any one time. The electronic patient information system flagged patients with a learning disability. Staff also identified these patients by the use of a yellow smiley sticker on their medical records. At the time of our inspection, we did not review any medical records of patients with learning disabilities.

**Medicines**
Overall, the management of medicines was safe. Nursing staff administered medicine in line with best practice and there were effective monitoring systems in place. However, there were some omissions in fridge temperature monitoring.

Pharmacy staff worked seven days a week; Monday to Friday 9am to 5.30pm, Saturday 10am to 3pm and Sunday 10am to 1.30pm. Out of hours, there was a non-resident on-call pharmacy service for advice and supply of urgent medication. Ward staff told us a pharmacist visited the ward daily and carried out drug chart checks to review prescribing practices. The pharmacist marked drug charts following review so other healthcare professionals knew this had occurred. Wards received replenishment of stock medicines on Fridays to avoid low stock levels over the weekend when there was reduced pharmacy support. However, staff told us they did not always receive medicines in a timely manner. On Will Adams ward, a patient was unable to take their blood pressure medicine for three days as this had yet to be dispensed by pharmacy. On the medical infusion unit, a patient could not start their intravenous therapy, as the medicine had not been dispensed by pharmacy, which caused a delay to their treatment. This was not identified as a risk on the acute medicine programme risk register.

All staff kept treatment rooms and medicine cabinets locked at all times. There was restricted access by use of a keypad. Staff chained all medicine trolleys that were not in use to the wall and kept these locked to prevent theft. Registered nurses held keys to the medicine trolleys to enable them to carry out drug rounds.

All medicines we checked during the inspection were in date. Different types of medicine such as tablets and liquid medicines were kept in separate areas within the medicine cabinets.

We reviewed 17 prescription charts and doctors signed and dated all prescriptions. All charts identified if the patient had an allergy and all entries were legible. However, in three of the prescription charts, nurses had not documented a reason for omitted medicines. This meant other staff might not understand the rationale for withholding medicine and cause confusion.

We saw good identification and diagnosis to antimicrobial times. However, when doctors prescribed an antimicrobial, they did not always record the clinical indication or duration of treatment. This was not 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.

Medical gases we checked were in date and were stored securely on the wards. Medical care underwent a clinical audit in July 2017, which found poor compliance to prescribing oxygen standards. It found zero per cent of patients had a fully completed oxygen prescription in their drug chart and 57% per cent of patients had no evidence of an oxygen prescription. Actions from the audit included additional teaching for medical staff and the implementation of posters in clinical areas to raise awareness. We received assurance this had been addressed and was no longer a problem.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Controlled drug cabinets were secured to the wall and staff kept these locked at all times. The nurse in charge held the keys to the controlled drugs cabinet during the shift. This prevented unauthorised access. Staff on all wards completed a controlled drug stock check once a day, normally at night. We looked at one randomly selected page in the controlled drug logbooks of four wards. The stock balances were correct and two people signed each check. This is in line with the Nursing and Midwifery Council Standards for Medicine Management. However, we found one omission of the daily check on Will Adams ward, which we escalated to the ward manager.
We observed the administration of a controlled drug to a patient on Lawrence ward. The nurses appropriately recorded, administered and disposed of the controlled drug. This included checking the patient details on their wristband against the details on the drug chart and their allergy status before administration. This was in line with the Nursing and Midwifery Council Standards for Medicine Management.

Each ward had a drug fridge. Staff checked the temperature of the drug fridge once a day to ensure medicine was stored at the correct temperature. We checked the fridge temperature records for March 2018 in three areas. We found no omissions in the medical infusion unit, two omissions on Milton ward and four omissions on Lawrence ward. This meant staff did not have assurance on these days that the medicines in the fridge were stored at the correct temperature and fit for use.

Ward management displayed patient safety alerts from the trust or the Medicines and Healthcare Products Regulatory Agency within treatment rooms. For example, in Lawrence ward we saw a patient safety alert dated November 2017 regarding a never event relating to insulin administration. This demonstrated shared learning of medicines mismanagement.

The medicine management group met monthly and discussed patient safety alerts, policies, audits and medicine incidents. We saw the meeting minutes for September, October and November 2017, which showed these items on a standard agenda.

The pharmacy team carried out trust wide medicines management audits in February, May and August 2017. Areas of the audit, which had declined in August 2017, included clinical room doors kept locked, locks for secure areas changed in the last 3 months, expired medicines found in clinical areas and fridge storage issues such as unlocked doors. Areas of the audit, which had improved in August 2017, included fridge and room temperature monitoring and action taken in the event of temperature excursions. The pharmacy team discussed the results of these audits with the nurse in charge and actions agreed to address any issues identified. The pharmacy team planned to re-audit the clinical areas in March 2018.

**Incidents**

Staff had a good awareness of incident reporting. The trust investigated incidents effectively and we saw evidence of shared learning from incidents. All staff had access to the electronic incident reporting system and understood their responsibility to report concerns. However, staff told us completing the incident report form was time consuming and complicated.

We reviewed 10 incidents reported by medical care services; this consisted of seven incidents resulting in no harm, two incidents resulting in low harm and one incident resulting in severe harm. Staff took appropriate initial actions to manage incidents such as falls. Specialists took part in the investigation phase, for example, the falls prevention team investigated falls and the tissue viability nurses investigated pressure ulcers.

The incident review group for the trust reviewed all incidents resulting in severe harm. There was clear documentation of learning from all incidents and application of the duty of candour. Regulation 20 of the Health and Social Care Act 2008 sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

The trust had a duty of candour policy, procedure and guidance in place which clearly outlined the key responsibility for staff. Between January and December 2017, 31 incidents triggered the application of the duty of candour. Compliance with the duty of candour was captured within the
electronic incident reporting system and the directorate governance manager ensured this was recorded.

We saw correct reporting of pressure ulcer and falls, in line with the Royal College of Nursing: Management of Pressure Ulcers: All pressure ulcers grade 2 and above should be documented as a local clinical incident.

In Tennyson ward, staff reported they discussed learning from incidents at team meetings. For example, at last week’s meeting they decided to implement a new pressure area care plan following learning from a root cause analysis (RCA). An RCA is a method of problem solving used for identifying the root causes of faults or problems.

In Will Adams ward, staff discussed learning from incidents at the board meeting. The ward had recently raised two incidents about failed discharges. The multidisciplinary team discussed the incidents and learning from the investigations to prevent another failed discharge.

In Harvey ward, staff told us they reported staffing levels as incidents when they were short staffed. They received feedback from incidents at daily safety huddles, handover and at team meetings.

In Milton ward, staff reported incidents electronically but often escalated them to the site lead. The matrons disseminated themes of incidents through the ‘Big Four Safety Message’, which the matron wrote weekly.

In Lawrence ward, we observed staff complete an incident form following a board ward in which staff identified a failed discharge. During the ward round, a patient escalated concerns regarding delays in care yesterday and the doctor apologised. This demonstrated staff applied the duty of candour.

In the endoscopy suite, the team had a communications folder to aid shared learning from incidents. The senior sister wrote briefings to the team, which outlined the incident and any learning. Staff signed the briefing to say they had read it. For example, we saw endoscopy briefings on an incident involving total parenteral nutrition in place (a method of feeding that bypasses the gastrointestinal tract) and an incident involving a delayed discharge in relation to pressure area care. The senior sister also wrote up briefings following the sisters meeting which enabled endoscopy staff to learn from trust wide incidents. Management in endoscopy encouraged staff to report incidents and staff felt supported to do so, which demonstrated an open culture.

In the cardiac care suite, nursing staff were more familiar with reporting incidents on the electronic system than medical staff. Although staff received feedback from incidents at monthly team meetings or through email, they felt the quality of the responses from senior management were poor. Staff felt management did not investigate incidents fully and gave examples of reported concerns, which had not been resolved.

There were monthly mortality and morbidity meetings held by the ‘Mortality and Morbidity Group’ these were well attended by a multidisciplinary team including representatives from the medicine directorate. We reviewed minutes of these meetings between January and November 2017 and saw they reviewed the learning from deaths action plan, current mortality data and mortality outliners.

Staff also received weekly themed safety bulletins circulated by the medical director and chief nurse, which included learning from incidents in the "Theme of the week".

**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 January 2017 to December 2017, the trust reported no incidents classified as never events for medicine.

Source: NHS Improvement - STEIS (01/01/2017 - 31/12/2017)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 46 serious incidents (SIs) in medicine, which met the reporting criteria set by NHS England from January 2017 to December 2017.

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

- Pressure ulcer meeting SI criteria with 10 (23% of total incidents).
- Slips/trips/falls meeting SI criteria with 10 (23% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with eight (17% of total incidents).
- HCAI/Infection control incident meeting SI criteria with six (13% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Since the last inspection, the trust had introduced multidisciplinary serious incident patient case reviews led by a consultant or a senior nurse according to the nature of the serious incident. The trust also held ‘swarm’ events to discuss themes of serious incidents if there was multiple serious incidents from a single cause such as falls resulting in harm.

Safety thermometer

We observed ‘green cross’ charts displayed in the sister’s office in Lawrence ward and in the corridor in Will Adams ward. These displayed current ‘safety thermometer’ information about key indicators such as falls and staffing levels. We did not see these charts displayed in other areas. This meant relatives and visitors to the hospital would not understand what the trust was monitoring and how each ward was performing against the targets set by the trust.
We saw the performance review scorecard for November 2017. It showed the trust target and actual compliance to seven metrics for each area. We saw all areas were meeting compliance with three out of seven metrics. These were proportion of harm free care (new harms), pressure ulcers grade three and four and ratio of actual to planned nursing hours.

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

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

Data from the Patient Safety Thermometer showed that the trust reported 21 new pressure ulcers, five falls with harm and 13 new urinary tracts infections in patients with a catheter (CUTIs) from December 2016 to December 2017 for medical services.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Medway NHS Foundation Trust**

- **Total Pressure ulcers (21)**
- **Total Falls (5)**
- **Total CUTIs (13)**

Trends over time were generally similar over time with an occasional increase in all three harm types, however due to the small numbers involved this does not necessarily reflect poor patient care.

*Source: Safety thermometer - Safety Thermometer*

**Is the service effective?**
Evidence-based care and treatment

Staff assessed the patient’s physical, mental health and social needs holistically. Overall, staff provided care, treatment and support in line with evidence-based guidance.

The trust received and reviewed all guidelines from the National Institute for Health and Care Excellence (NICE). Nominated clinical leads reviewed the guidelines and assessed the compliance level within their areas. Each directorate developed and monitored action plans to meet the guidance and scheduled audits to assess the level of compliance.

The minutes from various departmental and directorate-wide meetings showed that staff discussed clinical guidance, audit outcomes and developed plans to address any issues.

The service audited staff compliance with trust policies in several areas and reported the results at team meetings and through staff email. Nurses told us they participated in regular audits such as the hand hygiene audit, care plan audits and medicines management audits.

Medical staff on Will Adams ward told us they had participated in an audit to review the treatment and preventative treatment of spontaneous bacterial peritonitis (SBP). This is an acute bacterial infection of fluid within the abdomen. Staff told us they presented the outcomes and shared the learning to improve practice.

All adult inpatient services audited 10 patient notes monthly to monitor compliance with completing the National Early Warning System, a system used to identify acutely ill patients. Data provided by the trust showed between January and November 2017, inpatient service exceeded the trust target of 95%. Audit results were discussed at the Nursing and Midwifery Quality forum. All 18 patient records we reviewed showed evidence of regular observations. For example, pulse, blood pressure and temperature to monitor the patient’s health. We saw staff had completed all observations in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.

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

The trust had adopted the UK Sepsis Trust’s ‘sepsis six bundle’. This bundle provides clear guidance on sepsis management to reduce the risk of patient death from sepsis. Staff had good awareness of the bundle and we saw evidence of its use in practice. This demonstrated staff delivered evidence base care in relation to sepsis management.

The trust had adopted the Royal College of Physicians, ‘The Falls Safe care bundles’. These bundles identify interventions to take to reduce the risk of falls and intervention to take following a fall. Staff had good awareness of the bundle and we saw evidence of its use in practice. This demonstrated staff delivered evidence base care in relation to falls management.

Staff in the endoscopy unit carried out evidence based care in line with guidelines from the British Society of Gastroenterology. Staff were familiar with the guidelines and we saw documents within the unit displaying these. The service had achieved Joint Advisory Group on Endoscopy (JAG) accreditation in October 2017.

Doctors had access to an electronic ‘Medway green book’ app, which encompassed trust protocols for the management of common conditions for example sepsis. It also gave reference to best practice and most recent guidelines available. Staff reported this was extremely useful and they could access it remotely on their mobile phones.
All staff had access to policies and standard operating procedures on the trust intranet system. Staff demonstrated how the accessed the system. However, we saw some policies were out of date and staff found it difficult to know which the most up to date policy was. This meant staff might not access the correct policy.

In the cardiac care unit we saw protocols on anticoagulation for patients requiring a procedure were based on consultant preference. For example, different consultants accepted different international normalized ratio (INR) ranges for cardiac procedures. This is a measurement of how thin the blood is and doctors use this number to predict a patient’s risk of blood clots. This meant the protocols were not standardised and staff reported this had led to cancelled procedures. This meant staff did not always provide care that was in line with best practice guidelines.

**Nutrition and hydration**

Staff identified and monitored the nutritional and hydration needs of patients; however, we saw examples where staff failed to meet these needs.

Nursing staff completed nutritional risk assessments when patients were admitted to hospital in line with National Institute for Health and Care Excellence, QS24 statement 1: Screening for the risk of malnutrition. Risk assessments included a malnutrition universal screening tool. The Malnutrition Universal Screening Tool 'MUST' is a validated nutritional screening tool and is the most commonly used tool throughout the UK. It is a simple five-step tool designed to identify adults at risk of malnutrition and to categorise them as being at low, medium or high risk. Sixteen out of 18 patient records we checked showed completed malnutrition universal screening tool scores.

Patients at risk of malnutrition or dehydration had a nutritional care plan in place, which consisted of food or fluid balance charts. Although, we saw completed food charts, there were incomplete fluid charts. This meant it was not always possible to assess the patient’s hydration status. Overall, patients were not complimentary about the food provision on the wards. One patient said, ‘the food is not great, they are like school dinners.’ Another patient said, “The portions are small and I think I am losing weight.”

Patients who required a special diet, such as a puree meal, had a sign above their bed. This displayed instructions from the speech and language therapists on how to assist the patient to eat or drink.

However, during our inspection we observed one patient on Will Adams ward calling for a drink of water for 10 minutes. This demonstrated the staff did not always meet the needs of the patient, which could lead to dehydration. We escalated this to the nursing staff who assisted the patient.

One patient on Keats ward reported he was nil by mouth for a scan and had diabetes. He did not have breakfast, and then moved wards, which meant he missed lunch on both wards. Another patient told us he did not receive the cooked breakfasts prescribed by the dietician. This demonstrated poor management of these patients' nutritional needs.

**Pain relief**

Nursing staff assessed pain at set intervals to check if they were comfortable and recorded this on the ‘rounding’ sheets. In addition, pain was assessed as part of the patient’s four hourly observations. We saw staff asked patients to rate their pain on a scale of one to 10. One meant no pain and 10 represented extreme pain. On all records we reviewed, each patient had a recorded level of pain.

Staff asked patients about their pain and the effectiveness of the current pain management therapy such as medication. Where the pain management was ineffective, we observed doctors
offer the patient alternative options. One patient told us, “yesterday I had a procedure with a camera down my throat which was quite sore but as soon as I got back to the ward they fetched me some ice cream which helped.”

Patients reported pain management was good. One patient said, “they try their best with my pain and if I ask I can have my pain relief 20 minutes earlier.” Another patient said, “if I need any pain relief in between drug rounds, I just push my buzzer and the nurse will bring me some”.

**Patient outcomes**

**Relative risk of readmission**

**Medway Maritime Hospital**

From October 2016 to September 2017, all patients at the Medway Maritime Hospital had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England average.

Two out of the top three elective specialties (based on count of activity) had a higher than expected risk of readmission (gastroenterology and clinical haematology) whilst medical oncology had a lower than expected readmission when compared to the England average.

Two out of the top three non-elective specialties (based on count of activity) had a higher than expected risk of readmission (general medicine and cardiology) whilst geriatric medicine had a lower than expected readmission when compared to the England average.

**Elective Admissions - Medway Maritime Hospital**

![Elective Admissions Chart]

*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 - Medway Maritime Hospital**

![Non-Elective Admissions Chart]

*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.*
Sentinel Stroke National Audit Programme (SSNAP)

Medway NHS Foundation Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade D in latest audit, April to June 2017. For the same time period 12 months previously (April to June 2016) the trust also achieved grade D.

Medway Maritime Hospital

The stroke unit employed a stroke analyst in 2018. They audited patient notes and inputted data to the Sentinel Stroke National Audit Programme (SSNAP). The analyst reviewed the data and produced a report, which he disseminated. The analyst reported having real time data; this meant staff could implement changes to practice to improve real time patient outcomes. This had led to a working group who planned to develop stroke specific care plans.

In addition to this, the trust appointed a consultant geriatrician in January 2018 in order to address the poor compliance with a seven-day consultant led service particularly out of hours. The consultant is part of the stroke clinical review group, the stroke board for Kent and Medway and the sustainability and transformation partnership.

Heart Failure Audit

In the 2015/16 National Heart Failure Audit the trust had a case ascertainment rate of 85%, which was the same as the national aggregate.

(Source: Royal College of Physicians London, SSNAP audit)
The trust scored better than the national aggregate (England and Wales) for all of the following five key metrics:

- Crude proportion of inpatients admitted with Heart Failure (HF) who receive input from the specialist team - Trust: 98.2%; National: 79.0%.
- Crude proportion of inpatients admitted with HF who receive cardiology follow up – Trust: 53.4%; National: 47.2%.
- Crude proportion of patients with HF with reduced fraction who are discharged from hospital on an ACEI/ARB – Trust: 99.5%; National: 73.7%.
- Crude proportion of patients with HF with reduced fraction who are discharged from hospital on a beta-blocker – Trust: 100.0%; National: 52.0%.
- Crude proportion of patients with HF with reduced fraction who are discharged from hospital on a Mineralocorticoid receptor antagonist (MRA) – Trust: 97.9%; National: 45.4%.

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

National Diabetes Inpatient Audit

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

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

The 2017 National Diabetes Inpatient Audit identified 92 inpatients with diabetes at Medway Maritime Hospital. 89.0% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile 3. Previously, in 2016, the trust had scored in quartile 1 when compared nationally for this metric with 76.5% of patients with diabetes reporting that they were satisfied or very satisfied with the overall care of their diabetes while in hospital.

In the 2017 audit the trust performed in quartile 1 for four metrics:
- Prescription errors - Trust: 9.0%; England: 19.0%.
- Insulin errors: Trust - 11.9%; England: 18.6%.
- Percentage minor hypo - Trust: 11.4%; England: 16.7%.
- Meals timing - Trust: 50.6%; England: 62.6%.

The trust performed in quartile 4 for the following three metrics:
- Percentage management of diabetes – Trust: 12.0%; England: 8.3%.
- Admitted with foot disease – Trust: 14.8%; England: 9.1%.
- Foot risk assessment after 24 hours only – Trust: 21.4%; England: 9.6%.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

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

From April 2014 to March 2015, 39.6% of nSTEMI patients were admitted to a cardiac unit or ward at Medway Maritime Hospital compared to an England average of 55%. 92.8% of nSTEMI
patients were seen by a cardiologist or member of the team compared to an England average of 95.1%.

The proportion of nSTEMI patients who were referred for or had angiography at Medway Maritime Hospital was 97.2% compared to an England average of 79%.

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

National Lung Cancer Audit

The trust participated in the 2017 National Lung Cancer Audit and the proportion of patients seen by a cancer nurse specialist was 79.0% which, did not meet the national aspirational standard of 90%. The 2016 audit figure was 84.3%

The case mix adjusted one year relative survival rate was 39.2% which was within the expected range compared to other hospitals.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 19.4%, which was within the expected range when compared to other hospitals.

The proportion of fit patients with advanced NSCLC receiving systemic anti-cancer treatment was 54.0%, which was within the expected range when compared to other hospitals. This did not meet the national aspirational standard of 60%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 62.2%, which was within the expected range when compared to other hospitals. This did not meet the national aspirational standard of 70%.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

In the 2017 National Audit of Patient Falls the crude proportion of patients who had a vision assessment (if applicable) was 86%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 17%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 24%.

The crude proportion of patients with a call bell in reach (if applicable) was 81%.

None of these four metrics above met the national aspirational standard of 100%.

(Source: Royal College of Physicians)
Competent staff

Local management used the Medway online learning environment system to view and complete appraisals. The system enabled management to see when a staff member was due their appraisal. Nursing staff told us there was a shared approach to the appraisal process whereby band seven nurses carried out the appraisal for band six nurses, band six nurses carried out the appraisal for band five nurses and band five nurses carried out the appraisals for band four to two. Staff received training in the appraisal process if they undertook this responsibility. Staff we spoke with felt appraisals were in depth and beneficial. All consultants had a named appraiser who undertook their annual appraisals for revalidation. Qualified doctors had an educational/clinical supervisor who provided support and completed annual appraisals for revalidation.

Appraisal rates

From April 2017 to December 2017 80.9% of staff within medical care at the trust had received an appraisal compared to a trust target of 85%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target (%)</th>
<th>Appraisal completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>142</td>
<td>127</td>
<td>85%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>287</td>
<td>235</td>
<td>85%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>322</td>
<td>261</td>
<td>85%</td>
<td>81.1%</td>
</tr>
<tr>
<td>Other Non-Medical Staff</td>
<td>145</td>
<td>105</td>
<td>85%</td>
<td>72.4%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>21</td>
<td>15</td>
<td>85%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>3</td>
<td>1</td>
<td>85%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

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

An update from the trust showed the compliance rate for appraisals at March 2018, was 82% for the unplanned and integrated care directorate. This remained below the trust target of 85%.

All nursing staff attended a five-day clinical induction. This induction included practical and clinical teaching in topics such as pain management, discharge planning, handover and medicines management. Permanent and temporary nurses who worked at the trust received a 120-page induction pack, which contained competencies, summaries of policies, examples of good record keeping, common care plans and pathways. All locum doctors received a 75-page induction pack, which contained instructions for using the electronic systems, antimicrobial prescribing guidelines, fire safety and a staff handover checklist.

All staff completed a local induction checklist which included topics such as orientation to the area, how to use the bleep system and hand hygiene. The nurse in charge undertook this responsibility for nursing staff and medical staff received a handover from the previous doctor when they moved to a new area. However, junior doctors reported they had been on-call on the first day of their new placement with very little induction, which led to them covering more wards than necessary.

Nurses we spoke with reported they had good training opportunities to develop their skills and felt well supported by local management. For example, every year two nurses on Lawrence ward had the opportunity to undertake a funded chemotherapy course. Care support workers told us they
did not have any specialist training opportunities available to them but felt their line manager would grant them study leave to attend external courses.

There was no formal clinical supervision undertaken by nursing staff. However, nursing staff told us they received good support from their line manager and were encouraged to apply for promotions.

A range of specialist nurses supported the ward. For example, tissue viability nurses, the falls prevention team, safeguarding leads, diabetes care team and discharge co-ordinators. These teams had implemented new innovative ways of delivering teaching, which included bringing the teaching sessions to the ward. The specialist nurses swapped with the ward based staff to allow each one to attend training.

Medical care departments had several volunteers recruited in the role of ‘Dementia Buddies’. A volunteer told us they undertook specialist dementia training to carry out the role.

Doctors in training had a clinical supervisor to support their learning. The supervisor escalated any concerns to the college tutor and put an action plan in place. Trainee doctors told us their clinical supervisor was easily accessible and were on site three times a year.

Junior doctors and associate practitioners told us the medical team were supportive. Consultants or registrars often taught them aspects of medical care during the ward rounds. There was protected teaching time once a week for junior doctors; however, junior doctors we spoke with were often unable to attend due to their workload.

We observed that staff were professional and competent in their interactions with colleagues, patients and their relatives/carers during our inspection.

**Multidisciplinary working**

All patients received prompt screening by a multi-disciplinary team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multidisciplinary team assessment was undertaken and care plans established at the point of admission.

There were nurse led daily multidisciplinary board rounds where the team discussed each patient in turn. We observed these meetings during the inspection and found them to be comprehensive, well attended and each member of contributed to the discussions. However, staff did not follow the standard operating procedure for board rounds, as there was not a standardised approach across the departments.

The trust had an integrated discharge team that attended the multidisciplinary board rounds and took care of many practical aspects of discharge including liaising with family members, chasing care packages and working with social services. Staff felt the team provided good support and facilitated discharges well.

There were daily consultant led ward rounds whereby the consultant, medical staff, nurse in charge and pharmacist reviewed each patient. We observed excellent clinical assessments and the team had a high level of clinical knowledge.

We observed nursing handovers during our inspection and saw staff handed over psychological and emotional needs of patients and their relatives. This included poor quality of sleep, emotional state and behaviour.

The department had a ‘Hospital at Home’ service. This enabled patients who still required medical treatment to go home. For example patients who require intravenous antibiotics. Staff told us the team would proactively identify patients for this service.
We observed examples of good multidisciplinary working. This included effective working relations with speciality doctors, nurses, therapists, specialist nurses and general practitioners. Medical and nursing staff and care support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care. However, some medical staff reported frustrations with having high levels of medical outliers, as they were sometimes unable to review every medical outlier, which left many jobs for the ward staff to do. Outliers are patients admitted to wards outside of their speciality.

Medical, nursing and therapy staff of all grades described the good working relationships between staff and other directorates. In particular, staff reported a good relationship with the neurological and palliative care teams who often came the same day as the referral to review patients.

Clinical staff and therapists used integrated patient records. This improved communication and meant that care was better co-ordinated between healthcare professionals.

Seven-day services

In March 2017, the trust carried out an audit to review their compliance to the NHS seven days a week priority standards. Standard two states a consultant should assess newly admitted patients within 14 hours of arrival to the hospital. The audit showed a compliance rate of 58%. This was worse than the national average.

Standard five states inpatients must have seven-day access to diagnostic imaging services. The audit showed the trust provided this for all but two services; echocardiography and magnetic resonance imaging, which were not available at weekends.

Standard six states inpatients must receive a consultant review every 24 hours. The audit showed the trust met this standard in all specialities.

Standard eight states a consultant must review all patients on ambulatory care units twice a day. The audit results showed a compliance rate of 73%. This was better than the national average during weekdays but worse than the national average for weekends.

All inpatients had a daily review from a clinician, seven days a week. On Fridays, the medical team completed a weekend handover proforma, which outlined the plan of care for the patient over the weekend. Staff reported this worked well in practice and helped continuity of care for the patient.

The service had access to on-call physiotherapy services at weekends. There was also an on-call pharmacist available to provide pharmacy support in the evenings and at weekends. The hospital's diagnostic imaging department provided a 24-hour, seven-day on-call service.

The endoscopy suite offered a six-day service, Monday to Saturday 8.30am to 6.30pm. Staff reported they had recently introduced a regular Saturday service, which helped to keep waiting lists down.

The medical infusion unit offered a five-day service, Monday to Friday 8am to 6pm. Staff reported these hours matched the current demand for patient treatment.

The hospital had access to a psychiatric liaison service 24 hours a day, seven days a week.

Health promotion

The trust had a palliative care team working across the hospital. The team were able to complete fast track continuing healthcare checklist assessments and support families to find placements alongside the integrated discharge team.
We saw staff encouraged patient independence. Occupational health and physiotherapists worked with patients and discussed progress with fellow staff members. If patients were worsening, the therapy team raised this at the daily multidisciplinary board round.

The service supported patients to live healthier lives. For example, eating a healthier diet and smoking cessation. We observed staff discussing exercise regimes and dietary options with patients, and providing information on external agencies who could support patients who wish to stop smoking. We saw a variety of patient information leaflets were available throughout the wards we visited, for example, smoking cessation, support for living independently at home and nutrition.

**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 with a mental disorder and those who lacked the capacity to make decisions about their care.

The trust had a consent policy in place, which was overdue for review (February 2018). The policy was based on guidance issued by the Department of Health. This included information for staff on obtaining valid consent, consent flowcharts and links to consent forms.

Although staff demonstrated a good understanding of the legislation and best practice regarding consent, they did not always follow this in practice. We observed two occasions where consultants examined patients without first explaining their intentions to the patient and gaining their consent first.

Staff told us they gained patient consent before they contacted the patient’s general practitioner to gather further information. We observed a consultant gain consent from the patient to discuss their medical needs in front of the family members that were visiting.

Staff demonstrated a good understanding of the mental capacity act. Staff we spoke with were clear about how to assess a patient who lacked capacity. We observed a doctor complete a capacity assessment for a patient during the ward round and saw completed capacity assessments in patient records.

Between January and December 2017, medical care had made 50 deprivation of liberty safeguards applications to the local authority, of which only one had received approval at the time of inspection. Deprivation of liberty safeguards are part of the Mental Capacity Act 2005. The safeguards aim to make sure that patients are looked after in a way that does not inappropriately restrict their freedom. Staff recognised when patients who lacked mental capacity were deprived of their liberty. We observed the multidisciplinary team discuss deprivation of liberty safeguards during board rounds and saw completed applications in patient records. However, one urgent deprivation of liberty safeguards had breached its seven days application. We escalated this to the nurse in charge, who reported the trust safeguarding team had granted an extension until discharge. There was no documentation in the patient records to demonstrate any conversations between the safeguarding team and the local authority.

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

The trust provides training in mental capacity act (MCA) level 2 which includes MCA training and deprivation of liberty safeguards (DoLS) training. The trust reported that from April 2017 to December 2017 MCA training has been completed by 66.0% of staff within medical care.

A breakdown by nursing and medical staff is shown in the table below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental - hospital</td>
<td>68</td>
<td>170</td>
<td>40%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery</td>
<td>255</td>
<td>321</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

**Is the service caring?**

**Compassionate care**

Staff took the time to interact with patients and their relatives in a respectful and considerate way. We observed all members of the multi-disciplinary team had a good bedside manner and welcomed patients and their relatives to ask questions. This included catering staff who allowed patients time to make their menu choices. One patient told us how staff took the trouble to come and say goodnight. Although, two patients told us the staff were stretched so did not have time to chat, another patient said staff felt frustrated but they did not share this with patients.

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

Nursing staff carried out care rounds every two hours. During these rounds, staff asked patients about their levels of comfort and whether they wanted anything such as a drink or pain relief. This ensured all patients received care and attention at regular intervals.

In all areas we visited, we saw thank you cards from patients displayed. One card on Will Adams read, ‘you showed real care and compassion to her in her last few weeks and empathy to her family’. Another on the stroke unit read, ‘you are all a credit to the NHS’

We spoke with 12 patients and three visitors during our inspection. Overall, patients stated they felt safe in hospital. Some patients reported, ‘they are like family, they are really caring’ and ‘they’re been so good I’ve got to know everybody’. We asked patients for examples of excellent care. One patient told us a member of staff had cheered him up by participating in some Irish dancing together. Another patient told us staff were ‘as gentle as can be when changing her dressings’.

Staff did not always respond in a compassionate and timely way when patients experienced pain, discomfort or distress. We observed staff on Will Adams ward respond to patients that were confused and frightened. One patient stated she was scared and we heard the care support worker say, ‘do not worry I am looking after you and I will make sure you are safe’. However, another patient called out for assistance for 10 minutes and no staff went to reassure the patient. We observed medical staff speaking very loudly and asking leading questions to a patient living with dementia.

There were inconsistent practices to maintain patient’s privacy and dignity. Most staff drew the curtains around the patient’s bed space when undertaking physical examinations or when the patient was exposed. However, we observed on two occasions on Will Adams ward where staff
did not fully close the curtain to maintain the patient’s privacy, once when the doctor examined a patient’s abdomen and once when a patient used the commode.

Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 22%, which was worse than the England average of 25% from December 2016 to November 2017.

Friends and family test – Medicine wards response¹ (% recommended) from 01/12/2016 to 30/11/2017.

<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>
</tr>
</thead>
<tbody>
<tr>
<td>BRONTE</td>
<td>127</td>
<td>22%</td>
<td>91%</td>
<td>100%</td>
<td>63%</td>
<td>100%</td>
<td>92%</td>
<td>94%</td>
<td>92%</td>
<td>75%</td>
<td>100%</td>
<td>87%</td>
<td>90%</td>
<td>100%</td>
<td>91%</td>
</tr>
<tr>
<td>Dickens</td>
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<td>22%</td>
<td>88%</td>
<td>89%</td>
<td>79%</td>
<td>61%</td>
<td>75%</td>
<td>93%</td>
<td>60%</td>
<td>81%</td>
<td>77%</td>
<td>92%</td>
<td>92%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Harvey</td>
<td>126</td>
<td>22%</td>
<td>75%</td>
<td>71%</td>
<td>57%</td>
<td>90%</td>
<td>75%</td>
<td>81%</td>
<td>83%</td>
<td>75%</td>
<td>81%</td>
<td>86%</td>
<td>89%</td>
<td>75%</td>
<td>79%</td>
</tr>
<tr>
<td>Keats</td>
<td>157</td>
<td>20%</td>
<td>56%</td>
<td>83%</td>
<td>74%</td>
<td>71%</td>
<td>70%</td>
<td>75%</td>
<td>67%</td>
<td>70%</td>
<td>56%</td>
<td>54%</td>
<td>73%</td>
<td>53%</td>
<td>67%</td>
</tr>
<tr>
<td>LAWRENCE</td>
<td>144</td>
<td>21%</td>
<td>88%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
<td>78%</td>
<td>96%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lister</td>
<td>943</td>
<td>22%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LISTER ASSESSMENT CENTRE</td>
<td>475</td>
<td>25%</td>
<td>89%</td>
<td>87%</td>
<td>88%</td>
<td>84%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>NELSON</td>
<td>248</td>
<td>29%</td>
<td>93%</td>
<td>82%</td>
<td>85%</td>
<td>92%</td>
<td>92%</td>
<td>94%</td>
<td>82%</td>
<td>83%</td>
<td>100%</td>
<td>91%</td>
<td>100%</td>
<td>79%</td>
<td>90%</td>
</tr>
<tr>
<td>Surgical Assessment Unit</td>
<td>542</td>
<td>19%</td>
<td>85%</td>
<td>67%</td>
<td>79%</td>
<td>72%</td>
<td>77%</td>
<td>81%</td>
<td>66%</td>
<td>78%</td>
<td>67%</td>
<td>54%</td>
<td>67%</td>
<td>81%</td>
<td>72%</td>
</tr>
<tr>
<td>VICTORY</td>
<td>161</td>
<td>25%</td>
<td>57%</td>
<td></td>
<td>20%</td>
<td></td>
<td>78%</td>
<td>89%</td>
<td>87%</td>
<td>90%</td>
<td>90%</td>
<td>100%</td>
<td>93%</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>WAKELEY</td>
<td>274</td>
<td>22%</td>
<td>67%</td>
<td>79%</td>
<td>86%</td>
<td>84%</td>
<td>92%</td>
<td>64%</td>
<td>84%</td>
<td>80%</td>
<td>90%</td>
<td>80%</td>
<td>85%</td>
<td>94%</td>
<td>82%</td>
</tr>
<tr>
<td>WILL ADAMS</td>
<td>136</td>
<td>18%</td>
<td>55%</td>
<td>56%</td>
<td>86%</td>
<td>58%</td>
<td>82%</td>
<td>82%</td>
<td>60%</td>
<td>88%</td>
<td>75%</td>
<td>50%</td>
<td>83%</td>
<td>92%</td>
<td>74%</td>
</tr>
</tbody>
</table>

¹ Data only includes wards with total responses above 100; Top 12 wards shown per site.

The highest response rate was on Nelson ward with 29% of patients responding to the FFT survey. Will Adams ward had the lowest response rate at 18%. Lawrence ward had the highest overall scores with the recommend rate being 90% or more in 10 out of the 12 reported months. Trends on most other wards varied on a monthly basis, however generally lower scores were recorded for Keats ward.

Note that the 0% figures recorded for Lister ward and the Lister assessment centre are due to a change in the name of the ward in April 2017.

(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.

We saw examples of thank you notes and cards written to staff from patients expressing their gratitude and some wards displayed these.

The trust provided monthly "carers' coffee breaks" in the hospital canteen. The purpose of the carers' coffee breaks was to provide emotional support to the relatives and carers of patients living with dementia. We saw details of the coffee breaks advertised to carers of patients on Will Adams Ward.

A patient we spoke with provided examples of when staff had provided emotional support. One patient told us, “the last couple of days I have been quite tearful and they have dealt with that really well and been very compassionate”. Another patient told us, “I'm very independent, I was
really embarrassed the other day when I needed help on the commode the nurse gave me a cuddle and put me at ease.”

The trust provided a 24 hour on call chaplaincy service, which patients and relatives could access. The chaplaincy team and switchboard held a contact list of representatives of all major faith groups.

**Understanding and involvement of patients and those close to them**

Staff took into account patients’ preferences for sharing information with their families. We observed doctors obtain the patients permission to discuss their treatment with their relatives. This is line with the National Institute for Health and Care Excellence quality statement 13. Consultants offered to speak with patient relatives if there was bad news and we saw staff did this using the quiet dayrooms on the wards.

The trust undertook a patient survey in the cardiac care unit, which showed 100% of relatives of patients, stated they were able to speak to a nurse whenever they wanted to, and 95% felt able to share any worries that they had.

Staff had facilitated two weddings on the wards. Staff decorated the day room with flowers and staff invited the patient’s relatives to attend the celebrations.

The trust had implemented the ‘John’s Campaign’ which allowed open visiting day and night for carers of patients living with dementia. All carers were provided with a ‘carer’s passport’ which upon showing to the ward staff allowed them to stay outside of visiting hours.

In the trust’s end of life care survey 2017, 90% of respondents felt that they and other family members were kept informed of the patient’s condition and 56% of respondents reported that they were offered the services of the hospital chaplaincy. This demonstrated staff involved relatives in the patients care and recognised their need for support.

**Is the service responsive?**

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

The hospital had an Ambulatory Care Unit, which opened seven days a week from 8am to 10pm Monday to Friday and 8am until 6pm at weekends. The aim of this service was to expedite care through the emergency department and to help to reduce the number of patients who were admitted into general wards. Staff reported it received 40 patient referrals a day, however only about 10% of patients seen in the ambulatory care unit were admitted.

**Average length of stay**

**Trust Level**

From November 2016 to October 2017 the average length of stay for medical elective patients at the trust was 4.2 days, which was lower than the England average of 5.8 days. For medical non-elective patients, the average length of stay was 6.3 days, which was similar to the England average of 6.5 days.

Two out of the top three elective specialties (based on count of activity) had a similar length of stay compared to the England average (cardiology and respiratory physiology) whilst clinical haematology had a lower length of stay compared to the England average.
Two out of the top three non-elective specialties (based on count of activity) had a higher length of stay compared to the England average (geriatric medicine and cardiology) whilst general medicine had a similar length of stay compared to the England average.

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

![Elective Average Length of Stay Chart]

*Note: Top three specialties for specific trust based on count of activity.*

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

![Non-Elective Average Length of Stay Chart]

*Note: Top three specialties for specific trust based on count of activity.*

**Medway Maritime Hospital**

From November 2016 to October 2017 the average length of stay for medical elective patients at Medway Maritime Hospital was 4.2 days, which was lower than England average of 5.8 days. For medical non-elective patients, the average length of stay was 6.3 days, which was similar to the England average of 6.5 days.

Two out of the top three elective specialties (based on count of activity) had a similar length of stay compared to the England average (cardiology and respiratory physiology) whilst clinical haematology had a lower length of stay compared to the England average.

Two out of the top three non-elective specialties (based on count of activity) had a higher length of stay compared to the England average (geriatric medicine and cardiology) whilst general medicine had a similar length of stay compared to the England average.

**Elective Average Length of Stay - Medway Maritime Hospital**

![Elective Average Length of Stay Chart - Medway Maritime Hospital]

*Note: Top three specialties for specific trust based on count of activity.*
Meeting people’s individual needs

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 available in different languages. Staff told us that an interpreter service was available for those patients who needed assistance. In 2017, 99% of all interpretation and translation requests were fulfilled.

In 2017, the trust admitted 2250 patients living with dementia. There were systems in place to aid the delivery of care to patients living with dementia. The trust had a dementia and delirium specialist nursing team which staff could refer to either by phone, bleep or in person. The team assessed patients and liaised with local community services and the patient’s relatives. On discharge, staff referred these patients to community memory services if appropriate. The service used volunteers as ‘dementia buddies’ and had open visiting times for patient carers. Staff gave carers ‘This is me’ documents to fill in about the person they care for to enable staff to provide individualised care. The dementia and delirium team provided ‘twiddle muffs’ to dementia patients in order to help with agitation or restless fingers. The trust was in the bottom quartile for performance in six of the seven key performance indicators in the 2017 National dementia Audit. The trust told us the dementia clinical nurse specialist led on the actions to address the recommendations.

Overall, patients thought staff offered them enough drinks throughout the day and some wards, such as Lawrence ward, offered drinks to visitors. One patient said, ‘they come round to ask if I would like a cup of tea’. Another patient said, ‘the drinks trolley is brought round three or four times a day but I can ask if I want an extra drink’. One patient said, ‘I have my own cup-a-soup and it’s no trouble for them to go and make it for up me’.

The wards had protected mealtimes, staff invited relatives or friends of patients requiring help with eating to support their loved ones during this time. Catering staff served the food on red trays for patients who required assistance when eating. Staff reported they served these patients last so their food did not get cold while they waited for assistance.

In 2017, the trust admitted 422 patients with learning disabilities. The trust employed one specialist learning disability nurse. Staff referred patients via email or telephone. The specialist nurse reviewed the patient during their admission, to review and discuss their care and treatment. Patients with learning disabilities were highlighted on the electronic system. Endoscopy staff told us the specialist nurse informed them when a patient with learning disabilities was coming in so reasonable adjustments could be made such as an accompanying family member. However, we did not see evidence of communication aids for staff to use with patients with learning disabilities and the catering staff we spoke to said there were no easy read menus available.
The trust has a specialist diabetes team and specialist diabetes foot team. Staff referred patients to the teams via telephone or the electronic referral system. The electronic bed management system highlighted patients with diabetes. Nursing staff undertook mandatory training on the safe use of insulin and pharmacy staff undertook mandatory training on safe insulin prescription.

The general environment was designed to provide assistance for those with limited mobility. This included assisted bathrooms and lavatories, mobility aids and manual handling equipment.

Staff told us that specialist equipment such as bariatric equipment or specialist pressure relieving mattresses were available on request. This meant that the hospital was able to care for patients with mobility difficulties. One patient with limited sight told us, “The staff make special allowances for me as I am blind, they always guide me to the toilet.”

However, we saw two staff members become increasingly frustrated with a patient with mental health needs. Staff explained the patient required one to one nursing by a registered mental health nurse; however, this shift had remained unfilled. We saw the needs of this patient were not always being met effectively.

Between March 2017 and January 2018, medical care services reported 1446 breaches of mixed sex accommodation. This was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10(2) (a) ensuring the privacy of the service user. People using services should not have to share sleeping accommodation with others of the opposite sex, and should have access to segregated bathroom and toilet facilities without passing through opposite-sex areas to reach their own facilities.

Access and flow

Staff told us that patients were frequently admitted to other parts of the hospital because of pressure on bed capacity. Outliers are patients admitted to wards outside of their speciality. This was a risk as the general environment was not always appropriate and staff did not always have the experience and expertise to manage the ‘outlying’ patients’ conditions. Ward managers and matrons told us they spent a large proportion of their time trying to move patients to wards, which met their needs.

Discharge planning started at the point of admission. We reviewed the handover sheet on Lawrence ward and saw all patients had an estimated date for discharge. The medical services discharged 38,418 patients in 2017 and of 21% were delayed. Staff told us delays occurred due to waits for medication and obtaining the appropriate equipment in the patient’s home prior to discharge.

The trust had a discharge policy (due for review August 2018). It clearly identified standards for safe discharge including out of hours and self-discharge. It stated referrals to the integrated discharge team must be completed within 24 hours of the patient’s admission. This ensured complex discharges were supported by the team upon the patients admission. The policy also stated staff must discharge patients home before lunchtime. However, staff told us this rarely happened due to delays in obtaining the patient medication to take home. Some areas had worked around this by discharging the patient and getting the patient to return the following day to collect their medicines.

Data for 2017 showed 81% of patients did not experience any ward moves, 16% of patients experienced one ward move and 3% of patients experienced two ward moves. Patients we spoke with reported moving wards during their admission but told us staff explained this decision in advance of moving.
In 2017, there were 7626 patient moves between 10pm and 8am, with the most occurring on Lister assessment unit (28%); Wakeley ward (15%) and Dickens ward (13%). Moving patients during the night can lead to disorientation and should be avoided when possible.

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

From February 2017 to January 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medical care was worse than the England average. Performance ranged from 65% to 80% compared to an England average of 88% to 90%. Performance generally improved from February to October 2017 but this was followed by deterioration from November 2017 to January 2018 with 66% of admitted patients treated within 18 week in the latest month.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for medical care broken down by specialty is below. Of the two specialties with RTT data reported at the trust, one specialty (gastroenterology) performed better than the England average.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>72.6%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>100.0%</td>
<td>94.0%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Learning from complaints and concerns

Summary of complaints

From January 2017 to December 2017 there were 167 complaints about medical care. At the time of reporting 119 of these complaints had been closed. The trust took an average of 55 days to close these complaints. The trust has a target to close complaints within 30 days and complex complaints within 60 days. Only 37.8% of complaints were closed within 30 days and 59.7% of all complaints were closed within 60 days.

The majority of complaints had more than one theme. The most common themes of complaints
were:

- All aspects of clinical treatment – 66
- Discharge and transfer arrangements – 33
- Admission - 29
- Attitude of staff – 27
- Communication / information to patients – 21
- Delays/concerns regarding medication – 18
- Patients’ property and expenses – 12
- Delay in diagnosis – 11
- Lack of general nursing care and attention – 10
- Lack of general medical care and attention – nine

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

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

In 2017, the trust received 231 complaints within medical care. This had increased compared with 116 from August 2015 to July 2016. However, the average time the trust took to investigate and close complaints had improved. From August 2015 to July 2016, it took 80 days and in 2017 it took 55 days. The trust continued not to meet the trust’s complaints policy, which states the complaints response time should be within 30 days, unless the complainant agreed a longer period.

Staff confirmed that complaints were discussed at clinical governance meetings and information disseminated to staff through team meetings, briefings and ‘the big 4’ key messages. We reviewed a sample of team meeting minutes and saw staff discussed complaints. We saw the wards displayed ‘you said, we did’ posters on noticeboards. This detailed how they had responded to both positive and negative feedback.

We saw and heard evidence to suggest good learning from complaints. We saw an example of a complaint in endoscopy. The patient had communication difficulties but staff directed their relative to the waiting room and was not updated about the patient’s care. The Joint Advisory Group on Gastrointestinal Endoscopy Accreditation guidelines recommends only patients are admitted to the endoscopy area, however exceptions can be made. All staff signed to say they had read the complaint and the related guidance.

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.

We saw leaflets in areas about how patients could make compliments, complaints, concerns and comments. The leaflet outlined contact details for the patient advice and liaison service and how to make a formal complaint.

We reviewed five formal complaints relating to medical care services in the last 12 months and the trust’s responses. In all five cases, 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 regulation, under the Health and Social Care Act (Regulated Activities Regulations) 2014. From complaint responses, we also saw the trust implemented changes to practice following complaint learning.

Is the service well-led?
Leadership

The management and directorate structure had undergone changes since our last inspection. Trust wide there were two directorates who reported to the board. The medical care service was in the unplanned and integrated care directorate and led by the executive director of clinical operations who reported directly to the chief executive. The directorate had a deputy medical director and deputy director of nursing. The directorate was divided into three programmes that were each led by two clinical directors and a head of operational performance. Speciality leads and service managers supported them.

At the time of our inspection, there were two interim heads of operational performance. Matrons told us the new structure meant there was clearer oversight of each programme and better governance. However, frontline and support staff told us at the focus groups held before the inspection that the management structure was top heavy and there was a lack of understanding of the new structure.

Three matrons managed nursing staff in the acute medicine programme and two matrons managed nursing staff in the acute specialist medicine programme. Overall, staff told us the matrons were very responsive when they raised concerns. However, some senior sisters told us as the speciality and ward matron have a crossover of roles; they received duplicate emails asking for different things but said they stated they felt this was teething problems, which will resolve once the matron roles are clearer. Some senior sisters also told us they wanted more visibility of the matrons as they invited them to the monthly team meetings but the matrons did not attend regularly. Staff told us sister seniors were very visible, approachable and supportive.

Staff told us although they knew the names of senior management, there was poor visibility of the board. A record of all executive and non-executive director visits showed they had carried out visits four times during 2017. Frontline and support staff told us at the focus groups held before the inspection that they felt there was a ‘them and us’ attitude which demonstrated a disconnection between staff and management.

Vision and strategy

The trust’s vision was to aspire to be the best by using the trust’s values in everything they did. We saw values statements based on the word “BEST”, which meant “Bold, Every person counts, Sharing and open and Together”. All staff were able to tell us the trust’s vision, ‘BEST’ but not all staff members were familiar with the trust’s values.

We saw poster displays and other publications about the vision and values as we visited the wards. These were readily available for staff, patients and the public to view. In addition to information published for staff on the trust intranet, the trust published information about its mission, values and vision on its public website.

The ambulatory care unit had a clear vision for the future, to extend the unit into the genitourinary medicine unit so more patients can be treated and cared for. Staff told us the success of the ambulatory care unit had generated income for the trust, which helped the trust to come out of financial special measures.

The trust’s strategy for 2017/2018 was based on four main objectives; integrated health care, innovation, our people and financial stability. These were split into 13 programmes, which aimed to improve the care provided for patients. We saw progress against the strategy were monitored and reviewed at board meetings.

Culture
Managers across the trust promoted a positive culture that supported and valued staff. Staff we spoke to reported they were encouraged to raise concerns and received feedback on their performance.

Staff spoke in positive terms about the team working with medical and specialist support to provide care. Doctors told us they had protected teaching time on Tuesdays, and informal teaching throughout the working day.

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

The service encouraged openness and honesty. The trust provided training to staff around duty of candour as part of the “lessons of the week”. We saw information and guidance on duty of candour available to staff on the medical wards. All staff we spoke with had a good understanding of duty of candour and could describe their responsibilities relating to it.

The trust monitored workforce performance indicators in order to plan recruitment and monitor trends. Staff told us the trust had undertaken a huge recruitment drive locally, nationally and internationally, introducing recruitment and retention incentives. We saw the dashboard for the unplanned and integrated care directorate for March 2018. The metrics showed a 13% turnover rate (target 8%), a 21% vacancy rate (target 12%) and a sickness rate of 4% (target 4%). However, spend on temporary staffing had improved compared to the previous year. The total spend on substantive staff had increased by 3% and the total spend on agency staff decreased by 11%.

**Governance**

There were clear lines of accountability from ward to board through the medical specialities, through the directorate governance structure.

The clinical governance lead for each specialty reported to the directorate clinical governance lead. The directorate governance leads co-chaired the directorate governance board with the deputy director of nursing and attended the quality assurance committee, serious incident panel and quality safety group.

Each medical specialty in either an acute medicine or speciality medicine speciality had a patient safety lead. The patient safety lead reported to the clinical governance lead for each speciality. The clinical governance lead for each specialty reported to the directorate clinical governance lead.

The directorate clinical governance lead reported to the deputy director of nursing and the deputy medical director for, who reported to the executive director of clinical operations, who linked with the board.

The clinical governance leads held weekly incident review meetings. At these meetings, staff discussed incidents related to their speciality from the previous week. The clinical governance lead took forward any incidents categorised as moderate harm or above for discussion at the weekly trust-wide harm-free meeting. This enabled further investigation and sharing of learning across other areas of the trust. In addition to this, risks were discussed. Staff told us they were well attended and learning was shared.

**Management of risk, issues and performance**

Each directorate had a performance dashboard and the key performance indicators were aligned with the five key questions: safe, effective, caring, responsive and well led. The dashboard was updated every month and discussed at the programme board.
Each programme had a risk register, which fed into the directorate register. The directorate register fed in to the trust risk register.

The unplanned and integrated care directorate management board meetings took place on a monthly basis. We reviewed three sets of meeting minutes from January 2018 and March 2018, which demonstrated attendance of medical, nursing, and support staff. Key issues, risks and performance were discussed each meeting.

The department carried out local audits to monitor quality and patient safety. Audits included hand hygiene, pressure area scoring, infection control and documentation. In addition to this, consultants took part in a variety of national audits.

**Information management**

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

Staff were able to access patient information using an electronic system and paper records. All staff had access to information technology systems to track patients through the hospital. The trust used an electronic flagging system to identify patients who were vulnerable or those who were living with complex needs.

Staff had access to policies through the trust’s intranet. We saw that staff could access policies in a timely manner.

**Engagement**

All 4459 members of staff employed by the Trust were invited to complete a staff survey in September 2017. The response rate to the survey was 40%. This is the same as the national average response rate across the NHS for acute trusts but 9.5% lower than response rate the trust saw in 2016.

The trust saw a 3% decline overall in the staff engagement index compared to the 2016 staff survey. The staff engagement index consists of three key findings: recommendation of the trust as a place to work or receive treatment; staff motivation at work and staff ability to contribute to improvement at work. The staff engagement index for the trust was lower than the national average for acute NHS trusts. Staff we spoke with were not aware of any quality improvement projects in medical care and felt demotivated when staff were distributed across the trust to manage staffing levels.

The trust a dedicated app for staff called @MFT. Trust staff designed the app and provided them with access to a wide range of systems and information, news and updates, important policies and mandatory training.

The Forward app was developed by junior doctors while they were at Medway and it provided a secure platform for clinical staff to communicate with one another.

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services for example the consultation on stroke services. In April 2017, the trust employed a full time engagement officer. The trust had appropriately 50 community organisations in Medway and Swale, which enabled it to build relationships with local residents. Speakers from the trust facilitated a community group for stroke prevention. The trust...
surveyed the community groups they worked with and found 86% had seen an improvement in hospital engagement with the community and 79% said they felt more informed about the trust than they did a year ago.

**Learning, continuous improvement and innovation**

At the last inspection, the trust was developing the frailty model in partnership with the clinical commissioning groups. At this inspection, the model was active and showed it had reduced the number of falls in the community and thus reduced the number of admissions to the hospital. The trust aimed to deliver a similar model for chronic pulmonary disease.

The trust had one of the lowest delayed transfers of care rates in the country. It had worked hard with external partners improve the discharge processes for patients. This demonstrated there was better patient flow through the hospital and better discharge planning.
Surgery

Facts and data about this service

The trust delivers a range of general and specialised surgical services including planned and emergency procedures. These include inpatient and day care services covering a range of specialties including colorectal, breast, vascular, orthopaedics, urology, maxillofacial, ear nose and throat, chronic pain management and laparoscopic key hole surgery.

(Source: Trust Acute Routine Provider Information Request – Context acute tab)

The trust has 14 day case and 158 inpatient surgical beds. The service has 17 main operating theatres. Four of the 17 operating theatres are for day surgery. These form part of the Sunderland Day Care Unit. The trust has seven surgical wards: Arethusa, Kingfisher, McCulloch, Pembroke, Phoenix, Sunderland and Victory.

The service has a pre-operative care unit, where patients change, prepare and have admission checks before going to theatre for elective surgery. The pre-operative care unit has 12 small cubicles, with seating for patients and their relatives and four consultation rooms. For emergency admissions, the hospital has an eight-bedded surgical assessment unit with a four-bay assessment area adjacent to Kingfisher Ward. The hospital’s emergency department can refer patients to the surgical assessment unit for assessment pending emergency surgery. The surgical assessment unit also has a triage room, a seated waiting area and a clinic room.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust had 22,919 surgical admissions from November 2016 to October 2017. Emergency admissions accounted for 41.5% of all admissions (9,515) and 58.5% (13,359) were elective admissions, of which 9,321 were day case and 4,083 were inpatient stays.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The trust had introduced a new electronic learning management system. This allowed staff to access training on tablet devices, smart phones, laptops or desktops. This supported staff to stay updated for a range of mandatory training topics.

Two staff demonstrated how they accessed the system on their smart phone and tablet device. They described the system as easy to use, were able to access it during working hours and at home to complete training. Staff told us they were given protected time to complete training.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training across 10 and nine courses for medical/dental staff and qualified nursing/midwifery staff, respectively.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical/dental staff and qualified nursing/midwifery staff in surgery is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving and Handling</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>88</td>
<td>116</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>88</td>
<td>120</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>81</td>
<td>116</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>80</td>
<td>115</td>
<td>70%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>81</td>
<td>117</td>
<td>69%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>78</td>
<td>115</td>
<td>68%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>6</td>
<td>10</td>
<td>60%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>64</td>
<td>115</td>
<td>56%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT Level 2</td>
<td>63</td>
<td>117</td>
<td>54%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff in surgery did not achieve the trust’s training completion target of 85% in nine out of 10 courses. The worst training completion rates were in PREVENT level two with 54%, followed by adult basic life support with 56% compliance. PREVENT is part of the government counter-terrorism strategy that aims to reduce the threat to the United Kingdom from terrorism by stopping people becoming terrorists or supporting terrorism.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>210</td>
<td>229</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>208</td>
<td>232</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>205</td>
<td>229</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>200</td>
<td>231</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>197</td>
<td>233</td>
<td>85%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>182</td>
<td>231</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>180</td>
<td>232</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>159</td>
<td>222</td>
<td>72%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>155</td>
<td>232</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The nursing and midwifery staff in surgery achieved the trust’s training completion target of 85% in five out of nine eligible training courses. The worst training completion rates were in adult basic life support with 67% followed by PREVENT level two with 72% compliance.

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

Following this inspection, trust information provided to us showed an overall 85.5% of staff had completed mandatory training as at June 2018 achieving the trust’s training completion target of 85%. This meant staff had the correct level of training in line with trust policy. Having a sufficient level of mandatory training meant staff were supported in fully and correctly applying the appropriate skills for their roles.

After our visit, the trust provided us with further data on paediatric basic life support training completion rates. This showed 100% of medical and dental, qualified nursing and midwifery staff
Safeguarding

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training. Of these, 72% of staff in surgery had completed safeguarding training from April 2017 to October 2017.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for medical/dental staff and qualified nursing/midwifery staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level two)</td>
<td>64</td>
<td>95</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level two)</td>
<td>72</td>
<td>113</td>
<td>64%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff in surgery did not achieve the trust target of 85% for the two eligible safeguarding courses.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level two)</td>
<td>181</td>
<td>226</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (Level two)</td>
<td>180</td>
<td>225</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

Qualified nursing and midwifery staff in surgery did not achieve the trust target for the two eligible safeguarding courses.

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

Following this inspection, trust information provided to us showed an overall 91% staff had completed safeguarding adults level 1 training and 81.5% had completed level two training. It also showed 96% staff had completed safeguarding children level 1 training and 86% had completed level two training. Only 12.7% of relevant staff had completed safeguarding children level three training. This demonstrated surgery staff did not achieve the trust’s training completion target of 85% in safeguarding adults level two and safeguarding children level three training.

This meant not all staff had the correct level of training in line with the national intercollegiate guidance, “Working together to safeguard children” (March 2015). Not having a sufficient level of safeguarding training may prevent all staff from correctly identifying and reporting safeguarding concerns.

However, staff we spoke with were able to describe the correct processes for reporting safeguarding concerns for vulnerable adult and children and young people. Staff provided examples of times they had appropriately raised vulnerable adult and child safeguarding concerns. We saw safeguarding folders available to staff on McCulloch and Phoenix wards with contact details for the trust’s safeguarding team and details of how to raise a concern. During the
inspection, we saw one staff member had made a safeguarding referral through the correct channels and followed the trust’s safeguarding processes.

Cleanliness, infection control and hygiene

The previous inspection in November 2016 found worn corridor flooring in theatres, covered with tape. During this inspection, we saw cracks remained on the corridor flooring in theatres. Staff had covered the damaged areas with tape. This remained contrary to the Department of Health’s Health Building Note (HBN) 00-09: infection control in the built environment HBN 00-09, which states, “Flooring should be seamless and smooth, easily cleaned and appropriately wear-resistant”. Damaged flooring can harbour dirt and dust, and make cleaning difficult.

We saw holes in the wall of an anesthetic room where cupboards had been removed. This was contrary to the Department of Health’s Health Building Note (HBN) 00-09: infection control in the built environment HBN 00-09, which states, “Wall surfaces should be maintained so that they are free from fissures and crevices”. Damaged walls can harbour dirt and dust, and make cleaning difficult.

We saw the clinical hand wash basins in all the wards we visited were in line with the Department of Health’s Health Building Note (HBN) 00-09: infection control in the built environment HBN 00-09 for hand hygiene facilities.

The trust did not meet National Specifications for Cleanliness in the NHS regarding the frequency of audits in theatres. The specifications state that all very high-risk areas should have weekly audits. The frequency of audits can drop to monthly if they pass the required percentage on a regular basis and management are confident they can maintain the scores.

The Sunderland day care unit theatres had not passed the required percentage on a regular basis to support a reduction to monthly audits. This was not in line with the specification or the trust’s operational cleaning plan, which stated, “The pass rate for this category is 98% and [very high risk areas] are audited weekly”. From April 2017 to March 2018, the Sunderland Day Care Unit theatres passed only 50% of their audits. This meant the they needed weekly cleaning audits in order to comply with the specification and trust policy. The consequences of not monitoring very high risk areas weekly is that an area may fall below the required standard for up to four weeks before any action is taken. This may increase the risk of hospital acquired infections.

However, data showed the main theatres consistently achieved between 98% and 100% pass rate for 92% of their cleaning audits from April 2017 to March 2018.

Methicillin-resistant Staphylococcus aureus (MRSA) is a type of bacteria resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. Trust data showed surgical services reported 15 cases of from April 2017 to March 2018. Of these, there were seven on McCulloch ward, four cases on Phoenix Ward, two cases on Arethusa ward, and one each on Pembroke and Victory wards. All 15 patients tested positive for MRSA post-48 hours of hospital admission. This meant it was likely they had acquired MRSA during their hospital stay. We saw the service took action to address the root causes of infection and help prevent a recurrence such as the deep clean of the wards. However, the mandatory module of infection prevention and control training rate did not achieve the trust target of 85%. This may have contributed to the outbreak.

Methicillin-sensitive Staphylococcus Aureus (MSSA) is a type of bacteria which lives harmlessly on the skin and in the nose. We saw there were seven cases of MSSA bacteraemia from April 2017 to March 2018. Of these, five cases patients tested positive for MSSA bacteraemia less than 48 hours following admission. This meant the patients did not contract MSSA from the ward. However, the two cases happened in May 2017 on Phoenix Ward and in December 2017 on
Kingfisher/Surgical Assessment Unit, the patients were tested positive for MSSA bacteraemia more than 48 hours following admission. This meant the patients contracted MSSA from the ward.

In the same reporting period, surgical services reported 12 cases of Clostridium difficile (C. diff). Four cases occurred on Arethusa and Phoenix Wards, two cases on McCulloch Ward, and one case each on Kingfisher/Surgical Assessment Unit and Victory Ward. Of these, six cases developed C.diff after 72 hours post-admission. This meant 50% of the patients contracted C.Diff from the hospital. We did not see evidence that the service had taken any further actions to address this high cross-infection rate. This meant the trust could not be assured that cross infection was minimised.

The trust took part in the Public Health England surgical site infection surveillance service. 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 hip replacements and knee replacements.

As part of the surgical site infection surveillance service, the trust sent out post-operative questionnaires to patients. This helped them identify more patients who developed a SSI after discharge but did not receive further treatment at the trust.

The trust’s SSI report for April 2016 to March 2017 showed 2.2% of patients developed an SSI following knee replacements during this period. This was worse than the average infection rate of 1.5% for other hospitals that sent patient questionnaires during the same period.

In the same period, data showed 1.1% of patients developed a SSI following hip replacement during this period. This was the same as the average infection rate of 1.1% for other hospitals that sent patients questionnaires during the same period.

The trust carried out monthly hand hygiene audits. The audits measured staff compliance with hand hygiene policies, such as hand washing and "bare below the elbows". Audit data from April 2017 to March 2018 showed the compliance for this service ranged from 91% to 100%. This was worse than the trust target of 100%. The service missed some audits, for example; we saw there was no data reported for the Pre-Operative Care Unit for five out of 12 months during this period. This meant the trust might not have had assurances staff in this area were compliant with infection prevention control policies and practices. This had not changed since the last inspection.

However, in all clinical areas we visited, we saw a high level of staff compliance with infection prevention control practices such as bare below the elbows, hand washing and use of alcohol hand gel. We saw staff cleaned their hands appropriately before and after patient contact. This was in line with the National Institute for Health and Clinical Excellence (NICE) QS61, quality statement three: hand decontamination. We also saw staff used personal protective equipment such as gloves and aprons appropriately.

All clinical areas we visited were visibly clean and tidy. We saw comprehensive cleaning schedules displayed at the entrances to wards and theatres. We saw cleaning checklists in main theatres, which provided evidence of daily cleaning and monthly deep cleans. The service performed monthly cleaning audits and displayed the results in each area. We spoke with cleaning staff, who were able to describe the colour coding system they used for cleaning equipment in line with the National Specifications for Cleanliness in the NHS. The use of specific coloured reusable cleaning equipment such as cloths and mops in different clinical and non-clinical areas helps minimise the spread of infections. We also saw details of the National Specifications for Cleanliness colour coding displayed in the sluice on Phoenix ward to remind staff.
We saw isolation of a patient with a suspected infectious condition in an individual room on McCulloch ward. There was clear signage on the patient’s door to alert staff to take additional infection prevention control precautions. Staff discussed the need for additional personal protective equipment precautions during a safety huddle. We saw the ward manager ensured only vaccinated staff treated the isolated patient. Staff also checked the patient’s visitors were immune before allowing them into the patient’s rooms. This helped minimise the risk of infection spreading to staff and visitors.

In all clinical areas we visited, we saw the correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw staff had labelled sharps bins and all the sharps bins were not overfilled. This was essential to prevent injury to staff and patients from sharp objects such as needle sticks.

The service sent surgical instruments off-site for sterilisation. The trust told us the agreed turnaround time was 18 hours. Theatre staff sent items for sterilisation three times a day and told us they could obtain sterile instruments within six hours if required. This ensured there were sufficient sterile instruments available for surgery.

The trust has a system for managing the risk of Legionella (Legionnaires disease), a lung infection caused by Legionella bacteria. Legionella bacteria is spread when water supplies become contaminated with the bacteria which is more likely in larger, more complex water systems such as those found in hospitals. One staff member we spoke with explained the hospital managed Legionella risk by flushing taps daily, submitting temperature readings weekly and testing the water for Legionella bacteria quarterly. We reviewed the most recent Legionella quarterly tests. The March 2018 results demonstrated that no legionella was detected.

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

**Environment and equipment**

We observed the service had suitable premises and equipment for surgical patients in the majority of the clinical areas we visited. Two of these premises: the corridor flooring in theatres and the wall of an anaesthetic room, were not suitable as outlined in the cleanliness, infection and hygiene section of this report.

We checked eight adult resuscitation trolleys in the following areas: Arethusa Ward, McCulloch Ward, Phoenix Ward, Victory Ward, Surgical Assessment Unit, Sunderland Day Care Unit, one trolley in main theatres and the Discharge Lounge. All trolleys were tamper evident, and equipment and drugs were within their use-by dates. We also saw checklists for all eight trolleys showing evidence staff checked the trolleys daily. This meant emergency equipment was available, safe and fit for purpose.

In main theatres, we checked the anaesthetic machines and saw log books showing evidence of daily checking without any gaps. Examples of the daily checks included calibrating the oxygen sensor, checking the valves and gases, and flushing the system. This was in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. We also saw
maintenance records showing evidence of six-monthly maintenance checks. This meant the anaesthetic machines worked safely.

We checked 26 pieces of equipment in all the clinical areas and saw all equipment was labelled with dates showing they had been serviced in the past year. This meant the service maintained equipment so that it was safe and fit for purpose.

In all the clinical areas we visited, we checked 48 disposable supplies and pieces of equipment such as needles, syringes and equipment to manage blocked airways, and we saw they were all sealed and in date. This meant disposable equipment for once-only use was safe and fit for purpose.

The UK Sepsis Trust produced “sepsis six” boxes which contained all the equipment staff needed to treat patients with sepsis. We saw these were available on the surgical wards. We checked the boxes on Arethusa and Phoenix Wards and saw they were complete, with all items within their recommended use-by dates. On both wards, we saw records providing evidence staff checked the boxes daily. This meant the wards had appropriate equipment for the treatment of sepsis readily available.

Assessing and responding to patient risk

We saw sepsis information was available to staff. The information was posted in the staff rooms on the wards. The hospital had a sepsis lead nurse and staff told us they were available if required. Staff we spoke with demonstrated an awareness of the trust’s policy for sepsis management and an understanding of sepsis signs and treatment. They told us they were working to improve knowledge with training, monitoring and sepsis champions. The trust told us this service had not completed any sepsis audits for the last 12 months but had plans to complete one by end of October 2018. This meant the trust could not be assured if they were safely assessing and responding to patients at risk of sepsis.

We saw evidence of completed risk assessments, including falls assessments, in the patient records we reviewed. We saw patients identified as being at high risk of falls following assessment had individual falls management plans.

The trust used a yellow wristband system to enable staff to easily identify patients assessed as being at high risk of falls and provide them with additional support. We saw patients with high falls risk wearing the yellow wristbands during our visit. Staff also highlighted these patients during nursing handovers. This ensured staff starting their shift knew to provide extra support to these patients. Staff on McCulloch Ward described safety measures the surgical wards used to help prevent falls in patients at high risk, such as low-lying beds.

We saw sensor mats in use on Phoenix Ward. The sensors alerted staff when a patient left their bed so that staff could assist them if necessary.

We saw evidence of venous thromboembolism (VTE) assessment in the patient records we reviewed. VTE is a condition where a blood clot forms in a vein. We saw prescriptions of VTE prophylaxis, such as anti-clotting drugs and anti-embolism stockings, where clinically indicated. We saw one patient on the Surgical Assessment Unit (SAU) and one patient on the Pre-Operative Care Unit (POCU) wearing prescribed anti-embolism stockings in preparation for surgery. We saw one patient on McCulloch Ward received their regular anti-clotting medicine at the recommended time and wearing prescribed anti-embolism stockings. This meant staff appropriately managed patients with a VTE risk during our visit.

We saw evidence in patient records the service routinely checked the pregnancy status of all female patients of childbearing age before elective surgery. Staff checked pregnancy status using
a urine pregnancy test with the patient’s consent. This was in line with NICE guideline NG45: “Routine preoperative tests for elective surgery”.

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 for three procedures. 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 staff members left the theatre) and debrief. We saw staff completed all the required checks fully and accurately, including marking of the surgical sites for all three procedures.

We reviewed two checklists adapted from the World Health Organisation (WHO) Surgical Safety Checklist for Radiological Interventions only. The WHO checklist for radiological interventions is a national core set of safety checks for use in any environment where interventional radiology is carried out. Interventional radiology refers to a range of techniques which rely on the use of radiological image guidance to diagnose and treat diseases. Similar to surgery, the checklist consists of five steps to safer radiological interventions. These are team briefing, sign in (before anaesthesia), time out (before radiological intervention starts), sign out (before any staff members leave the room) and debrief. We saw staff completed all the required checks fully and accurately.

The completion of WHO checklists meant the service had systems to protect patients from incidents and injury associated with surgery and interventional radiology.

The service audited staff compliance with the WHO checklist and calculated the percentage compliance each month. We saw copies of the audits from January to December 2017. Throughout this period, we saw a high level of compliance, which ranged from 95.6% to 98.6%. At the last inspection, the service achieved a high level of compliance which ranged from 95.2% to 98.3% for a 12-month period from September 2015 to August 2016. This meant the service had maintained a high level of compliance since the previous inspection. The WHO records and observational audits provided the trust with assurances staff performed the necessary checks to help keep patients safe during surgery.

The service used the National Early Warning System (NEWS) track and trigger flow charts. NEWS is a simple scoring system of physiological measurements (for example, blood pressure, temperature and pulse) for patient monitoring. This enabled staff to identify patients who were becoming unwell, before they became critical, and provide them with increased support.

The trust provided NEWS training to staff and we saw written information for staff on “recognising patients of concern” and “responding to patients of concern”. The trust asked all relevant staff to sign to confirm that they understood the trust’s policy.

The trust monthly NEWS chart audits to assess staff completion of NEWS charts for the last 12 months showed that performance for most of the surgical wards was 100%. Only two wards did not achieve 100% of charts filled in correctly with Arethusa Ward achieving 91.7% and Victory Ward achieving 92.9%. This was worse than the trust target of 100%. The audit showed staff on all wards calculated 100% of scores correctly and escalated 100% of patients for medical review correctly in line with trust policy on all surgical wards. We saw staff received feedback on the NEWS audits at ward meetings to help improve performance where relevant. The audits helped provide the trust with assurances around the appropriate management of deteriorating patients.
We reviewed seven patients’ NEWS charts. We saw staff had completed all seven charts fully and accurately. We saw evidence of increased monitoring and medical review when clinically indicated in line with the NEWS guidance. During a patient handover on McCulloch Ward, we saw further examples where staff had escalated deteriorating patients with a raised NEWS score for medical review.

Nursing staff on the surgical wards had daily safety huddles. We observed safety huddles on McCulloch and Phoenix Wards. Staff highlighted patients at increased risk for extra monitoring. This included patients with a raised NEWS score, patients with a safeguarding alert, patients with sepsis, patients with communicable infections in isolation and patients at high risks of falls and pressure ulcers. The safety huddles on both wards took place at the nurses’ stations. This meant nursing staff could see the ward and easily hear and respond to call bells if patients rang them.

Staff told us they had 24 hour access to specialist mental health staff if they had concerns about a patient’s mental health. They were able to describe how to make an urgent referral if required. Staff told us they knew how to contact the mental health specialists, and that they were easy to access and they responded in a timely manner.

**Nurse staffing**

The trust reported their registered nursing staff numbers as below for December 2017. The trust had a nursing shift fill rate of 86.9%.

The service had 43.6 whole time equivalent (WTE) less qualified nursing and health visiting staff than it had planned, to provide safe care within surgery.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing and health visiting staff (qualified nurses)</td>
<td>332.0</td>
<td>288.4</td>
</tr>
</tbody>
</table>

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

We reviewed qualified nursing and care support staff rotas for random dates, on the pre-operative care unit (POCU), McCulloch and Phoenix Wards.

On POCU, we saw the morning shift had adequate numbers of qualified nursing staff and one unfilled care support staff for the afternoon shift. One of the qualified nursing staff was the senior sister. This meant they had to stop their management duties to provide safe care on the unit.

Staff on POCU told us there was always a shortage of one qualified nursing staff than the service had planned. The senior sister explained they would escalate shortage of staff to the matrons but were always told other wards were more in need. We saw rotas for January 2018. These showed one qualified nursing staff less than planned and not filled every day, and one to two care support staff less than planned, which were not filled for 12 days in the month. We saw staff had raised this as an incident but staff told us the issues remained. Following the inspection, the trust informed us they were in the process of merging nursing establishments in recovery and POCU to allow flexible staffing between the two areas to cover any shortfall. While we did not see this on the staffing template at the time of inspection, the trust assured us that the rota template was in the process of update. This meant the service ensured they strived to achieve safe levels of nursing and care support staff to provide safe care within surgery.

On Phoenix Ward, there was a full complement of qualified nursing and care support staff on all shifts for the week. However, one of the qualified nursing staff included in the rota was the interim
ward manager. They had to split their time between caring for patients and management duties. We observed on two occasions staff only attended to patient call bells after five rings.

We saw the staffing board on McCulloch Ward showed two qualified nursing staff less than planned for the morning shift and these were not filled during our visit. This meant the ward did not have adequate numbers of qualified nursing staff to provide safe care within surgery. One patient told us they would sometimes have to wait for a staff to attend to them after they had called for help.

The Association for Perioperative Practice (AfPP) guidelines on staffing levels for patients in the perioperative setting 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 two of the 17 theatres and saw only one scrub practitioner each in both theatres together with the circulating staff member, anaesthetic assistant practitioner and recovery practitioner. The guidelines advise caution that one scrub practitioner could be used if only one case was on the list. However, we saw the lists for both theatres had more than two cases. This did not meet the AfPP guidelines and meant that insufficient staff numbers were available to cover each list, to provide safe care within surgery.

Vacancy rates

The trust reported an annual vacancy rate from January 2017 to December 2017 of 9.8% for qualified nursing and midwifery staff in surgery. This was better than the trust’s target of 12%.

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

Turnover rates

The trust reported an annual turnover rate from January 2017 to December 2017 of 14.0% for qualified nursing and midwifery staff in surgery. Although the trust had a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate which is the data that has been provided by the trust.

The turnover rate for surgery was worse than the trust’s voluntary target.

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

The high turnover rate may have resulted from the prolonged unfilled shifts of qualified nursing and support care staff we saw during our inspection. Staff told us it felt like a “vicious circle” as staff felt stress during prolonged spells of staff shortage and many had left the trust because of it.

Sickness rates

The trust reported an annual sickness rate from January 2017 to December 2017 of 3.4% for qualified nursing and midwifery staff in surgery. This was better than the trust target of 4%.

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

Bank and agency staff usage

From January 2017 to December 2017 the trust reported a bank and agency shift fill rate of 20.2% in surgery with a further 5.2% of shifts remaining unfilled. A breakdown by staff type is shown below:
<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>637 (1.4%)</td>
<td>8,221 (17.7%)</td>
<td>1,701 (3.7%)</td>
<td>46,474</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>10,097 (13.2%)</td>
<td>5,828 (7.6%)</td>
<td>4,649 (6.1%)</td>
<td>76,401</td>
</tr>
</tbody>
</table>

Nursing assistant shifts were mainly filled by bank staff whilst qualified nursing shifts were mainly filled by agency staff.

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

Medical staffing

The trust reported their medical staffing numbers as below for December 2017. The trust had a medical staffing over-establishment of 1%. This is 1.2 whole time equivalent (WTE) medical staffing more than the trust had planned, to provide safe care within surgery.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental - Hospital</td>
<td>125.8</td>
<td>127.0</td>
</tr>
</tbody>
</table>

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

Vacancy rates

The trust reported an annual vacancy rate of 0.2% from January 2017 to December 2017 for medical and dental staff in surgery. This was better than the trust’s target of 12%.

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

Turnover rates

The trust reported an annual turnover rate from January 2017 to December 2017 of 49.3% for medical and dental staff in surgery. Although the trust had a voluntary turnover target of 8% (which excluded fixed term contracts, junior doctors, retirements, dismissals, etc.), there was no set target for the overall turnover rate, which is the data that has been provided by the trust.

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

Staff we spoke with during our visit did not highlight any major issues about the turnover of medical staffing. The inclusion of junior doctors on annual rotation usually in the month of September may have accounted for the high turnover rate.

Sickness rates

The trust reported an annual sickness rate from January 2017 to December 2017 of 0.2% for medical and dental staff in surgery. This was better than the trust target of 4%.

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

Bank and locum staff usage

The trust was unable to provide the number of shifts available per month due to data being
collected manually, therefore bank and locum agency fill rates for medical staffing could not be calculated.

From January 2017 to December 2017, 1,340 shifts were filled by agency staff, 81 shifts were filled by bank staff and 353 shifts remained unfilled.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37</td>
<td>7</td>
<td>40</td>
<td>84</td>
</tr>
<tr>
<td>Middle grade</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>SHO</td>
<td>1,107</td>
<td>61</td>
<td>136</td>
<td>1,304</td>
</tr>
<tr>
<td>SPR</td>
<td>196</td>
<td>13</td>
<td>171</td>
<td>380</td>
</tr>
</tbody>
</table>

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

Staffing skill mix

As of October 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher. This meant the trust had a lower proportion of senior doctors than the England average.

Staffing skill mix for the whole time equivalent staff working at Medway NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>Junior*</td>
<td>15%</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)
Surgery was consultant led. To ensure all specialties had the correct level of cover, the service had seven consultants on call at any one time. The seven on-call consultants covered general surgery, urology, ear, nose and throat (ENT), anaesthetics, vascular, orthopaedics and orthodontics.

Each surgical speciality had at least three tiers of on-call cover; from junior doctors through to consultants, 24 hours a day, seven days a week. Consultants were on site from 8am to 8pm daily and on-call out of hours. There were consultant led ward rounds twice a day, including weekends. On-call consultants attended the hospital out-of-hours when there was an emergency.

We observed a medical handover in the doctors’ office on the Surgical Assessment Unit (SAU). Doctors handed over patients from the night shift to their colleagues starting the day shift. Doctors from the night and day shifts attended, as well as a general consultant to provide oversight. We saw the process was effective, with clear communication amongst doctors.

Records

We saw patient records were stored appropriately on Arethusa, McCulloch and Phoenix Wards. For example, we saw medicine charts kept within the patients’ records in an attended area next to nurses’ stations. This meant staff minimised the risk of personal and confidential data exposure and loss.

We reviewed records for seven surgical patients. Overall, we saw an appropriate standard of documentation. We saw staff had signed and dated all entries in line with professional guidance such as the General Medical Council and Nursing and Midwifery Council. However, we also saw loose documents inside patient files. Failure to effectively file paperwork risked confidential patient data falling out. This meant there was a risk of unauthorised access to confidential data and accidental loss of essential medical information.

All the records we reviewed contained patient care plans that identified all their care needs. We saw staff had fully completed the care plans in all the records and also saw evidence of pre-operative assessment in all the records we reviewed.

Staff told us discharge information was communicated electronically to a patient’s GP as soon as the patient was discharged. One staff member demonstrated how they would do this through the trust’s electronic patient management system. This meant patients were able to receive continuity of care after discharge within the community.

Medicines

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

We observed medicines were stored securely within locked cubboards and were within their expiry dates in all the clinical areas we visited.

On McCulloch Ward, we saw medicines were kept with drug charts on a lockable trolley so that the nurse could move around the ward with the medicines during a drug round. We observed the
nurse carrying out a drug round checking the correct medicines and dose against a patient’s drug chart. The nurse also checked the expiry date of each drug. We saw that the nurse asked the patient to state their name and date of birth, and checked this against the chart before giving the medicine to the patient. The nurse also told the patients which medicine they were giving them. The nurse stayed with the patient while they took their medicine. This meant staff ensured the correct patient received the correct medicine at the correct dose. It also ensured there were no unused medicines left on the ward, which may be subject to misuse.

We checked controlled drugs throughout the wards and theatres. Controlled drugs are medicines liable for misuse that require special management. We saw the controlled drugs’ cupboards were locked in all areas. Only authorised staff could access controlled drugs by asking the nurse in charge for the keys to the cupboard. We checked the controlled drugs’ registers in all areas and found two members of staff had signed for all controlled drugs. This was in line with national standards for medicines management.

We randomly checked the stock level of CDs on Arethusa, McCulloch and Victory Wards and saw the correct quantities in stock according to the stock list, and all were within their expiry dates.

We checked the medicines fridges on Arethusa, McCulloch and Victory Wards and saw the fridge temperatures on all the wards were within the expected ranges. Records on all wards showed staff had checked the fridge temperatures daily. All temperatures recorded were within the expected ranges and there were no gaps on the checklist. This meant the wards stored refrigerated medicines within the recommended temperature range to maintain their function and safety.

We saw posters to remind staff on critical medicines (medicines which should not be omitted) and look alike/sound alike medicines in appropriate areas to promote safe administration.

We saw throughout the wards and theatres medicines waste was handled in line with policy.

We reviewed seven medication administration records (MAR). On all seven MAR charts, we saw staff had recorded patient allergies and medicine reflected the patients’ care plans. For example, we saw staff had not given a patient any sedatives after an entry in the care plan stated, “Do not give sedatives”. We saw evidence of pharmacy oversight in all records.

Staff checked relevant patients had appropriate antibiotic cover during a trauma team briefing in main theatres. Patient records showed evidence of antibiotic prescription where clinically indicated.

**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 January 2017 to December 2017, the trust reported no incidents classified as never events for surgery.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**
In accordance with the Serious Incident Framework 2015, the trust reported 28 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from January 2017 to December 2017.

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

- Slips/trips/falls meeting SI criteria with eight (29% of total incidents).
- Diagnostic incident including delay meeting SI criteria, including failure to act on test results with five (18% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with five (18% of total incidents).

The trust reported 13 SIs for a one-year period from May 2014 to April 2015 and five SIs from September 2015 - August 2016. Therefore the 28 reported SIs from January 2017 to December 2017 had increased significantly.

The overall number of incidents had risen since our last visit. For the past 12 months, this service reported 2,999 incidents. From September 2015 to August 2016 was 1,057. This meant there were 1,942 more incidents than in the previous year. The matron we spoke with told us the rise in incidents were due to staff being better at reporting.

We reviewed incidents involving surgical patients reported for the past 12 months. Of the 2,999 incidents reported, we saw the trust graded the vast majority of incidents (97.9%) incidents as either "no injury or harm" or "low harm". This demonstrated a positive culture of reporting incidents because it showed staff reported “near misses” when there was no harm to patients. The proportion of no harm and low harm incidents was similar to the previous year. From September 2014 – August 2015, the service graded 95.1% of incidents as either "no injury or harm" or "low harm". This suggested an improvement in the incident reporting culture over time.

The service used an online software system for reporting incidents. Staff demonstrated how they could access the system easily. They could describe the process for reporting incidents and gave examples of times they had done this. Staff told us their managers encouraged them to report incidents and supported them with this process.

Matrons or senior sisters investigated incidents with oversight by the surgical directorate governance manager. Matrons and senior sisters attended weekly incident meetings led by the surgical directorate governance manager. This enabled the sharing of incident learning between different clinical areas related to surgery.
Staff told us the relevant matron or senior sister subsequently fed back to the team with learning from incidents at monthly ward or theatre team meetings. We saw copies of various ward meeting minutes that showed evidence of feedback following incident learning. Staff gave us examples of learning from incidents, such as a security incident on McCulloch Ward where the main door to the ward was open. This resulted in staff ensuring the main door kept shut all the time and visitors using the intercom system for entry to the ward. Staff we spoke with felt that incident reporting and learning had improved since our last inspection.

We also saw “governance boards” in staff rooms. The boards displayed details of incident investigations and learning from all surgical wards. A nursing staff told us the service had continued their learning using this method since its introduction over a year ago. Staff we spoke with said they read the information on the boards and felt they were useful. One nurse on Phoenix Ward told us the boards enabled better sharing of incident learning with other wards. This meant staff had embraced the practice of transparency and shared learning to help minimise incidents recurring.

The Duty of Candour is a legal duty on health and social care services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. All staff we spoke with were aware of the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. Staff provided examples of times the service had exercised Duty of Candour, including an example when a patient was injured following a fall. We saw guidance on Duty of Candour available in staff areas. We saw evidence from root cause analysis investigations that the service applied DoC following serious incidents.

“The service held regular monthly mortality and morbidity meetings. The purpose of the meetings was to allow clinicians to discuss patient deaths and other adverse events in an open manner, review care standards and make changes if needed.

We saw mortality and morbidity meeting minutes for this service for February, March and April 2018. Consultants discussed areas of good practice, areas for improvements and recorded actions. This had improved since our last inspection. However, the minutes we viewed lacked records of learning to prevent recurrence. There was no evidence that staff completed or discussed learning actions from previous meetings. This meant the department might have missed opportunities to effectively share and learn from complications and errors, as well as prevent future recurrences and improve standards”.

Safety thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported 21 new pressure ulcers, two falls with harm and five new urinary tract infections in patients with a catheter from December 2016 to December 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Medway NHS Foundation Trust
The rates of patients reported to have a new pressure ulcer was generally similar across the 12 month period with higher rates reported in June 2017. However, due to the small number involved this may not reflect a deterioration in care.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

We reviewed policies, guidelines and standard operating procedures in main theatres. All policies we saw were comprehensive, within their review dates and referenced relevant national guidance. This included NICE and the Royal College of Surgeons (RCS). The trust stored all policies and guidelines on an electronic system. Staff were able to demonstrate how they could easily access the documents through the electronic system. For example, we observed staff had applied guidelines when discussing the order of an emergency surgery list. This meant staff provided care and treatment based on national guidance and evidence.

The service audited staff compliance with trust policies in several areas and reported the results monthly. For example, we saw monthly WHO surgical safety checklist and falls audits. We saw “governance boards” in staff rooms, which demonstrated staff received feedback on local audit results and areas for improvement. For example, on Arethusa Ward staff received feedback on completion of the falls risk assessments and the areas for improvement.

Surgical services had a comprehensive local audit programme to measure performance. We saw audits in areas such as anaesthetics and consent. The trust also participated in national audits such as the national prostate cancer audit for patients who had surgery for prostate cancer.

All seven patient records we reviewed showed evidence of regular observations. For example, oxygen saturation, blood pressure and temperature to monitor the patient’s health post-surgery. We saw staff had completed all observations in line with NICE guideline CG50: Acutely ill patients in hospital- recognising and responding to deterioration.
We saw the service provided care in line with NICE guideline CG83: Rehabilitation after Critical Illness. For example, we saw staff on McCulloch Ward assessing the ongoing needs of a patient before discharge home and arranging additional rehabilitation services for after discharge.

**Nutrition and hydration**

The trust used the Malnutrition Universal Screening Tool (MUST) as part of pre-assessment screening. The tool enabled staff to identify patients at risk of malnutrition and make adjustments to ensure patients received adequate nutrition and hydration when required. We reviewed seven patient records on Victory and McCulloch Wards which showed all had evidence of a MUST assessment. We also saw all the patient records contained care plans which took account of the patient’s assessed nutrition and hydration needs.

The trust catered to special dietary requirements such as sugar-free, fat-free and gluten-free diets for patients who needed them. We saw a patient on Phoenix Ward who was on a sugar-free diet for medical reasons. Patients we spoke with told us there were various food options. They said some options were available everyday and some on different days of the week.

The service had access to dietitians on-site who provided patients with specialist dietician input before and after surgery when required. The dietetic service was also available to bariatric patients (patients with a body mass index of 40 or above) to help them lose weight before surgery.

We saw the service had an effective process to ensure patients fasted for an appropriate period before undergoing general anaesthetic. Staff asked each patient to confirm when they last ate and drank during the checking process on arrival in theatres. Patients were allowed to drink clear fluids up to two hours before their operation in line with guidance from the Royal College of Anaesthetists. Patients we spoke with confirmed they had fasted for the appropriate period before surgery in line with the pre-operative information given to them by staff.

The service had introduced fasting audits since the last inspection. The results for the past 12 months showed for non-emergency procedures, 48% of patients fasted excessively for fluids and 12% of patients fasted excessively for solid food. For emergency procedures, 76% of patients fasted excessively for fluids and 19% of patients fasted excessively for solid food. Excessive fasting meant more than six hours for fluid and more than 24 hours for solid food. The report showed recommendations to improve the fasting times by working with the Pre-Operative Care Unit. Following this inspection, the trust informed us this service had implemented the audit recommendations. For example, patients that can be identified during the WHO checklist that are going to wait for longer than two hours for surgery are now given water up to two hour before surgery. In addition, paediatric patients are always given a sugary drink such as orange squash at the time of their admission.

Patients we spoke with told us staff in recovery offered them a drink after their operation. We observed patients had water jugs available at their bedsides on the wards. We saw staff replaced water jugs that were half filled on McCulloch Ward.

Staff on the surgical wards monitored patients’ fluid balance and recorded observations on fluid balance charts. We reviewed seven patient fluid balance charts on Victory and McCulloch Wards and saw staff had completed them fully. This enabled staff to effectively monitor patients’ fluid balance to minimise the risk of dehydration. This had improved since the last inspection.

**Pain relief**

We reviewed seven patient records and all records contained a fully completed pain assessment tool. During our observations, we saw staff asked patients to rate their pain between the scale of one to 10. One meant no pain and 10 represented extreme pain. We reviewed all seven patient
medication administration records and saw staff prescribed and administered pain relief appropriately.

During a drugs round on McCulloch Ward, we saw the nurse asked patients whether they had any pain. For one of the patients who showed non-verbal signs of being in pain, we observed the nurse responded quickly to check the pain score and administer the appropriate pain relief. The nurse told us they would escalate to a medical staff or anaesthetist for pain relief review if it becomes ineffective. Two patients we spoke with on Phoenix and McCulloch Wards told us staff responded quickly when patients on the wards were in pain.

The service had appropriate safety measures for patient controlled analgesia (PCA) and epidurals. An epidural is an injection in the back to provide patient pain relief in parts of their body. For example, the service prescribed anti-emetic medicine to prevent nausea and vomiting. Medical staff also prescribed reversal agents and fluids for use in the event of an emergency.

The trust had an acute pain service that provides specialist advice for managing severe short-term pain such as after surgery. The team was available Monday to Friday, from 9am to 5pm. Outside these hours, staff could access support from the outreach team with assistance from the on-call anaesthetist.

Patient outcomes

Relative risk of readmission

Trust level

From October 2016 to September 2017, all patients at the trust had a worse than expected risk of readmission for both elective and non-elective admissions when compared to the England average.

Two out of the top three elective specialties (based on count of activity) had a worse than expected risk of readmission (urology and ENT), while colorectal surgery had a better than expected readmission when compared to the England average.

Two out of the top three non-elective specialties (based on count of activity) had a worse than expected risk of readmission (urology and ENT), while trauma and orthopaedics had a better than expected readmission 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
National Hip Fracture Database

In the 2017 national hip fracture database, the trust’s risk-adjusted 30 day mortality rate was 7.2%. This was within the expected range compared to other trusts.

The proportion of patients having surgery on the day of or day after admission was 69.6%, which was worse than the national aspirational standard of 85% and similar to other trusts (within the middle 50% of results). The 2016 figure was 71.0%.

The perioperative medical assessment rate was 89.5%, which was below the national aspirational standard of 100% but similar to other trusts (within the middle 50% of results). The 2016 figure was 90.4%.

The proportion of patients not developing pressure ulcers was 77.9%, which was below the national aspirational standard of 100% and worse than other trusts (in the bottom 25% of results). The 2016 figure was 93.9%.

The average length of stay was 20.9 days, which was similar to other trusts (within the middle 50% of results). The 2016 figure was 17.5 days.

(Source: National Hip Fracture Database 2017)

National Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, from April 2015 to March 2016 60.6% 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 figure from April 2014 to March 2015 was 62.4%.

The risk-adjusted 90-day post-operative mortality rate from April 2015 to March 2016 was 5.0%, which was within the expected range for trusts in England and Wales. The figure from April 2014 to March 2015 was 5.2%.

The risk-adjusted two-year post-operative mortality rate from April 2013 to March 2014 was 24.2% which was within the expected range for trusts in England and Wales. The figure from April 2011 to March 2012 was 23.9%.

The risk-adjusted 30-day unplanned readmission rate from April 2015 to March 2016 was 9.3%, which was within the expected range for trusts in England and Wales. This metric was not reported from April 2014 to March 2015.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection from April 2012 to March 2015 was 53.8%, which was within the expected range for trusts in England and Wales. The figure from April 2011 to March 2014 was 57.0%. This meant performance had improved in this area.
National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0% for abdominal aortic aneurysms from January 2014 to December 2016, which was within the expected range compared to other UK trusts. The figure from January 2013 to December 2015 was 4%. An abdominal aortic aneurysm is a bulge or swelling in the aorta, the main blood vessel that runs from the heart down through the chest and tummy.

Within carotid endarterectomy, the median time from symptom to surgery from January 2016 to December 2016 was 23 days, which was worse than the national aspirational standard of 14 days. The figure from January 2015 to December 2015 was 13 days. This meant the performance had declined in this area. Carotid endarterectomy is a surgical procedure to unblock a carotid artery. The carotid arteries are the main blood vessels that supply the head and neck.

The 30-day risk-adjusted mortality and stroke rate from January 2014 to December 2016 was 1.3% which was within the expected range compared to other UK trusts. The figure from January 2013 to December 2015 was 2.4%. This meant the performance had improved in this area.

Oesophago-Gastric Cancer National Audit

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 13.1%. 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 was 28.4%. Therefore, performance had improved in this area.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 40% which was similar to the national aggregate. The 2015 figure was 43.5%.

This metric is defined at strategic clinical network level and the network can represent several cancer units and specialist centres. The result can therefore be used as a marker for the effectiveness of care at network level. Better co-operation between hospitals within a network would be expected to produce better results.

National Emergency Laparotomy Audit

In the 2017 National Emergency Laparotomy Audit (NELA), the crude proportion of cases with pre-operative documentation of risk of death was 97% which was better than the national standard of 80%.

The crude proportion of cases with access to theatres within clinically appropriate time frames was 77% which gave the trust an amber rating (indicating 50-80% of cases met this standard).

The crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre was 78%, which gave the trust an amber rating (indicating 50-80% of cases met this standard).
The crude proportion of highest-risk cases admitted to critical care post-operatively was 98%, which was better than the national standard of 80%.

The risk-adjusted 30-day mortality for the trust was 14.0%, which was within the expected range compared to other trusts in England and Wales. The 2016 figure was 14.4%.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2015/16 outcomes for groin hernias was similar to the England average except for the groin hernia EQ VAS, where the trust performed worse than the England average for the proportion of patients whose outcomes worsened.

For hip replacements, performance was similar to the England average.

For knee replacements, performance was similar to the England average except for the knee replacement EQ VAS, where the trust performed better than the England average.

(Source: NHS Digital)

Competent staff

Appraisal rates

From April 2017 to December 2017, an overall 79.5% of staff within surgery at the trust had received an appraisal. This was worse than the trust target of 85%.

A split by staff group can be seen in the table below:
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target (%)</th>
<th>Appraisal completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>1</td>
<td>1</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>112</td>
<td>99</td>
<td>85%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>204</td>
<td>167</td>
<td>85%</td>
<td>81.9%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>230</td>
<td>185</td>
<td>85%</td>
<td>80.4%</td>
</tr>
<tr>
<td>Other Non-Medical Staff</td>
<td>101</td>
<td>76</td>
<td>85%</td>
<td>75.2%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>26</td>
<td>8</td>
<td>85%</td>
<td>30.8%</td>
</tr>
</tbody>
</table>

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

We reviewed three staff competency folders on Arethusa Ward. We saw evidence of competency assessment in areas relevant to their roles. This included medicines administration, sepsis management and use of medical equipment such as blood pressure monitors, scanners and suction units. We saw staff records in all the three folders were up-to-date. However, on Phoenix and McCulloch Wards, the matron told us the competency assessments for staff were out-of-date. The matron told us they had developed new templates to assess competencies since their appointment to the post in spring 2017 but told us they have not been implemented to date as they were awaiting approval from the practice development team. Without this, learning needs for nursing staff cannot be identified. This meant the trust could not be assured staff were appropriately skilled to provide safe care within surgery.

Nursing staff who applied for a permanent position at the trust had a competency-based assessment. We saw evidence of competency assessment in areas including NEWS, medicine calculation and patient observations in a new staff member’s folder. However, we saw Phoenix and McCulloch Wards had out-of-date templates for checking competencies. The templates awaiting approval were comprehensive and covered all aspects of a competency assessment unlike the out-of-date templates. This meant the trust could not be assured of all basic nursing competencies when making offers of employment.

The trust supported nursing and medical staff through revalidation with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw evidence of continuing professional development towards NMC revalidation in the staff competency folders we reviewed.

The service provided agency staff with an induction. Agency staff in theatres and on surgical wards told us they received a trust induction booklet to keep a record of their induction progress. The nurse in charge would go through the booklet with the agency staff and both staff members signed to confirm the staff received their induction. We saw a copy of the induction booklet which covered a range of topics including safeguarding, incident reporting, hand hygiene, falls management and sepsis. This process ensured agency staff worked to trust policies and procedures.

A ward manager showed us the trust electronic rostering system, which provided details of the competencies of each agency nurse. This meant senior staff could be assured agency staff had the necessary training and skills for their role.

The trust measured comparative outcomes by consultant. This meant the trust would be able to identify any deterioration in consultant performance and provide additional training or support.
Multidisciplinary working

We observed a “board round”, which demonstrated positive examples of multidisciplinary team working. The board round consisted of clinicians, nursing staff, physiotherapists, occupational therapists, the hospital and community discharge teams. We saw effective multidisciplinary and inter-agency input from the community discharge team for patients who had additional needs after their discharge. This meant the service ensured a safe discharge for patients with complex needs.

All seven patient records we reviewed showed evidence of entries from a wide range of professional input into the patients’ care. This included speech and language therapist, pharmacist, mental health specialist and acute pain team.

We observed a discharge on the Admissions and Discharge Lounge. We saw a patient received a walking frame to take home with them to maximise their independence while they continued their recovery. We saw a nurse counselling the patient on medicines to take home. We also saw the nurse telephoned a service providing ongoing occupational and physiotherapy in patients’ homes to confirm the patient’s discharge from hospital. The service was an initiative provided by the trust in collaboration with the local council and community healthcare trust. The nurse also telephoned the patient’s next of kin to confirm they were at home to receive the patient.

Patients we spoke with told us they saw good communication between nursing and medical staff, and the different wards.

Seven-day services

All surgical patients had a daily review from a clinician, seven days a week. Consultants led ward rounds most of the time and staff told us registrars often led the weekend ward rounds for general surgical patients with consultant oversight.

The service had access to an on-call physiotherapy services at weekends. There was also an on-call pharmacist available to provide pharmacy support in the evenings and at weekends.

The hospital’s diagnostic imaging department provided a 24 hour, seven-day on-call service. Staff we spoke with told us they could access the diagnostic imaging service with a quick response. This allowed surgical staff 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 the “NHS Services, Seven Days a Week, Priority Clinical Standard Five (2016)”.

The service had an emergency theatre, which was available seven days a week for urgent operations.

The service had access to 24 hour, seven days a week emergency consultant-directed interventional radiology services. This was in line with the “NHS Services, Seven Days a Week, Priority Clinical Standard Six (2016)”.

Health promotion

The service supported patients to live healthier lives. For example, mobilising joints, eating a healthier diet and smoking cessation after surgery. We observed staff discussing exercise regimes and dietary options with patients, and providing information on external agencies who could support patients who wish to stop smoking. On McCulloch Ward, we saw patients could access
information leaflets for example, smoking cessation, support for living independently at home and nutrition.

Staff on the Pre--Operative Care Unit explained the process for using a tool to collect and evaluate incoming surgical patients’ information. Patients met with a pre-assessment nurse prior to surgery to discuss their operation, health and risks. Patients received a copy of the questions they would discuss with the nurse prior to the appointment so that they could be prepared. This enabled staff to identify additional support or intervention for patients who may require it.

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

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

The trust provided training in the Mental Capacity Act 2005 (MCA) level two, which included MCA training and Deprivation of Liberty Safeguards (DoLS) training. From April 2017 to December 2017, the trust reported 73.1% of staff within surgery had completed MCA training. This was worse than the trust target of 85%.

A breakdown by nursing and medical staff is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental - hospital</td>
<td>71</td>
<td>120</td>
<td>59%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery</td>
<td>195</td>
<td>239</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

The 2017 training completion rate was worse than 2016 figures; DoLS with 80.4% and MCA with 81.1% completion. Trust data provided to us after the inspection showed 76% training completion rate as at June 2018 which was worse than the 2016 figures. This meant not all relevant staff had training to enable them to assess mental capacity and work within the legal requirements of the Mental Capacity Act (2005).

However, staff we spoke with could describe their roles and responsibilities under DoLS. For example, during a mental capacity assessment, staff on the Phoenix Ward told us they recognised a patient was highly agitated and felt it was in the patient’s best interests to have one to one support by a dedicated qualified nurse day and night. Staff recognised this would constitute a deprivation of liberty under the Mental Capacity Act (MCA 2005) as it would stop the patient leaving the ward. Staff liaised with the trust’s safeguarding team, who applied for a standard authorisation for DoLS. This action was proportionate and in line with the requirements of the MCA (2005). We saw dedicated areas on governance boards in staff rooms to record the details of any patients with a DoLS in place. This enabled staff to be aware of any current DoLS.

We saw written consent for surgery in all seven patient records we reviewed. We saw consultants had documented the risks and benefits of surgery, in line with General Medical Council guidance. We saw patients and consultants signed consent forms before the day of 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.

Pre-operative nurses we spoke with told us they considered capacity in every case. They would escalate any questions or concerns about capacity to their manager. Staff told us both their manager and the safeguarding lead were involved in the process and decision-making at best interests’ meetings when held.

Staff across the wards told us they worked with family members at best interests’ meetings where patients lacked capacity, to get the best outcomes for patients.

Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family Test response rate for surgery at Medway NHS Foundation Trust from December 2016 to November 2017 was 25%, which was worse than the England average of 29%.

Friends and family test – Surgical wards response\(^1\) (% recommended) from 01/12/2016 to 30/11/2017.

<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>
</tr>
</thead>
<tbody>
<tr>
<td>ARETHUSA</td>
<td>174</td>
<td>22%</td>
<td>90%</td>
<td>71%</td>
<td>78%</td>
<td>90%</td>
<td>89%</td>
<td>62%</td>
<td>57%</td>
<td>72%</td>
<td>86%</td>
<td>76%</td>
<td>83%</td>
<td>79%</td>
<td>76%</td>
</tr>
<tr>
<td>Kingfisher</td>
<td>270</td>
<td>29%</td>
<td>57%</td>
<td>77%</td>
<td>85%</td>
<td>86%</td>
<td>69%</td>
<td>71%</td>
<td>76%</td>
<td>80%</td>
<td>88%</td>
<td>94%</td>
<td>86%</td>
<td>89%</td>
<td>79%</td>
</tr>
<tr>
<td>MCCULLOCH</td>
<td>420</td>
<td>25%</td>
<td>90%</td>
<td>76%</td>
<td>85%</td>
<td>91%</td>
<td>92%</td>
<td>78%</td>
<td>61%</td>
<td>71%</td>
<td>90%</td>
<td>71%</td>
<td>88%</td>
<td>71%</td>
<td>82%</td>
</tr>
<tr>
<td>PEMBROKE</td>
<td>175</td>
<td>24%</td>
<td>81%</td>
<td>82%</td>
<td>81%</td>
<td>63%</td>
<td>84%</td>
<td>79%</td>
<td>80%</td>
<td>33%</td>
<td>67%</td>
<td>76%</td>
<td>33%</td>
<td>67%</td>
<td>76%</td>
</tr>
<tr>
<td>PHOENIX</td>
<td>336</td>
<td>21%</td>
<td>88%</td>
<td>85%</td>
<td>95%</td>
<td>84%</td>
<td>85%</td>
<td>85%</td>
<td>73%</td>
<td>83%</td>
<td>82%</td>
<td>77%</td>
<td>79%</td>
<td>86%</td>
<td>82%</td>
</tr>
<tr>
<td>SUNDERLAND</td>
<td>721</td>
<td>30%</td>
<td>90%</td>
<td>86%</td>
<td>77%</td>
<td>99%</td>
<td>91%</td>
<td>93%</td>
<td>88%</td>
<td>98%</td>
<td>88%</td>
<td>90%</td>
<td>94%</td>
<td>93%</td>
<td>91%</td>
</tr>
</tbody>
</table>

The average response rate for each ward was between 21% and 30%. The percentage of patients who would recommend the trust was generally over 70%, however some wards saw lower recommend rates in individual months. On Arethusa ward, only 57% recommended the trust in June 2017, on Kingfisher ward 57% of patients recommended the trust in December 2016 and on Pembroke Ward in October 2017, only 33% of patients who responded to the survey said they would recommend the trust to family and friends.

(Source: NHS England Friends and Family Test)

We observed nursing handovers on MuCulloch and Phoenix Wards. Staff demonstrated they maintained patients’ privacy and confidentiality. We saw two nursing staff around the patients’ beds with the curtains closed. They reviewed patients’ observation and medicine charts and checked patients had their call bells within reach. This meant nursing handovers took place discreetly and staff ensured other patients could not overhear their discussion.

We saw nursing staff discussed personal information discreetly at patients' bedsides such as enemas and catheter care. This enabled staff to maintain patients’ privacy, dignity and confidentiality during handovers. Therefore, staff followed the correct processes for bedside handovers.

We saw a nurse obtained patient consent before they started to perform a bedwash on a patient, with the curtains closed. The nurse explained to the patient they will ensure the patient’s body
parts were covered other than where they washed. This meant staff maintained the patient’s privacy and dignity.

We spoke with eight patients and four relatives on McCulloch, Phoenix and Victory Wards. Most of the patients felt they received good care. Examples of their comments were; “Care is second to none”, “doctors good and honest”, “relatives offered drinks” and “I can’t fault it”.

However, one patient on Phoenix Ward told us care was “generally pretty good” but said, “night staff a bit sharp, noisy at nurses’ station”. They told us they had been in “five or six different wards” and “moved once in middle of night early hours”. They also said, “The visiting times have changed from 10am to 8pm” and their partner “was not informed”. We raised this with the nurse in charge and we were told they had not been informed of the change. We observed the nurse checked with a senior staff member and they extended their apologies to the patient and their partner.

We also saw examples of compassionate care during our visit. This included staff in theatres maintaining patients’ dignity. On Phoenix Ward, we saw a clinical support staff help cover a patient when their gown slipped as they walked across the ward. On McCulloch Ward, we saw a nurse quickly attended to a patient experiencing physical discomfort and closed the curtains to main the patient’s privacy and dignity.

Staff told us they weighed all patients in private spaces to maintain privacy and dignity.

**Emotional support**

Nursing staff provided emotional support to patients and relatives in the first instance. A patient we spoke with on Phoenix Ward told us about a time staff comforted them when they were upset and took time to talk to them. The patient said, “They are giving me emotional support, they are just lovely caring people and they have made my not very nice experience much more bearable”.

During nursing safety huddles, we saw nursing staff showed awareness of patients suffering from anxiety or depression. We saw staff made appropriate referrals for mental health support for these patients.

The trust had a chaplaincy service to provide emotional and spiritual support for patients and their loved ones. Nurses talked about meeting patients different religious needs. They said the chaplaincy service was accessible to patients from different faiths.

Staff referred patients who had cancer surgery for specialist counselling according to the patients’ wishes. The referral form for counselling included an option to refer a patient’s relative, carer or friend. This meant patients’ loved ones also had access to emotional support.

The trust provided monthly “carers’ coffee breaks” in the hospital canteen. The purpose of the carers’ coffee breaks was to provide emotional support to the relatives and carers of patients living with dementia. We saw details of the coffee breaks advertised to carers of patients on Arethusa Ward.

The service had implemented a bereavement service that enabled families of patients who had died to obtain the answers they need and raise concerns. The purpose was to reduce complaints, inquests, litigation, provide support for families and carers and reduce psychological morbidity from abnormal grief reactions. This service was consultant-led. This meant staff provided an opportunity to offer emotional support to families and carers of patients who had died.

**Understanding and involvement of patients and those close to them**
Evidence-based literature identifies the involvement of patients as an advantage of bedside handover. We saw staff involved patients during nursing handovers at the patients' bedsides. We observed they introduced themselves before the handover and involved the patient in their care. On McCulloch Ward, we saw the nursing handover did not disturb a patient’s sleep. We also saw nurses leaned over and explained medical terms fully to patients. This meant patients were fully involved in their care during bedside nursing handovers.

We saw staff on the Admissions and Discharge Lounge involved patients’ relatives in their care. This included keeping them informed about discharge arrangements with the patients’ consent.

One patient told us staff respected their wishes not to be woken up in the night for routine observations. This meant the patient could sleep well at night. This demonstrated staff involved patients as partners in their care and understood their needs.

Pre-operative staff described finding the best way to communicate with each individual patient. For instance, depending on the patient’s needs they might draw pictures or use a monitor to communicate information to patients.

The trust engaged in the “Hello my name is…” initiative, which aimed at staff introducing themselves to patients. All patients we spoke with told us staff had always introduced themselves before any treatment or therapy. We also observed staff had introduced themselves in their interactions with patients.

**Is the service responsive?**

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

The service provided a diverse range of elective and emergency surgery to meet the needs of the local population. Surgical services covered general surgery, ear, nose and throat (ENT), orthodontics, anaesthetics, urology, orthopaedics and vascular.

Commissioners set performance targets for improvements in care delivery relevant to surgery around mixed-sex accommodation breaches and waiting times for cancer surgery. We saw evidence of regular engagement between the trust and commissioners around the planning and delivery of services.

Patients planning elective hip replacement had an occupational therapy review before surgery. This enabled staff to arrange appropriate equipment to meet their needs while they recovered in hospital following surgery. For example, raised chairs and mobility equipment.

In theatres, staff held a weekly meeting to plan theatre capacity and review staffing for the week ahead. Staff told us the service usually cancelled one to two day surgery lists in advance each week. This was usually due to lack of available surgeons or anaesthetic staff.

The service had a dedicated emergency surgical theatre and an orthopaedic trauma theatre which are available seven days a week for urgent operations. We saw the team review the emergency list at the start of their shift and moved patients to other theatre lists where appropriate. This enabled the service to prioritise urgent surgery for patients with the greatest clinical need.

At the last inspection, data from May to July 2016 showed theatre utilisation at the trust ranged from 61.7% (in theatre DS02 in July 2016) to 100.2% (in theatre TH03 in June 2016). Theatre TH07 saw the highest variation in theatre utilisation, ranging from 75.2% in July 2016 to 93.5% in May 2016. At the time of the previous inspection, the service had introduced a new dashboard to
monitor theatre utilisation more closely in an effort to improve efficiency. Trust information provided to us following this inspection showed 79.8% theatre utilisation for all theatres for April 2018. Of these, utilisation for main theatres was 87% and day case was 71.1%. This provided the service information to monitor the efficiency on theatre utilisation.

The Surgical Assessment Unit (SAU) introduced a “hot clinic” in 2016. The clinic ran Monday to Friday, 9am to 5pm. The purpose of the clinic was to reduce waiting times for patients needing ultrasound scans and minor procedures such as abscess drainage. It also helped reduce pressure on SAU beds and the emergency department. For example, the clinic allowed patients who attended the emergency department in the evening to go home overnight if they were well enough and attend a pre-booked scan in the hot clinic the next morning. The clinic also took referrals direct from GPs for patients needing an urgent scan. A surgical registrar led the clinic and also added patients to waiting lists for elective surgery and took consent where this was appropriate following assessment. This also helped reduce pressure on outpatients’ clinics and saved patients from waiting for an outpatient appointment.

The service had a Pre-Operative Care Unit. Patients went to unit before elective surgery for admission checks. Patients changed into their gowns and waited to go to theatres. The facility had four consultation rooms and 12 small cubicles with comfortable seating for patients and relatives.

**Meeting people’s individual needs**

A mixed sex breach is when male and female patients share the same bay. We did not see any mixed sex breaches during our visit to all areas within surgery. However, trust data from March 2017 to January 2018 showed there were 1,906 mixed-sex breaches within the surgical areas. This ranged from 15 breaches on Victory Ward to 1,477 breaches in the Surgical Assessment Unit. A breakdown of the number of breaches for all the areas is shown below:

<table>
<thead>
<tr>
<th>Surgery ward / area</th>
<th>Number of mixed sex breaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arethusa</td>
<td>26</td>
</tr>
<tr>
<td>Kingfisher</td>
<td>38</td>
</tr>
<tr>
<td>McCulloch</td>
<td>76</td>
</tr>
<tr>
<td>Pembroke</td>
<td>31</td>
</tr>
<tr>
<td>Phoenix</td>
<td>119</td>
</tr>
<tr>
<td>Sunderland Day Case Unit</td>
<td>124</td>
</tr>
<tr>
<td>Surgical Assessment Unit</td>
<td>1,477</td>
</tr>
<tr>
<td>Victory</td>
<td>15</td>
</tr>
</tbody>
</table>

The reasons for most of the breaches were not recorded. Only five breaches were recorded; two on Victory Ward as they accommodated the patients from the emergency department, one on McCulloch Ward due to stopping a patient being in recovery overnight and two on Phoenix Ward due to capacity issues.

Staff on the wards told us they often had mixed sex breaches. They reported the breaches on the trust’s incident reporting system and escalated to the senior management team. However, mixed sex breaches were a common occurrence due to bed shortages. Following the inspection, the trust informed us they implemented new guidelines and processes in April 2018, and had set an agreed trajectory to eliminate mixed sex accommodation breaches.

We saw ward placements of patients with intensive care need in recovery. We raised our concerns with the senior sister and we were told the acute response team would normally allocate a critical care trained nurse to care for the patient. However, we did not see this during out visit. This meant...
high acuity patients were in an inappropriate environment as there could have been insufficient nurse to patient ratios and specialists skills to meet the patients’ needs for additional support.

The trust had access to interpreters of many different languages, who provided both face-to-face and telephone interpreting services. Staff could book interpreters via the trust intranet or by telephone. Staff we spoke with knew how to arrange interpreters for patients who needed them. During a nursing handover on McCulloch Ward, we observed staff discussing the need to involve a language interpreter to discuss a patient’s discharge plans. We saw staff responded quickly to arrange this. We also saw the interpreter service responded immediately confirming an interpreter was available in the next hour. This is considered best practice as interpreters should be impartial and have appropriate training so staff have assurances they communicate important medical information correctly and do not try to influence the patient’s decisions.

The trust had a dedicated dementia and delirium team consisting of one clinical nurse specialist and one clinical support staff. The service used the "blue butterfly scheme". We saw staff placed a blue butterfly magnet above the bed of patients living with dementia. This provided a discrete way to help staff easily identify patients living with dementia and better meet their needs. The trust also had “dementia buddies”. These were trained volunteers available to spend one to one time with patients living with dementia. We also saw patients’ relatives and carers could access information leaflets on delirium.

Patients living with dementia and their carers completed a “this is me” passport. The passports provided person-centred information about the patient. This enabled staff to recognise and respond to the patient’s individual needs. Patients with learning disabilities also had individual care passports. Staff told us patients and carers completed the passports before their admission. This enabled staff to begin meeting the patient’s individual needs as soon as they arrive in hospital for their operation.

The trust had resources available for patients living with dementia who were recovering from surgery. Patients on Arethusa Ward also had access to a digital activity reminiscence system (DART). DART was a very large touch-screen tablet. Staff could programme a patient’s favourite vintage TV programmes, sports matches and music linked to their “this is me” passport. The trust also used “twiddle muffs”. Twiddle muffs were knitted bands with attachments to provide comfort and stimulation to patients living with dementia.

Arethusa Ward has implemented "John’s Campaign". This was a national initiative to allow open visiting for carers of patients living with dementia. This enabled carers to provide stimulation and help with the patient’s recovery. Carers had a carer’s passport, which enabled them to visit patients living with dementia at any time they wanted.

We saw a list of bariatric equipment in main theatres. This allowed staff to safely treat bariatric patients. Staff told us they could request additional bariatric equipment, such as wheelchairs, from the hospital’s equipment library. Staff gave us examples of times they had done this.

### Access and flow

#### Average length of stay

**Trust Level – elective patients**

From November 2016 to October 2017, the average length of stay for all elective patients at the trust was 2.4 days, which was better than the England average of 3.9 days.

All of the top three specialties at the trust (based on count of activity) had a lower length of stay when compared to the England average.
Trust Level – non-elective patients

From November 2016 to October 2017, the average length of stay for all non-elective patients at the trust was 4.4 days, which was similar to the England average of 5.0 days.

For the top three specialties at the trust (based on count of activity) one had a similar length of stay when compared to the England average (general surgery) and two had a lower (better) length of stay (trauma and orthopaedics and urology).

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

From February 2017 to January 2018 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. Performance ranged from 46% to 59% compared to an England average of 69% to 72%. There was a small improvement in performance from November 2017 to January 2018 with the best performance of the 12 months reported in January 2018 (59.1%).
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty is shown below. Of the four specialties with RTT data reported at the trust, only one specialty (urology) performed better than the England average. The worst performance was reported in general surgery.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>This trust</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>86.6%</td>
<td>76.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>39.0%</td>
<td>64.2%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>36.1%</td>
<td>61.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>28.8%</td>
<td>72.7%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

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.

The trust performed better than the England average for six out of the eight last quarters for the percentage of patients whose operation was cancelled and were not treated within 28 days. The trust’s performance was worse than the England average in quarter three 2016/17 (11%) and quarter four 2016/17 (18%) before improving to better than the England average again.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Medway NHS Foundation Trust
Cancelled Operations as a percentage of elective admissions - Medway NHS Foundation Trust

Over the two years, the percentage of cancelled operations as a percentage of elective admissions at the trust showed a decline overall with a marked increase in one quarter (quarter three 2016/17). The trust’s performance was worse than the England average for the first five quarters but for quarter one 2017/18 to quarter three 2017/18, the trust performed similar to the England average. Cancelled operations as a percentage of elective admissions only included short notice cancellations.

(Source: NHS England)

We saw medical outliers (medical patients on non-medical ward) occupying surgical beds. Staff told us the trust frequently used surgical beds for medical outliers due to a trust-wide shortage of beds. This meant beds intended for surgical patients were decreased. This situation then affected the flow of patients throughout the entire hospital and in particular the emergency department, potentially causing longer waits for the emergency department patients who required surgical assessment. Doctors we spoke with told us they currently had over 40 medical outliers throughout their surgical wards and this was worse over the winter period.

Staff used the recovery area in main theatres for overnight stays for patients recovering from surgery when demand for surgical beds exceeded capacity. This had not improved since we found this as an issue in our last two inspections. This was an inappropriate area to provide inpatient care as it had no facilities for patients to wash or use the lavatory. It also resulted in relatives of overnight patients visiting while patients who had immediately left theatre recovered.

Using recovery as an inpatient area also affected the flow of operating lists. We saw patients recovering in anaesthetic rooms due to the lack of recovery space. This delayed operations for subsequent patients on the list. We found this was a problem in our last two inspections and had not shown signs of improvement.

Staff told us delays in operating lists caused by the flow issues meant patients further down the operating list often had their operations cancelled. The matron told us they would make every effort to not cancel a patient on the list by default unlike what we found in the last inspection.
Although this had improved, the flow issues remained. Staff told us if they cancelled a patient, they would rebook the patient’s operation for the following morning.

Staff told us theatre lists always started on time since the implementation of new processes. The matron who had been in post for six months had introduced the new system. The average surgical start time was 8.30am (compared to 9am at the last inspection). This meant patients’ waiting time for their operation to start had improved by an average of 30 minutes. Although staff in theatres were initially resistant to adopt the new process, they now saw the benefit of it.

The trust could not provide the requested data on surgical bed occupancy rates at this inspection. This meant the trust could not be assured if all surgical beds were occupied. We were unable to compare the rates from the previous inspection, which ranged from 82.5% to 100% from September 2015 to August 2016.

Staff told us some patients had bed moves and discharges at inappropriate hours. One patient told us they were moved in the early hours and had been in five to six different wards. The late timing of discharges reduced the availability of beds on the ward, which contributed to night-time bed moves. It may have also caused some patients to arrive home from hospital late in the evening. This could cause difficulties for vulnerable patients, such as those with additional social care needs or elderly patients.

Learning from complaints and concerns

Summary of complaints

From January 2017 to December 2017, there were 147 complaints within surgery. At the time of reporting, 118 of these complaints had been closed. The trust took an average of 39 days to close these complaints. The trust had a target to close complaints within 30 days and complex complaints within 60 days. Only 42.4% of complaints were closed within 30 days and 83.1% of all complaints were closed within 60 days.

The majority of complaints had more than one theme. The most common themes of complaints were:

- All aspects of clinical treatment – 70
- Admission – 31
- Attitude of staff – 22
- Discharge and transfer arrangements – 22
- Communication / information to patients – 15
- Lack of general medical care and attention – 14
- Lack of general nursing care and attention – 14
- Complications during/following operation - 10

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

The latest trust data of 147 complaints within surgery had increased compared with 113 from August 2015 to July 2016. However, the average time the trust took to investigate and close complaints had improved. From August 2015 to July 2016, it took 105 days and in 2017 it took 39 days. The trust continued not to meet the trust’s complaints policy, which states the complaints response time should be within 30 days, unless the complainant agreed a longer period.

Staff we spoke with at all levels told us they received learning following complaints through their ward meetings and one to one meetings. We saw complaint feedback displayed on the governance boards and relevant folders on the surgical wards. Nursing staff were able to tell us
about changes to practice following lessons learnt from complaints. For example, one staff told us how improved communication with a patient's family had helped resolve their concerns informally without the need for escalation to a formal complaint.

We reviewed four formal complaints relating to surgical services in the last 12 months and the trust’s responses. In all four cases, 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. From complaint responses, we also saw the trust implemented changes to practice following complaint learning.

### Is the service well-led?

#### Leadership

The trust had restructured the senior management team in late 2017. A few staff told us they were not clear who their immediate managers were. They reported poor communication from the senior management team. They said some senior leaders were not appropriately skilled to carry out their roles. Staff gave an example where senior leaders had not communicated the changed visiting times for visitors, and found out only when visitors challenged them.

Not all staff told us that senior leaders were visible and approachable. All staff were able to identify the chief executive but not all staff were able to identify the deputy director of nursing. Staff told us the chief executive officer was approachable and had an “open door” policy.

Most staff we spoke with felt well supported by their line managers. We also saw that the matrons were visible on the wards and supported staff with patient care during busy times. Matrons filled clinical shifts in theatres when necessary, for example, due to staff sickness. However, matrons had several wards to oversee and could not always support staff with direct patient care during staff shortages.

#### Vision and strategy

The strategy for this service included improvements to theatre productivity, and recruitment and retention of more nursing staff. It also included plans to improve patient access and flow, which we also identified as areas for improvement at our last inspection in 2016 and during our visit. The trust had partnerships with local universities, which helped recruitment of newly qualified nurses. The trust also held nursing open days every other month to help attract registered nurses considering coming to work for the trust. However, staff told us the trust had failed to address the issue of retaining nursing staff. One of the matrons recognised that one of the options to help retain nursing staff was to improve access to training and development. However, the trust had yet to approve these since its proposal six months ago. We saw patient access and flow had not improved since our last inspection in 2016.

We saw that service had embedded improvements in a number of areas since implementation as a result our last inspection in 2016. This included recognition and escalation of deteriorating patients, learning from incidents, improved complaints processes, staff recruitment and referral to treatment times for colorectal cancer. However, the service recognised it still had more work to do.

The trust’s values were be bold, every person counts, sharing and open; and together (BEST). We saw the trust values displayed throughout the hospital. Staff we spoke with knew the values and could describe how they worked to them. For example, staff told us being bold was not being
afraid to raise concerns and report incidents. This showed the values were embedded within the service.

**Culture**

We found staff morale had improved at our last inspection in 2016. However, a few staff told us morale had returned to an “all time low” like how it was felt when the trust was in special measures. They reported morale had improved immediately after the trust had come out of special measures but this was short lived. Some staff on the wards told us they felt “exhausted” due to the prolonged staff shortage. In theatres, staff felt morale had improved after some resistance with new processes. However, we saw the matron position was interim. This meant uncertainties for theatre staff.

Before our inspection, we received information about bullying in general within surgery. However, managers told us they took these concerns seriously and the trust carried out a full investigation into these allegations. The investigation found the allegations were unsubstantiated. We spoke with 49 staff members, including doctors, across the areas we visited. Mostly of the staff told us they did not experience or witness bullying or harassment. They described supportive working relationships with their managers and colleagues. However, a few staff reported they had been told off by a senior manager for raising their concerns about staff behaviour.

A few staff we spoke with in the service felt the culture had deteriorated since the trust implemented the new management structure in late 2017. They said morale was worse because they felt some senior leaders lacked the appropriate skills to carry out their roles and the prolonged insufficient nurse staffing levels. Staff on the wards talked about positive working relationships with their colleagues and managers but felt the senior management team did not listen to them. On Phonex and McCulloch Wards, we saw staff supporting each other and working as a team during very busy periods.

The trust awarded “wow awards” to staff nominated by patients for providing a great patient experience. Staff on Phoenix Ward also told us they could nominate colleagues for the “team member of the month” award. Each month, a member of staff received a box of chocolates and a certificate. This helped staff feel valued by patients and colleagues.

The service encouraged openness and honesty. The trust provided training to staff around Duty of Candour as part of the “lessons of the week”. We saw information and guidance on Duty of Candour available to staff on the surgical wards. All staff we spoke with knew what Duty of Candour was and could describe their responsibilities relating to it.

**Governance**

Each surgery specialty for example, urology, vascular, orthopaedics, ear, nose and throat (ENT), general surgery and orthodontics had a clinical lead. The clinical lead for each specialty reported to the co-clinical directors for surgery who linked with the trust board. The co-clinical directors reported to each surgical specialty held monthly meetings, which included consultant, matron and management representation.

Surgical specialty governance meetings fed into the surgery programme board. The service discussed governance and quality issues at monthly surgical, critical care and perioperative programme board meetings which fed into the monthly directorate management board meetings. We saw copies of the minutes, which showed evidence of coverage around key areas. These included incidents, NICE guideline updates, safety alerts, performance dashboard, risk register and clinical audits.
The lead for perioperative governance also held weekly incident review meetings. At these meetings, staff discussed incidents related to surgery from the previous week. The perioperative governance lead took forward any incidents categorised as moderate harm or above for discussion at the weekly trust-wide harm-free meeting. This enabled further investigation and sharing of learning across other areas of the trust.

Management of risk, issues and performance

We reviewed the trust and service risk registers. We saw that items on the register matched the things senior staff told us were on their “worry list”. This included patient flow and the nursing staff shortage, which also fitted with areas we identified for improvement during our inspection. We saw evidence of mitigation of identified risks, for example, appropriate induction topics for junior doctors covering night shifts. However, we did not see the worn floors in the corridor of the main theatres and holes in a wall in the anaesthetic room on the trust-wide or service risk registers.

We saw the surgical dashboard, which monitored monthly performance in a number of areas. These included complaints response times, mortality, waiting times for surgery, discharge times and mixed-sex accommodation breaches. We saw that the service compared performance to the previous month to identify trends. This meant managers could identify emerging concerns and obtain assurances if they were performing well. We saw any corrective actions had a named lead and a completion timescale to ensure accountability.

We also saw the theatre dashboard, which monitored theatre activity. The theatre dashboard included trends in operation start times, use of the emergency theatre, consent and WHO surgical safety checklist compliance.

Information management

We saw in theatres, staff used paper to record all surgical cases despite having an adequate electronic theatre management system. This meant staff had to draw information from paper trails making it an ineffective use of their time. This could also potentially mean the trust could not be assured that the risk of information loss was minimised.

The trust was unable to provide the number of medical staffing shifts available per month due to the data being collected manually. This meant the trust could not calculate the bank and agency medical staffing fill rates. The trust also could not be assured on effectively made changes in a timely manner when required. However following this inspection, the trust assured us they were on plan to implement electronic rostering for medical staff by September 2018.

Engagement

Since the last inspection, we found the trust had introduced several public engagement initiatives. For example, engaging with the local community, stakeholders and public to obtain more information about the trust and involved people to have a say in the future improvement of their services. The trust ensured an active presence at health and community fayres. This enabled the trust to hear patient experiences first-hand. The trust also had trust governors who held sessions in the community. This enabled them to learn of the public’s experiences of accessing healthcare support.

The trust had helped promote and facilitate commissioning engagement events to enable local service redesign. For example, they supported engagement on vascular and stroke services as part of service reviews. They facilitated a focus group with patients who had chronic obstructive pulmonary disease. This enabled them to use the findings to inform service redesign.
Staff told us the chief executive ran weekly staff forums to engage with staff. Staff who had attended a session said they found it useful. However, many staff working in the surgical directorate said they did not have time in their working day to attend a session because they were so busy.

The trust improved on a number of measures by acting on information from the 2016 staff survey. Results from the 2017 survey showed several areas had improved. Examples of these are the reporting culture which had improved by 14%, action regarding staff health and wellbeing by 0.23%, recognition and value by the organisation by 0.16%, confidence when reporting unsafe clinical practice by 0.15% and fairness of procedure for reporting errors, near misses and incidents by 0.14%. Staff also reported a decrease of work-related stress by 4%. This meant the trust recognised where significant attention and work was required, which included staff perception of an expectation to attend work whilst feeling unwell and experiences of harassment which remained higher than national averages for other NHS acute hospitals.

The trust had introduced culture development workshops to enable them to better understand the barriers to staff engagement which were implemented in December 2017. Senior managers told us this was a valuable method of staff contact and was vital to increase staff engagement.

The trust had relaunched “staff awards” and “Medway Observations”, which was a local culture survey. Staff told us the trust was actively committed to “Fab Change” day; with staff pledging their commitment to support changes within their areas of work and across the trust.

The trust told us they introduced the “Professional Pyramid”. This is designed to address behavioural activity before it is allowed to have a negative impact on staff. The training delivery and implementation began in March 2018. This meant it was too early to ascertain the outcomes of this initiative.

Senior staff told us the trust held management master classes. This gave front line managers and staff access to a range of management and personal development skills.

The trust had membership in the Kent Resilience Forum, which brought together emergency services and other responders such as the NHS, utilities and the voluntary sector.

**Learning, continuous improvement and innovation**

The hospital introduction of a trust-wide deteriorating patient programme in 2016 had seen the improvement of staff education and training in key areas including national early warning scores (NEWS) in the last inspection. During this inspection, we saw staff had embedded learning.

Nursing staff on surgical wards told us the twice-daily “safety huddles” introduced since the last inspection had a positive impact on patients’ care. We saw staff had identified and highlighted patients at increased risk for additional monitoring to help improve patient safety.

The service had implemented “Da Vinci Robot”. This is a minimally invasive surgery tool to provide care to patients undergoing prostate surgery. Under the control of a highly-trained surgeon, the tool was able to perform complex and precise procedures in a way not possible with human hands. The trust is the hub of the West Kent Urology Cancer Centre. This meant prostate cancer patients across the whole region could benefit from this service. The service also had future plans to expand the range of procedures carried out by the tool.

The trust participated in the National Emergency Laparotomy Audit (NELA) project. This was consultant-led and had seen a reduction in mortality from 22% to 12% for emergency laparotomy.
This service had also been selected as one of 14 pilot sites to take part in the Royal College of Surgeons Cholecystectomy quality improvement project.

The service had implemented a bereavement service that enabled families of patients who had died to obtain the answers they need and raise concerns. The purpose was to reduce complaints, inquests, litigation, provide support for families and carers and reduce psychological morbidity from abnormal grief reactions. This service was consultant-led. The team sent an invitation to the patients’ next of kin within 24 hours of the death, to attend a one-hour meeting. Trust data showed the feedback forms demonstrated that 44% of the 18 families reported that they would otherwise have submitted a complaint to the hospital. Of the 18 families, 78% stated they had obtained closure, obtained answers to the questions they needed or felt their concerns were listened to.
Critical care

Facts and data about this service

The trust identified critical care as: “the treatment and monitoring of people who are in a critically ill or unstable condition”. The critical care team supported the care of inpatients across all of the hospital specialities.

The trust had 25 critical care beds. Medway Maritime Hospital had three adult critical care wards:

- Level 3 intensive care unit (ICU) – nine beds
- Level 3 surgical high dependency unit (SHDU) – 10 beds
- Level 2 medical high dependency unit (MHDU) – six beds

We inspected the following services:

- Intensive Care Unit (ICU)
- Medical High Dependency Unit (MHDU)
- Surgical High Dependency Unit (SHDU) ‘Trafalgar’

The Neonatal intensive care unit was not inspected because it is part of the Children’s and Young adult’s services.

The intensive care unit provided care for critically ill patients with complex needs such as those requiring advanced respiratory support (ventilation), advanced renal support (hemofiltration) and other complex therapies. The unit was adjacent to the main theatre department which facilitated the transfer of complex surgical patients directly into the unit.

The medical high dependency unit (MHDU) treated patients largely referred from accident and emergency, the medical assessment unit (MAU) and the general medical wards. This service also provided step-down care to patients discharged from the intensive care unit (ICU) requiring intermediate treatment and monitoring prior to discharge to a general ward.

The unit provided a wide range of medical care which included: advanced non-invasive respiratory support (vapotherm, bi-level positive airway pressure and continuous positive airway pressure); advanced cardiovascular support (including inotropes) and continuous monitoring of vital signs (including both arterial and central monitoring). The unit was located at the medical high dependency unit, adjacent to the medical admissions unit which facilitated the transfer of patients directly to the unit.

Patients admitted to the surgical high dependency unit (Trafalgar) were referred for a variety of reasons. This included the complex nature of their surgical procedure, their existing medical conditions, or they may be transferred from the intensive care unit and required more complex monitoring and care prior to going back to the general wards.

The unit provided a range of critical care treatment which included non-invasive ventilatory support equipment for the treatment of sleep apnoea and other respiratory and cardiac problems, advanced cardiovascular support including the use of inotropic drugs (drugs that affect the strength of contraction of heart muscle) and the continuous monitoring of vital signs including arterial and central monitoring.
An acute response team provided a supportive role to the wards medical, surgical and nursing staff when caring for deteriorating patients and supporting patients discharged from critical care. This team was available 24 hours a day, seven days a week.

Before our inspection, we reviewed performance information from and about the trust and data from the Intensive Care National Audit and Research Centre (ICNARC). The trust was a part of the South East Critical Care Network.

During our inspection we visited all three adult critical care units and the acute response team. We spoke with 32 staff members who included all grades of medical and nursing staff, senior managers, clinical support workers, physiotherapists, occupational therapist and pharmacists. We spoke with three relatives and six patients. We observed the care and treatment patients were receiving, attended multi-disciplinary unit rounds and reviewed 12 patient records including medicine prescription charts.

Before our inspection, we reviewed performance information from and about the trust and data from the Intensive Care National Audit and Research Centre (ICNARC).

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

Staff told us they were provided with a trust wide induction and a service induction. Mandatory training was identified during these inductions and completion rates checked during supervision or appraisals.

The trust supported staff to stay up-to-date with a range of mandatory topics through the Medway online learning management system. This learning system allowed staff to access training via smart phone, tablet device, laptop or desktop, and worked on a self-service basis. A member of staff demonstrated how they accessed the system on their phone, they described the system as easy to use, and could access the system during working hours and at home to complete training.

Mandatory 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 mandatory training. A breakdown of compliance for mandatory courses for medical and dental staff in critical care is shown below:
The most recent data available indicated 86% of medical staff were compliant with mandatory training, which was better than the trust target.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and midwifery staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>64</td>
<td>67</td>
<td>96%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>62</td>
<td>67</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>60</td>
<td>65</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>59</td>
<td>64</td>
<td>92%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>60</td>
<td>66</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>56</td>
<td>67</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>53</td>
<td>65</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>50</td>
<td>64</td>
<td>78%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>42</td>
<td>63</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met the training target in five out of nine eligible training modules for qualified nursing staff in critical care. The lowest training compliance rate was for adult basic life support with 67% compliance.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)
We were shown that sepsis training was also available through the online training system and encouraged to be reviewed on a yearly basis.

Staff told us senior staff encouraged them to attend mandatory training and complete electronic learning modules. However due to clinical workload staff said they would often need to complete training after work hours or complete training during their non-working days.

**Safeguarding**

Staff were clear about the definition of a safeguarding issue and how to escalate safeguarding concerns. Staff gave a recent example of when safety concerns about a patients' relative had been identified. Appropriate action was taken by contacting the local safeguarding lead and local authority safeguarding board and the relative was found a place of safety.

Staff knew how to access the trust’s safeguarding policy and the safeguarding team. We saw the safeguarding policy had up to date information on escalation. The contact numbers for the head of safeguarding adults and the nurse specialist were displayed on the unit’s notice boards. for. Child safeguarding contacts were also available.

The trust told us staff were made aware that female genital mutilation was a safeguarding issue through safeguarding training. There was a service operational procedure available to guide staff through the referral process.

Data was collated by the audit office and submitted to the Department of Health as required. Relevant information was shared with named general practitioner, social care and health visiting using concerns and vulnerability forms, safeguarding hub referrals and electronic discharge notifications.

**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. 84% of staff in critical care had completed safeguarding training from April 2017 to October 2017.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for medical and dental staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>47</td>
<td>54</td>
<td>87%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>48</td>
<td>56</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>2</td>
<td>4</td>
<td>50%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the target for the two eligible safeguarding courses for medical and dental staff in critical care.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for qualified nursing and midwifery staff in critical care is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>57</td>
<td>66</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>52</td>
<td>65</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met the target for one of the two eligible safeguarding courses for qualified nursing and midwifery staff in critical care.

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

**Cleanliness, infection control and hygiene**

The units we visited were visibly clean and tidy. Housekeeping staff were employed by the trust and all areas displayed on boards the cleaning schedules for the area and the most recent housekeeping audit scores. For example on the intensive care unit, the cleaning schedule showed the risk assessment for each area to be cleaned, the times staff could access the area and a weekly lists of tasks, the schedule was signed to show recent cleaning had been completed. The unit housekeeping cleaning audit score for the past year showed that for ten months the unit achieved the target score of 98% and on the other two months the scores were no more than 2% away from target.

There were checklists to show that clinical staff made a daily check of their clinical area and conducted cleaning to the equipment in use in the bed space.

Infection prevention and control information was displayed to staff and visitors on all inspected critical care units. There was information for visitors about infections, for example methicillin resistant staphylococcus aureus, explaining care and treatment.

We saw each bay presented information on “being hands aware”. Hand wash facilities were available in each bay and alcohol gel was available at every bed space. We also saw patient leaflets regarding handwashing were available at the entry of the units.

We observed medical and nursing staff were compliant with key trust infection control policies, for example, hand hygiene and were bare below the elbow. This is in line with Nation Institute of Health and Care Excellence (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.

All units displayed the most recent hand hygiene results for example on the medical high dependency unit for the month of March the audit result was 100%. Results for all three units during the past twelve months showed an improvement with an overall average score of 96%.

We observed appropriate use of personal protective equipment such as disposable gloves and aprons on all areas. All areas had access to single rooms which enabled staff to care for patients that required nursing in isolation. On the intensive care unit, there was one patient being managed in isolation and we saw that appropriate signage was in place.

The surgical high dependency unit had two bays and two side rooms for treating patients. Bay areas had the ability to be screened and we saw disposable curtains being used. These were dated and changed every six months in line with policy.
In all three units we observed all the equipment was visibly clean and labelled with the date it had been cleaned when not in use. The units’ sluices were also clean and tidy with all commodes clean and labelled with “I am clean” stickers attached. We noted the patient assisted shower was clean on the surgical high dependency unit.

We saw that kitchen area in the critical care unit was clean and tidy. Linen storage areas were generally clean and tidy. However, in the intensive care unit stationary store there was a lot of paper stored on the floor and the floor appeared dusty. Paper stored on the floor could be a potential safety hazard for trips and falls and also obstruct the normal cleaning process of the room.

All units had sharps bins which were correctly assembled, dated and signed. Staff knew how to seal and dispose of sharps bins. This was in line with Health and Safety (Sharp instruments in Healthcare) Regulations 2013.

The hospital had published an annual infection prevention and control (IPC) report 1st April 2016 to end March 2017 demonstrating all ongoing surveillance the service completed and was underway for the current year. There was a designated director of infection prevention and control and infection prevention and control team in line with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of Healthcare associated infections and related guidance. The team included qualified infection control nurses and microbiologist. There were infection prevention and control link persons for all the critical care units.

Environment and equipment

We noted that access to all inspected units was managed by intercom or keypad. This ensured access to the critical care units was controlled and ensured safety. Members of staff would identify themselves and the ward for which they were working and asked how they could help us.

We saw fire extinguishers were present on all inspected services and in date. We also saw that fire exists were checked and clear. We spoke to the critical care matron who said there had been a table top fire evacuation exercise jointly with theatres. We were told there was also bespoke fire warden training. We also saw the fire safety logbook and reference manual and these clearly stated who the fire safety advisor was. The fire safety policy was available to all staff.

There were information staffing boards throughout the critical care services; these were up to date and showed staff numbers, names and designations. These were accompanied by photographs of the staff.

Resuscitation trolleys in all the critical care units were checked daily. We saw a selection of checks over the past two months and all were complete. All equipment was clean and stock was within date.

There was emergency tracheostomy and difficult intubation equipment available on the units. The emergency equipment checklists had been completed and were up to date.

At the entrance of the surgical high dependency unit we saw there was a notice board giving patients and relatives clear information about the purpose of the unit as well as information and pictures explaining what equipment was used and why. The information board also presented patient satisfaction results for the past three months and included verbal patient feedback.

We saw that the relative’s waiting room was comfortable and had tea and coffee making facilities. Children’s toys were available and were visibly clean and tidy.

In all critical care units we found appropriate waste segregation and disposal systems in place with the use of different coloured bags to identify the different categories of waste, the bins clearly...
stated what should be disposed in them. This was in accordance with HTM07-01, Control of Substances Hazardous to Health and the Health and Safety at Work regulations.

We saw that equipment stores were tidy. We performed random stock checks and saw all stock was in date. We inspected the main equipment storage room at the intensive care unit. All equipment was stored appropriately and in an organised manner. We were told that all equipment had a designated name for ease of identification. This was seen on monitors and helped staff quickly identify which monitor was being used and if any issues occurred to identify the equipment correctly.

We randomly checked eight pieces of equipment to see if they had stickers showing service dates. Five had stickers, three did not. We asked to see the equipment services copy inventory for intensive care unit assets and a list of 447 pieces of equipment were seen. All details were completed and contained asset identification, descriptor, manufacturer, model, serial number and service interval. We also saw reports of equipment sent to repair and these appeared to be complete.

The trust told us that all staff received training in specialised equipment used in the intensive care unit to ensure safe practice. The trust provided evidence that staff completed equipment awareness training and had competencies on the use of equipment in the unit.

There were daily checklists that showed staff made checks on the equipment in use in the patient bed space.

We saw that the current medical device policy showed the required frequency of training and level of training identified as low, medium or high risk depending on the equipment. Training for new equipment introduced to the unit was provided by the manufacturer. There was a lead equipment nurse who was responsible for auditing equipment training and service data and ensuring training arrangements for staff. This nurse supported ongoing competency training for staff although this was the responsibility of the individual staff. Staff was split in four training teams to facilitate yearly updates and promote equipment days that could cover all staff. Training needs were also discussed at staff’s annual appraisal.

We saw that a patient hoist was available and was cleaned and serviced. The hoist had information attached to it showing how to use the hoist correctly and the appropriate patient weight the equipment could support.

Assessing and responding to patient risk

Staff had easy access to ‘The Green book’. This book consisted of 36 emergency situations and their respective algorithms for the management of acute clinical emergencies. This enabled staff to have quick access to this information. For example, it identified what actions should be taken in the case of when the patient had hyponatraemia, which means a low salt level in the blood which can give rise to complications. We saw this book located in key areas such as attached to the resuscitation trolley in the surgical high dependency unit.

The acute response team (ART) provided outreach critical support cover 24 hours a day; seven days a week. The acute response team covered all the wards and departments in the hospital and accepted referrals from any member of staff, they were involved with massive haemorrhage call outs and resuscitation. The acute response team nurses also had Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) training so they could order X-rays enabling diagnostic tests to be done in a timely way.

The trust used the national early warning score system for the monitoring of vital signs in adult patients to highlight early signs of when a patient’s condition may be deteriorating and may
require a higher level of care. This was in line with the Royal College of Physicians (2012) National Early Warning Score (NEWS) standardising the assessment of acute-illness severity in the NHS: There should be a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response.

In the critical care units staff demonstrated that the NEWS score was in place before the patient was transferred to the ward areas.

The unit had a sepsis box to ensure staff had prompt access to the appropriate equipment and treatment required for patients diagnosed with sepsis. Staff were trained in recognising sepsis.

Staff completed relevant risk assessments and care bundles, for example, pressure ulcer, venous thromboembolism (VTE) and intravenous cannula risk assessments. These were fully completed in the three patient records we reviewed.

Staff we spoke with knew how to access the mental health team. However, they told us they could experience delays in the mental health team attending the unit if the accident and emergency unit was busy.

We saw evidence of coordinated care between wards, departments and the critical care units at the clinical co-ordination centre. Patient flow and bed status on the critical care unit, any unwell patients on the wards and any patient’s potentially needing surgery were constantly reviewed and discussed. This meant there was coordinated approach to assessing and managing patient risk.

**Nurse staffing**

The trust reported their registered nursing staff numbers as below for December 2017. The trust had a nursing fill rate of 89.9%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>76.2</td>
<td>68.5</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.

The trust reported an annual vacancy rate from January 2017 to December 2017 of 7.5% for qualified nursing and health visiting staff in critical care. This was better than the trust’s target of 12%.

(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.

The trust reported an annual turnover rate from January 2017 to December 2017 of 14.6% for qualified nursing and midwifery staff in critical care. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate which is the data that has been provided by the trust.

(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.

The trust reported an annual sickness rate from January 2017 to December 2017 of 3.7% for qualified nursing and midwifery staff in critical care. This was better than the trust target of 4%.

(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 January 2017 to December 2017 the trust reported a bank and agency fill rate of 11.4% in critical care with a further 8.1% of shift remaining unfilled. A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>8 (2.2%)</td>
<td>6 (1.6%)</td>
<td>17 (4.7%)</td>
<td>365</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>679 (4.9%)</td>
<td>930 (6.7%)</td>
<td>1,134 (8.2%)</td>
<td>13,870</td>
</tr>
</tbody>
</table>

Only 14 out of 365 nursing assistant shifts were filled by bank or agency staff whilst 8.2% of qualified nursing shifts remained unfilled.

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

Staffing on the intensive care unit was planned to be at a ratio of one registered nurse for each level three patient and one registered nurse for every two, level two patients. In line with the Guidelines for the Provision of Intensive Care services, 2015. Each shift was to have a supernumerary nurse in charge but this was not the case on the day of the inspection. Staff told us that at busy times or if there was sickness the nurse in charge would not be supernumerary.

On the surgical high dependency unit (SHDU) we saw that staffing for this unit normally consisted of a shift of six nurses and a care support worker. This assured there was one to two nurses per patient. This was in line with the guidelines that level 2 patients require a registered nurse/patient ratio of a minimum 1:2 to deliver direct care. We reviewed the electronic staff rota and saw that during at least two days in March 2018 there was a shortage of one nurse per shift. On the surgical high dependency unit, we observed that the service only needed to use agency staff on infrequently and only one or two agency staff per shift.

On inspection the medical high dependency unit (MHDU) was staffed with three nurses with a senior nurse supernumerary and in charge. The nurses were supported by a care support worker and another supernumerary nurse training for the acute response team. This met the staffing requirements. We were told staffing was highlighted on the ward watcher database and should extra support be needed staff could rely on the support of the acute response team.

Staff told us that critical care nurses sometimes felt that staffing rotas did not reflect what staffing levels were actually like on all critical care units. This was because nurses would often be called to support other wards due to staff shortages or would be relocated to recovery beds meaning that
staff on the wards would be short of the recommended staffing levels identified in the Guidelines for the Provision of Intensive Care Services, 2015.

On the intensive care unit when the unit was at capacity, if there was a level three patient in the theatre recovery area one nurse would be required to manage the patient there. When speaking to the matron this was identified as a true statement but we were assured that patients’ needs and provision of care was not affected as there were continuous bed rounds and risk assessments to ensure staff was always located where they were most needed and to support patients with highest risks.

The acute response team had a cover of two nurses per shift from 8:00am to 8:30pm and one person on twilight hours. The team was led by three band 8a nurses and there were a total of 15 whole time equivalent (WTE) nurses that made up the acute response team. We were told there was one vacant post in this service.

**Medical staffing**

The trust reported their medical staffing numbers as below for December 2017. The trust had a medical staffing fill rate of 92.7%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental - Hospital</td>
<td>62.8</td>
<td>58.3</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.

The trust reported an annual vacancy rate of 8.3% from January 2017 to December 2017 for medical and dental staff in critical care. This was better than the trust’s target of 12%.

*(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.

The trust reported an annual turnover rate from January 2017 to December 2017 of 45.3% for medical and dental staff in critical care. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate which is the data that has been provided by the trust.

*(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.
The trust reported an annual sickness rate from January 2017 to December 2017 of 1.0% for medical and dental staff in critical care. This was better than the trust target of 4%.

(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.

The trust was unable to provide the number of shifts available per month due to data being collected manually, therefore bank and locum agency fill rates could not be calculated.

From January 2017 to December 2017 268 shifts were filled by agency staff whereas 92 shifts were filled by bank staff and 27 shifts remained unfilled.

A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>87</td>
<td>4</td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td>SHO</td>
<td>70</td>
<td>24</td>
<td>5</td>
<td>99</td>
</tr>
<tr>
<td>SPR</td>
<td>111</td>
<td>64</td>
<td>13</td>
<td>188</td>
</tr>
</tbody>
</table>

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

Critical care services were meeting the Guidelines for the Provision of Intensive Care Services, 2015 for consultant cover. We were told consultant work patterns delivered continuity of care with a consultant in intensive care medicine available twenty four hours a day, seven days a week. Consultants also attended twice daily ward rounds.

A senior sister told us that the medical high dependency unit had cover until 12:00am and weekend cover until 6:00pm. Out of hours medical cover was provided by the medical team with assistance from the intensive care unit and surgical high dependency unit trainees and anaesthetic on-call as required. During this period of time, if any patient deteriorated significantly an arrest call was made to ensure an immediate medical response.

We were told that senior house officers (SHO) provided cover over night time. However there were two vacant posts and the rota was one in four weeks which did not give assurance of appropriate staffing.

The lack of junior doctors rotating in to the critical care units was identified as a risk and was noted in the risk register for the directorate. The junior doctors on call rota showed multiple gaps as there were three vacant posts. The development of the advanced critical care practitioner role was being supported to mitigate this shortage. There were four staff undergoing this training.

Records

The intensive care unit (ICU) and surgical high dependency unit (SDHU) used an electronic system to record patient data. This system was praised by staff as it was easy to use and enabled data to be viewed at any time. All critical care units used the electronic system ward watcher to ensure all bed spaces were monitored.
On the medical high dependency all patient records were manual as they were not using an electronic database. We saw two sets of patient records which were complete with including observation charts designed to capture all patient observations including fluid charts, pain assessment, nausea scores and recording all nursing interventions with two hourly observations recorded. These showed regular and complete observations of the patient’s condition.

We reviewed nine patient records on the electronic system that showed that nursing documentation included care bundles and risk assessments. Nursing records were accurate, complete and in line with trust and professional standards. Records we reviewed showed evidence of holistic assessments which focused on details other than physical health needs. For example, additional information for a patient with confusion or delirium.

We also saw medical documentation was complete, in line with trust and professional standards and recorded that care was delivered in line with the Guidelines for the Provision of Intensive Care Services, 2015. For example, there was evidence of a consultant review on admission to critical care and of daily input from the multidisciplinary team.

The physiotherapy team completed records that met the National Institute for Health and Care Excellence (NICE) CG83 (rehabilitation after critical illness) requirements during a patient’s stay in critical care.

The critical care admission and discharge forms presented clear documentation of the time and decision to admit to intensive care. This was in line with the NICE CG50 acutely ill adults in hospital: Recognition and response to acute illness in adults in hospital).

**Medicines**

Critical care services had a dedicated pharmacist. During the week between the times of 9:00am to 5pm access to advice and required medicines was good. Weekend access to medicines and advice was more difficult. On occasions staff had to access medicines from other wards and staff described this as time consuming when they were busy on the ward.

We spoke to a pharmacist who said that due to staff shortages in the pharmacy department they could not be present on all ward rounds. This could potentially mean that pharmacists were not capturing issues at the point of presentation and potentially medicines may be given that have not been checked by the pharmacist. However, we saw no evidence of incidents due to medicine mismanagement.

Staff kept accurate records of medicines and performed daily balance checks in line with the trust policy. We checked two patients’ drug charts. Patient’s medical history and allergies were checked and all drugs were signed as given. We also did two random checks on the controlled drugs register and the daily balance checks were documented and correct. We also saw evidence that controlled drugs risk assessments were checked daily.

Fridge and freezer temperatures were checked and recorded on a daily basis. This ensured that stored drugs and products were kept at a temperature to ensure the integrity of the drug.

The inspected critical care units had appropriate systems to ensure that medicines were handled safely and stored securely. Controlled drugs were appropriately stored with keypad access restricted to authorised staff.

**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 January 2017 to December 2017, the trust reported two incidents classified as never events for critical care.

One never event occurred in September 2017 which was a retained foreign object post procedure which related to a guide wire being left in situ in a patient. The second never event was a misplaced naso-gastric tube and took place in November 2017.

(Source: Strategic Executive Information System (STEIS))

Both incidents had a root cause analysis completed as per clinical guidelines and this process was seen as an opportunity to review practices and disseminate learning. Duty of candour was exercised in both instances.

The never event involving the guide wire retention also led to learning and service development opportunities. The local safety standard for invasive procedures (LocSSIPs) was amended and a new separate checklist established. There was also a renewed culture of involving all the staff in the safety routines of these procedures. Staff were aware of these changes. The findings and actions taken were presented at the quality improvement committee.

The never event involving the misplaced naso-gastric tube prompted the trust to enhance nurses training in naso-gastric tube placement. Additionally a flow chart was developed showing the management of the naso-gastric tube for patients with and without an endotracheal tube. Learnings were shared in a similar way to the previous incident.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from January 2017 to December 2017.

Two of the SIs reported were the never events detailed above. The third SI was a pressure ulcer meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

We saw evidence of incidents being discussed in monthly team meetings. Additionally there were Green team meetings held three times a year. These team meetings were used to discuss incidents and update learning outcomes into the ‘Green Book’. This was an area of good practice as it allowed emergency algorithms to be reviewed and updated in line with learning from incidents.

The information governance board on the critical care units displayed learnings from incidents and complaints. For example on the medical high dependency unit following a patient fall, identified actions such as the “lying and standing blood pressure must be completed on all patients who are at high risk of falling within 24 hours of admission and if their condition changes”. There was also mention of one incident recorded of a pressure ulcer on display for staff awareness.

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

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

Data from the Patient Safety Thermometer showed that the trust reported one new pressure ulcer, no falls with harm and two new urinary tract infections in patients with a catheter from December 2016 to December 2017.

(Source: NHS Digital)

We saw evidence of patients being assessed for venous thromboembolism (VTE) on all critical care units. This was in line with NICE QS3 Statement 1: All patients, on admission, receive an assessment of venous thromboembolism and bleeding risk using the clinical risk assessment criteria described in the national tool and NICE QS3 Statement 4: Patients are re-assessed within 24 hours of admission for risk of venous thromboembolism and bleeding. Patients were also assessed for pressure ulcer and falls risk and reviewed on a risk basis.

Audit nurses for each unit looked at the data for venous thromboembolism, pressure ulcer and falls risk and ensured the information was complete for each patient. If a risk assessment was missing this would be prompted immediately and if any risks were identified these would be reviewed on ward rounds.

We spoke to staff member who said that they completed the service collected data for the safety thermometer on a monthly basis. This would include six fluid charts, six NEWS charts if possible, the audit for pressure ulcers and six patients information. Where omissions were found on completion of fluid charts and NEWS staff was alerted to this. This was good practice and we saw evidence of these alerts on the staff board.

We were told that every morning safety huddles in critical care units shared the safety message of the week. This was to promote a continuous culture of safety awareness.

Is the service effective?

Evidence-based care and treatment

The unit’s policies, protocols and care bundles were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM). For example, the green book which contained algorithms for a range of critical clinical emergencies showed reference to best practice and most recent guidelines available.

Staff demonstrated awareness of the policies and knew where to access them.

We saw evidence that protocols, policies and local safety standards (LocSSIPs) were clearly documented on the units’ electronic system, on the hospital’s intranet system or resource folders easily accessible at the units. In addition to the critical care protocols we saw protocols involving deprivation of liberty, Mental Capacity Act and pregnancy. We also saw LocSSIPs for nasogastric tubing, delirium, wounds and dressings, pressure ulcer prevention and management, nutrition, rehabilitation and infection control.
Staff told us they were able to deal with mental health needs in an appropriate way and knew where policies were located regarding the management of the emotional and psychological well-being of patients. Handovers were routinely done and documented highlighting the patients and their carers and relatives emotional needs as well.

The service ensured that Intensive Care Society standards and policies were reviewed. This was done with the use of interest groups and different staff who were assigned to review different protocols and guidelines. Any new practice or changes to guidelines would be highlighted in band six and seven meetings or operational meetings and weighed against the most recent evidence such as the NICE guidance or research. Any changes and suggestions would then be highlighted to senior level staff and ratification of guidelines completed through safety assurance groups. Dissemination of the findings was then transmitted through team meetings.

Critical care services and the trust were dynamically involved in studies and trials which could also influence provision of care. We saw evidence of the most recent trial to influence practice through the Optimise trial. This trial looked at improving treatment for patients suffering from acute pulmonary embolisms. Findings of this study would be shared with all relevant clinicians and best practice disseminated through practicing clinicians, reviewed local guidelines and procedures.

**Nutrition and hydration**

Nursing staff assessed patients’ nutritional and hydration needs using the malnutrition universal screening tool (MUST).

The critical care units had a feeding protocol in place. This provided guidance for staff on feeding patients who were unable to eat and needed to be fed by nasogastric tube. Staff had access to resources about nutrition in a folder. This was in line with Guidelines for the Provision of Intensive Care Services, 2015: All patients unable to take oral intake should normally have nutrition support (enteral or parenteral) commenced on admission, to ensure adequate nutrition to facilitate rehabilitation.

A dietitian visited the unit three times a week between Monday and Friday and could be called if any advice or urgent situation occurred. The dietician would also let the hostess know if there were any particular patient requirements. We were informed staff could refer patients to speech and language therapy if a swallow assessment was required.

Patients had varied food choices and could select their meals through one of the catering meal leaflets. These leaflets offered several options for lunch and supper for each day of the week on a weekly rota and were associated to dietary codes. The leaflet also identified if a patient required mealtime support or if they were on a special menu or diet. Additionally the leaflet also identified contact numbers for catering and housekeeping as well as a comments box. A reference to the hospitals restaurant and coffee house was also made with opening hours clearly identified.

We observed water was available and within reach for patients who were able to drink and staff and volunteers actively engaged patients asking if they were thirsty or needed any help. Patients could also use their call bells to ask for food or a drink.

During the last inspection it was noted that there was a lack of staff trained in vascular access which meant there could be a delay when patients needed feeding through a line directly into a vein. The development of a vascular access team was seen to been established with a specialist nurse now in post to facilitate this service who also supported the training of junior doctors.

**Pain relief**
The critical care units reviewed pain regularly during ward rounds. Pain was scored using the visual analogue scale. Non communicative patients had their pain assessed with the aid of electronic tablets and images or with the help of relatives as well as a pain scale and sensory observations. This was in line with Faculty of Pain Medicine, (2015) 6.4 Standard 3 - All in-patients with acute pain must have regular pain assessment using consistent and validated tools, with results recorded with other vital signs.

The critical care units had access to pain nurses who were part of the pain team led by an anaesthetist during the day time hours. This is in line with the Faculty of Pain Medicine, (2015) in particular: 6.4 Standard 1 - Acute pain management must be supervised by consultants and specialist nurses with appropriate training and competencies.

We saw updated patient controlled analgesia (PCA) and epidural policies. Patients said their pain was well managed.

**Patient outcomes**

**ICNARC Participation**

The trust has three units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. This was in line with Guidelines for the Provision of Intensive Care Services, 2015: The intensive care unit should participate in a National database for Adult Critical Care. We used data from the 2016/17 Annual Report.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

**Hospital mortality (all patients)**

For the intensive care unit at Medway Maritime Hospital, the risk adjusted hospital mortality ratio was 1.09 which was similar to other trusts.

For the medical high dependency unit the score was 1.07 which was similar to the national average of 1.00.

For the SHDU the risk adjusted hospital mortality ratio was 1.25 which was worse than the national average.

*(Source: Intensive Care National Audit Research Centre (ICNARC))*

We were told that the reasons for the risk adjusted hospital mortality ratio at SHDU being worse than the national average was due to the existence of medical outliers with poor clinical prognosis and bed pressures resulting from inappropriate referrals to SHDU. Additionally there was a trust drive to not cancel surgical elective patients booked further increasing bed pressures.

**Hospital mortality (for low risk patients)**

The risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% in all units at Medway Maritime Hospital was similar to the national average of 1.00 with the following scores reported:

- Intensive care unit: 1.09
- Medical high dependency unit: 0.90
- Surgical high dependency unit: 1.30
The trust also participated in monthly mortality meetings and most recent minutes of March 2018 showed active discussion of recent cases and those with reports outstanding. There was evidence this forum was active in addressing issues such as community follow-up care, using feedback regarding issues with out of hospital cardiac arrests and access to the GP.

The audit nurses on the critical care units demonstrated their monthly audit calendars and there was evidence that data was being regularly inputted and acted upon. This was in line with Guidelines for the Provision of Intensive Care Services, 2015: Presence of an Audit Calendar which is regularly updated and acted upon.

The acute response team (ART) participated in rehabilitation of intensive care patients and supported patients on the ward following discharge from critical care. The team met with the critical care consultant daily to ensure patients referred to the team had appropriate plans of care in place.

We were told that patients who were in critical care for more than two weeks were considered chronic patients and all consultants participated in their consultations.

Competent staff

Managers made sure staff were competent for their roles. Information provided by the trust showed that 64.8% of nurses in the intensive care unit had a post registration award in critical care nursing. This met the Guidelines for the Provision of Intensive Care Services minimum recommendation of 50%.

Critical care supported the advanced critical care practitioner training, run in conjunction with the University of Southampton. The course ran for two years and regular reviews and mentorship was in place. This course enabled staff to have the practical skills of line and catheter insertion, and other small invasive procedures. In developing assessment and diagnostic skills they would be able to support junior doctors. Advanced critical care practitioners supported critical care from 8:00am to 6:00pm or 8:00pm during days shifts. Since that last inspection there were four more trainees and trainees, other staff and managers were very positive about this initiative.

Appraisal rates

From April 2017 to December 2017 89.6% of staff within critical care at the trust had received an appraisal compared to a trust target of 85%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target (%)</th>
<th>Appraisal completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>1</td>
<td>1</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>57</td>
<td>56</td>
<td>85%</td>
<td>98.2%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>64</td>
<td>56</td>
<td>85%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>10</td>
<td>7</td>
<td>85%</td>
<td>70.0%</td>
</tr>
<tr>
<td>Other Non-Medical Staff</td>
<td>3</td>
<td>1</td>
<td>85%</td>
<td>33.3%</td>
</tr>
</tbody>
</table>
There were learning opportunities for the nurses in MHDU as staff rotated into the critical care unit every three months to improve their competencies managing level 3 patients. As well as clinical practice staff would also develop skills with the use of the electronic system.

All staff said they had regular teaching and learning opportunities during ward rounds and there was a culture of openness to identifying learning needs and improving competencies.

Staff would also use meetings, supervision sessions, appraisals and journal clubs as opportunities to continue to identify develop their competencies. Medical staff would also use e-portfolios to continue to develop competencies.

Staff said they were involved in several quality improvement programmes. One programme we heard of was aimed at completing allergy boxes correctly. This project also aimed at making staff understand the difference between intolerance to substances and side effects and also supporting staff to be able to teach patients about allergies.

The acute response team provided induction established simulations of critical care patients for their staff. The team also had advanced life support and IRMER training for diagnostics as part of their competency training.

Support staff in the kitchen area were supported in achieving a level two award in food safety in catering with updates every three years.

Staff we spoke with told us that staffing and workload had an impact on their ability to participate in training in addition to their mandatory training.

**Multidisciplinary working**

Staff we spoke with told us there was good teamwork and communication within the multidisciplinary team. Nursing staff told us medical staff were supportive and they felt they valued.

We observed examples of strong positive effective multidisciplinary working on the unit and at the bedside during our inspection.

Multidisciplinary staffing was generally in line with Guidelines for the Provision of Intensive Care Services, 2015 standards, however, it did not meet the full recommendations. A pharmacist visited the unit daily Monday to Friday. A dietitian visited the unit three times a week between Monday and Friday. The critical care rehabilitation team was present on the units 6 days a week with a rota for weekends and an on-call physiotherapist for out of work hours. Staff made referrals to the appropriate department if patients required speech and language therapy or a dietician. We saw in patient records that referrals to the multidisciplinary team were responded promptly within 24 hours.

Staff told us they could also access a dietician and speech and language therapy if this was an identified need for the patients. However, these were not integral members of the critical care rehabilitation team and required referrals to access their services. We were told response time to referral was very quick and provided at suitable times without risk to the patients.
We were told that doctors and nurses handovers happened at different times during the day however this did not affect patient safety and information sharing as multidisciplinary ward rounds that involved nurses, bed space nurse, doctors and consultants and the critical care rehabilitation team were in place. Occasionally if a patient was deemed well enough for the ward the acute response team would also attend the ward rounds. All night time discharges were followed up during handovers.

Pharmacy told us that due to limited weekend cover they would have a weekend handover. They would also support step down multidisciplinary working to other wards by providing counselling on substance misuse management, strong analgesia and anticoagulation medication. They would also liaise with other teams to ensure cover and support for the patient. We spoke to a critical care pharmacist who said that critical care units were being covered by one pharmacist as the other pharmacist was on maternity leave.

The critical care units regularly worked with other teams such as the pain service and mental health liaison nurse.

There was a dedicated critical care rehabilitation team. This team comprised of one dedicated physiotherapist and one occupational therapist that were responsible for providing respiratory management and rehabilitation for patients during admission and supporting them during discharge. We were told that there were also two additional rotational physiotherapy posts linked to the critical care rehabilitation team. This service was available 6 days a week from Monday to Saturday during the day time. Night time and Sundays were covered by an on call physiotherapist. This service was an example of good practice and in line with Guidelines for the Provision of Intensive Care Services, 2015.

**Seven-day services**

Critical care services were able to safely monitor patient outcomes and support care being delivered seven days a week.

A consultant in intensive care medicine was available and completed a ward round seven days a week. This was in line with NHS Services, Seven Days a Week, Priority Clinical Standard 2: Time to first consultant review: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of arrival at hospital.

Diagnostic services were accessible 24 hours a day, seven days a week. Reports were completed and delivered within stipulated time frames. This was in line with NHS Services, Seven Days a Week, Priority Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: Within one hour for critical patients, within 12 hours for urgent patients and within 24 hours for non-urgent patients

Critical care services had a dedicated pharmacist operating during the week between the times of 9:00am to 5pm. This ensured a minimum of five days a week cover from a pharmacist as per the guidelines for the provision of intensive care services, 2015.

The critical care rehabilitation team provided treatment six days a week during work hours. An on-call physiotherapist was available overnight and during Sundays. A pharmacist visited the unit Monday to Friday to check prescriptions and reconcile patients’ medicines. The unit had access to on call pharmacy cover when the dedicated pharmacist was not available.
Health care assistants were also available throughout the week to support patients and their relatives and personal care needs respectively.

**Health promotion**

There were procedures in place to support patients withdrawing from drugs or alcohol and the pharmacist would advise and support in such situations. We were told the trust were actively recruiting a nurse to support these patients.

Staff completed assessments about patients’ individual needs on admission and provided support as able and appropriate. We were told that the critical care services had identified an increase of patients with acute liver disease and in addition to the medical management patients and relatives were also provided with contact advice as well as drug and rehabilitation support links.

The multidisciplinary team provided health and self-care advice to patients to enable them to manage their own conditions. The critical care rehabilitation team would also conduct home visits when required and enable patients and those who support them to actively participate in their care and encourage self-management of their condition were possible.

The unit had access to psychiatric support in addition to the mental health liaison team.

We were told there were ongoing programmes such as the smoking cessation strategy being developed to support patients in actively achieving healthier lifestyles. Other staff involved in health promotion included the diabetic team nurse and mental health liaison nurse.

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

Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act, 2005. We observed staff obtaining verbal consent from patients before carrying out an intervention when possible. They also told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient’s capacity.

Staff we spoke with were able to explain the process they would follow for the use of restraint and where they would document this. We were told that critical care services tried to avoid using chemical restraint on patients and if safety gloves were required staff completed a capacity assessment prior to using them and reviewed patient’s capacity regularly. We noted that the restraint policy used by the critical care services was in need of reviewing from November 2017. There was always a recorded best interest around the use of restraint and a DOLS application.

Patients were supported were possible to make joint decisions with staff regarding their care and information sharing.

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

The trust provides training in Mental Capacity Act (MCA) level 2 which includes MCA training and Deprivation of Liberty Safeguards (DoLS) training. The trust reported that from April 2017 to December 2017 MCA training has been completed by 79.4% of staff within critical care.

A breakdown by nursing and medical staff is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental - hospital</td>
<td>42</td>
<td>56</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Is the service caring?

Compassionate care

Staff understood and respected the personal, cultural, social and religious needs of people and how these may relate to care needs. On admission staff spoke to the patient and family to identify cultural and religious needs. We saw these beliefs and needs registered on the patient’s admission sheets. With consent of the patient and families, this information was shared with external links such as the chaplaincy services. On the medical high dependency unit we saw a statement of philosophy of care which read “…we endeavour to provide a holistic approach when caring for critically unwell individuals encompassing physical, psychological, social and spiritual needs.” This statement also mentioned the care of relatives.

Staff took time to interact with people who use the service and those close to them in a respectful and considerate way. An example of this was when a family member asked to talk to the nurse about how they were worried their relative did not always express their discomfort because they did not want to disrupt the nurses work. The nurse listened to the family member and then spoke with the patient to say that if they were in any discomfort they should call immediately as this was part of the nurses and care assistant’s job.

We observed staff showing an encouraging, sensitive and supportive attitude to people who use the critical care services. Staff were always aware of the patient’s history and needs and established open communication links with the patient, family and carers. This was in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

Staff demonstrated that they raised concerns about disrespectful, discriminatory or abusive behaviour or attitudes. Staff gave examples of when patients may behave in this way because they are frightened or confused. They identified that in these situations they would try to identify what the cause of the behaviour may be and primarily attempt to de-escalate the situation. If the behaviour continued to escalate or after warning people that their behaviour was not appropriate, they would safeguard patients and implement their security protocol. All incidents were reported on an electronic database and learning outcomes were shared with the team.

Staff ensured that people’s privacy and dignity needs were understood and always respected, including during physical or intimate care and examinations. We witnessed staff introducing themselves to the patients before any interaction, asking for consent and providing an explanation of what they would be doing. If any intimate care or examinations were occurring a curtain would be used to provide privacy. This was in line with NICE 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.

Patients told us that staff responded in a compassionate, timely and appropriate way when they experience physical pain, discomfort or emotional distress. One patient said that staff were reassuring and any time he felt anxious staff would support him in managing his distress. Another patient praised the volunteers at the hospital as they were always available for a chat and a coffee and this made them forget their pain.
Emotional support

Staff had a good understanding of 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. A family member said that at times they felt they needed as much attention as their relative, who was a patient. They found staff to be supportive of their emotional needs either by finding them a quite space to step aside from the situation or offering some time to talk and help process their emotions.

Staff felt able to provide support to relatives and visitors as well as to patients and told us this gave them satisfaction in their role. Staff also advised families on finding other support and counselling services. An example of these services was the Winston’s wish bereavement for children leaflet and the useful contacts within the ‘Intensive care guide for patients and relatives’ booklet. Additionally staff said they would link with the psychiatric liaison team if they felt they were unable to support patients’ needs.

Staff said they would also support bereaved relatives by helping them assemble memory boxes, arrange friendship bracelets and do handprints. There were also organza bags available to keep locks of hair.

Patients told us that staff helped them emotionally throughout their journey through critical care. One patients’ relative added that they felt safe and reassured to see the emotional support and calmness of the nursing staff when their relative became distressed and confused. They said that staff would patiently sit with them and talk in a calm manner to help the patient feel settled again.

Staff also encouraged families and carers to bring some patients personal belongings to help patients recover. They also encouraged and supported them in keeping conversations even with patients who may not be conscious by providing assurance and privacy

Understanding and involvement of patients and those close to them

Patients and those close to them consistently said that staff were very good and clear about providing understanding about care, treatment and condition specific information. This is in line with NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.

Staff seek accessible ways to communicate with people when their protected equality or other characteristics made this necessary. Staff showed an understanding of these characteristics and demonstrated sensibility to these.

Staff ensured that people who used critical care services and those close to them were able to find further information, including community and advocacy services, or ask questions about their care and treatment. Staff said they were always available to provide advice to people and were aware of services and resources that could support patient queries.

Staff identified that if they were busy they would explain this to the person and provide a timeframe within which they could address them or request the support of another member of staff. Staff also said they would be honest if they were unable to answer questions relating to care and treatment and would escalate these to the matron or the most appropriate health professional.

Patients and those close to them said that staff involved them in the planning and decision making process about their care and treatment. They said that clinicians would discuss the risks and
benefits of procedures with them in a sensitive and understanding way and would ask them how they felt about it. Staff said that for patients who were unable to communicate or were unconscious they would involve with their next of kin and if none was identified would make decisions based on the best interest for the patient. People we spoke to said they felt valued and respected. This is in line with NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Staff said they would always involve the family and patient, when possible, on the decision of organ donation. Staff said that the approach was tailored to the person and their relatives and took into consideration matters such as the person’s health, emotional status and who they felt with most comfortable on the ward to provide this information. Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff had access to a specialist nurse for organ donation. The unit had a link nurse and lead consultant for organ donation.

Staff assured us that information provided by patients was treated confidentially and in a way that complies with the Data Protection Act. Staff said that if any information was of a sensitive nature they would try to arrange a side room to communicate this information. If this was not possible staff would draw the curtains and speak in a way that could not be overheard by other people present on the ward. Protected rest times were also used to communicate sensitive information. Additionally, staff used electronic recording systems and when patients requested privacy of information this was recorded. Staff supported people to make and review choices about sharing their information.

Is the service responsive?

Service delivery to meet the needs of local people

There was signposting around the hospital indicating where the different critical care units were located. Signs were clearly visible and were presented in dementia or visual deficit friendly colours as well as using pictograms. Staff at the information desk and volunteers were helpful in guiding people to correct locations.

Critical care provision was flexed to meet the differing care needs of level one, two and three patients. Services were divided into three units: Intensive care unit (ICU), medical high dependency unit (MHDU) and surgical high dependency unit (SHDU). At the time of inspection visiting times were from 10:00am to 8:00pm. These units were not located together which staff said put pressure staffing resources which could not be easily flexed in line with clinical need. The management team told us that there were plans for co-location and this was being discussed with the board. This was detailed on the risk register as still under discussion.

Intensive care unit was a ten bedded unit that provided care for patients requiring advanced respiratory support (ventilation), advanced renal support (hemofiltration) and other complex therapies. Patients received one to one or one to two nursing, depending on their needs. A doctor was available at all times and patients were seen regularly throughout the day. The unit had two guestrooms available to accommodate relatives who wished to stay overnight.
The medical high dependency unit comprised of six beds - five in a shared open bay and one side room. The unit had a side room available for private conversations with patients. Patients were largely referred from accident and emergency, Medical assessment unit and the general medical wards, but the unit also provided step-down care to patients discharged from the intensive care unit requiring intermediate treatment and monitoring prior to discharge to a general ward.

The surgical high dependency unit provided a range of critical care which included non-invasive ventilatory support using equipment such as Vapotherm, CPAP and BiPAP (ventilation devices used for treatment of sleep apnoea and a host of other respiratory and cardiac problems), advanced cardiovascular support including the use of inotropic drugs (drugs that affect the strength of contraction of heart muscle) and the continuous monitoring of vital signs including arterial and central monitoring. The unit had ten beds, two bays and two side rooms.

The acute response team supported critical care discharges to the hospital wards. This team also supported handovers and feedback between the critical care units and the wards so patients could experience good continuity of care.

There was a follow up clinic for patients who had been discharged from intensive care unit which gave an opportunity for patients to speak to the staff that had looked after them. The use of a patient diary helped understanding of what had happened during their stay and patients were supported psychologically for a period following their stay in the intensive care unit.

**Meeting people’s individual needs**

The service identified and met the information and communication needs of people with a disability or sensory loss. All communication needs and disabilities were recorded on admission and monitored regularly through ward rounds and huddles. The unit also had communication aids such as picture charts, booklets with basic sentences and electronic tablets. Support from the speech and language therapist was also available for assessment and specialist communication intervention when necessary. Staff also said they would involve relatives and family members to support communication. This was in line with NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.

Bay A and B on the surgical high dependency unit had four beds each which were mixed sex. Staff told us that they tried to provide same sex accommodation for critically ill patients in accordance with the Department of Health guidance but within a critical care area this was not always possible. To maintain patients’ privacy the bed spaces were separated by curtains and on the day of inspection all bed spaces were appropriately screened to maintain patient’s privacy and dignity.

The service met the Accessible Information Standard. One area of innovation was the installation of decibel reading equipment in the shape of an ear in the intensive care unit. The ear used a green, amber and red colour system to alert staff and patients if the environment was becoming too noisy.

Staff we spoke with knew how to access translation services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Occasionally staff would also be used to act as translators.

All units were supported by the critical care rehabilitation team which provided physiotherapy and occupational therapy on an individual basis. The critical care units also had access to other link services such as a specialist learning disabilities nurse and the mental health team although this...
service was not always available. The intensive care unit matron told us that the critical care service had identified the need for more mental health support and a post for a clinical psychologist was being considered and was highlighted in critical care operational meetings.

The trust was actively involved in the John’s campaign. This is a national scheme to support carers of patients with dementia by providing them with the opportunity to visit hospital as often as they wish at any time of day or night. Additionally, further support for patients with dementia is offered through the Butterfly Scheme, which allows people with memory impairment to request a specific form of personalised care during hospitalisation. We saw evidence of this with patients having a discreet image of a butterfly above their bed indicating to staff that they may need additional attention and support while in hospital. Critical care services also used the ‘This is me’ leaflet to support people who may experience delirium or be unaware of their surroundings.

The critical care team provided evidence of strong links with external services such as GP’s, district nurses and social care services. These links were used to support gathering of admission information or to support discharges from the service to the community. Discharges from the units to the community were supported and monitored on a patients’ individual needs basis through the nursing staff, matron or audit nurses. The critical care rehabilitation team also conducted home visits and engaged with family members and community teams when patient rehabilitation needs were identified. This was in line with guidelines for the provision of intensive care services, 2015, and the National Institute for Health and Care Excellence (NICE) CG83: rehabilitation after critical illness.

Staff supported patients and those close to them during referral, transfer between services and discharges. We were told that staff would always inform patients of possible changes to their care before it occurred. Before discharges staff would inform the patient and their family of where they would be discharged too and what expectations to have of the services being provided. Staff said this was particularly important as some patients reported a feeling of abandonment due to the reduction of one to one or two to one care given at critical care. The service used portable phones if patients wanted to inform their relatives of a potential discharge or establish a communication link should any queries arise. When possible staff would also introduce other team members that may later participate in their care.

Staff told us that appropriate discharge arrangements were in place for people with complex health and social care needs. As an example the intensive care unit provided follow up clinics. This was a new activity and was assigned to a nurse and a physiotherapist. We were told that the follow up clinics will link with social services if required.

**Access and flow**

The decision to admit to the unit was made by the critical care consultant together with the consultant or doctors already caring for the patient. In addition to this the trust had established a clinical co-ordination centre with huddles throughout the day which monitored and directed patient flow within the hospital. We witnessed critical care services and recovery beds being discussed in this centre. We were told the matron for the intensive care unit used to attend these meetings but now this is done mostly by the clinical co-director for critical care. We were informed that in the absence of the clinical co-director the bed manager would provide feedback to critical care services.

We reviewed five patients’ notes on the electronic records systems used in the intensive care and surgical unit and two patient records used in medical high dependency and all patients had been reviewed in person by a consultant in intensive care medicine within 12 hours of admission to intensive care. This was in line with Guidelines for the Provision of Intensive Care Services, 2015:
Patients should be reviewed in person by a Consultant in Intensive Care Medicine within 12 hours of admission to Intensive Care.

Staff on the units said that initial assessment, test results, diagnosis and treatment were completed and followed up as per guidelines. This was supported with the use of electronic records and automated prompts on the patient's record. We saw this system being used and records viewed were up to date, complete and detailed future activities in care and assessment.

**Bed occupancy**

From January 2017 to December 2017, the adult bed occupancy at Medway NHS Foundation Trust has been generally stable over time and was higher than the England average.

**Adult critical care Bed occupancy rates, Medway NHS Foundation Trust.**

![Graph showing bed occupancy rates](image)

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

We saw evidence that data relating to the number of occupied critical care beds were excessive compared to national average over the months of January, February and March 2018. Staff also reported that there was rarely a vacant bed available in the ICU, MHDU or SHDU with patients regularly being nursed in recovery beds. There was an escalation flow chart which showed actions to take in case of the unit being full this included the use of recovery if a bed was not immediately available.

We were assured by managers that patients in recovery beds were being nursed by critical care nurses and that the service was always aware of how many patients were in the recovery beds. The matron was updated about recovery beds occupancy by the recovery nurses, bed managers and clinical co-ordination centre. Patients were regularly reviewed and should any patients with urgent and complex needs be in a recovery bed they would transfer them to critical care and assess which patient if suitable could be moved to a recovery bed. This put additional pressure on staff in the critical care units in addition to the recovery unit.

**Delayed discharges**

For the ICU at Medway Maritime Hospital there were 3,285 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 5.1%. This was similar to the national average of 4.9%.

The percentage of bed days occupied by patients with discharge delayed more than 8 hours was worse than the national average of 4.9% for MHDU and SHDU with the following performance:
- MHDU: 14.1% based on 2,190 available bed days.
- SHDU: 14.6% based on 3,650 available bed days.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Staff identified that the reason the percentage of bed days occupied by patients with discharge delayed more than 8 hours was worse than the national average was because of poor flow within the hospital and the lack of available beds on the wards. Staff said that patients were being identified as ready to transfer to a ward appropriately but they could not transfer them. We were also told that in SHDU the increased delay in discharge was because the trust had ring-fenced elective short stay and orthopaedic beds and this was having a domino effect on the number of ward beds available. We were told these issues had been escalated and saw this detailed on the risk register.

Non-clinical transfers

All units at Medway Maritime Hospital performed similar to the national average of 0.39% for the percentage of patients that had a non-clinical transfer out of the unit with the following performance:

- ICU: 1.67% based on 479 admissions.
- MHDU – 0.00% based on 527 admissions.
- SHDU – 0.00% based on 889 admissions.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-delayed out of hours discharges to the ward

Compared with other units, units at Medway Maritime Hospital performed similar to the national average for non-delayed out of hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. The trust’s performance by unit was as follows:

- ICU: 5.6% based on 144 admissions.
- MHDU – 3.4% based on 332 admissions.
- SHDU – 1.6% based on 610 admissions.

(Source: Intensive Care National Audit Research Centre (ICNARC))

We were told that all out of hours discharges on the ward were reported as adverse incidents. This was in line with Guidelines for the Provision of Intensive Care Services, 2015: Transfer from critical care areas to the general ward between 10:00pm and 07:00am should be avoided whenever possible, and should be documented as an adverse incident if it occurs. Audits showed evidence of an increase in discharges occurring between 10:00pm and 6:59am. The service performed an admissions and discharges audit and results were sent to consultants and the intensive care unit matron. Results indicated that this increase was due to a shortage of beds on the wards between 7:00am and 9:59pm and an increase in patients coming in from surgery after hours.

We were told another reason for the increase in out of hours discharges was because surgical high dependency unit’s referral criteria was not clearly defined, junior doctors did not feel they had the authority to challenge senior doctors decisions to refer to the unit. Additionally we were told
surgeons were reluctance to send patients to normal wards, due to the benefits of enhanced recovery on critical care units, thus increasing the number of referrals to this unit.

We were told nursing rotas had increased for night shifts to address issues with patient flow and the need to maintain nursing levels safe.

Learning from complaints and concerns

Summary of complaints

The trust had a current complaint policy and standard of practice that should how complaints should be dealt with and the escalation process. From January 2017 to December 2017 there were eight complaints about critical care. At the time of reporting all of these complaints had been closed. The trust took an average of 31 days to close these complaints. The trust has a target to close complaints within 30 days and complex complaints within 60 days. Only 50% of complaints were closed within 30 days but 100% of all complaints were closed within 60 days.

The majority of complaints had more than one theme. The most common themes of complaints were:

- All aspects of clinical treatment – three
- Communication/information to patients – three
- Communication between staff – two

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

Staff encouraged people to make complaints and raise concerns. Staff said they would initially try to understand and see if they could de-escalate the complaint by talking to the patient or those close to them. If however the complainant did not feel satisfied they would direct them to the Patient Advice and Liaison Service (PALS). Staff would also make the matron aware of any complaints and how these were primarily addressed. Leaflets with information on how to raise concerns and complaints were also readily available.

We were assured by staff and PALS that all complaints were recorded, people were given regular updates and an explanation of the outcome of their complaint or concern given. This is in line with the NHS constitution which gives people the right to have complaints dealt with efficiently and be investigated and know the outcome of the investigation.

Staff used information from complaints to improve services and learn lessons. Information supporting staff to deal with complaints and lessons learnt was stored in a ‘Better Care together folder’. Additionally staff would use a secure electronic forum to disseminate learning from complaints. We were told no patient identifiable data was used on this application.

Staff gave an example of dealing with complaints that resulted in better care and patient satisfaction. A patient complained about noise on the ICU ward during night. Decibel reading equipment in the shape of an ear which provided immediate alerts in the form of a green, amber or red light was installed and reported to have made a difference in people’s attitudes and behaviours towards noise.

Staff said they would raise their own concerns with their immediate senior staff, during supervision and huddles or with the freedom to speak up guardians. Not all staff were aware of this service. Some staff said they would get advice from their professional bodies or trade unions. The Matron told us she operated an open door policy in case something needed to be said privately.
Is the service well-led?

Leadership

The leadership structure for critical services at the Medway hospital was in line with the Guidelines for the Provision of Intensive Care Services, 2015. The critical care services were part of the critical care and peri-operative programme which was overseen by the planned care directorate.

The critical care and peri-operative programme was led by two designated clinical co-directors and a head of operational performance. The leadership structure also included two speciality leads, both matrons, and a Service Manager. The Critical Care Units had an identified Lead Nurse who was formally recognised with the overall responsibility for the nursing elements of the service who was a matron.

We were told that the Acute response team did not have a clinical lead yet however they had requested a medical consultant to mentor their team. This was not yet formalised on the day of inspection.

Staff said they were still becoming familiar with the leadership structure because it was renewed in the last two months. Some staff told us the departmental structure was not very clear since their last change.

However staff understood who their line manager was. We were told staff were supported by their supervisors and knew who to speak to if they had any questions relating to their role or responsibility

We were told the head of operational performance was newly appointed but was aware of key concerns. Leaders were also aware of the key challenges to quality and sustainability. They were able to identify key issues such as flow and staffing and identified actions to address these issues.

The leadership team told us they tried to make themselves accessible to staff. However, staff we enquired said they did not feel that the leadership team was visible and said that any issues, concerns or feedback would be raised at team meetings or with the matron and then raised through the matron to the leadership team.

At the time of inspection succession planning did not offer assurances of sustainability. We were told the lead nurse for the critical care units was leaving in one week’s time. We spoke to the leadership team who said they did not have a replacement yet and were asking band 7 nurses to step into the matron’s position. Staff told us the matron in charge of the unit was a strong leader who fostered a positive culture and was supportive of their needs. Staff did not know who would now be leading the service. This was causing anxiety and unrest in the critical care units because staff were unsure how issues were going to be escalated to upper management.

Additionally, during our meeting with service leaders, it was not disclosed that one of the clinical co-directors for critical care would also be leaving in one week time. Staff were unaware of any replacements and we were not told of any adverts going out. As we were not made aware of this leave we could not challenge leadership with questions about succession and leadership planning.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. This was part of the Better, Best, Brilliant continuous improvement programme and overlapped with the vision established for critical care services.
Leadership showed a realistic strategy for achieving their priorities and delivering good sustainable care. Their strategic objectives involved working collaboratively with local partners, embracing innovation and digital technology to support best care, enabling people to give and achieve their best and deliver financial stability.

Staff said they identified with the trust’s and critical care service’s vision. However they did not feel they were always consulted or involved with planning. Leadership were aware of this and had established a culture programme to address some issues and reconnect with staff.

We heard how leadership was engaging with patients and public. This was being done by connecting with community groups in Medway and Swale, providing patients and relatives a pathway to feed back about services using tools such as the Patient Satisfaction Questionnaire, having a better awareness of how services are perceived externally and working closely with stakeholders and specialist interest groups.

We saw evidence that plans and strategy were being monitored and reviewed.

**Culture**

We were told there was a culture of safety awareness at all levels. Staff were motivated by their patients and their work saying they felt that patients were at the heart of their service. However, most staff said they did not feel supported by the current senior management. We often heard that things were just the way they were and staff had to accept it. We also heard staff say they wanted more stability and a break from constant changes at managerial level. Leadership were aware of this and had established a culture programme to address some issues and reconnect with staff.

Staff said they were not consulted on change. Staff gave a recent example were visiting hours on the critical care units were changed two days prior to our inspection. Staff were not consulted and informed and said that changes could have a potential impact on the care being provided to patients. Previous visiting hours were from 11:00am to 1:00pm and then resumed at 3:30pm to 8:00pm. These were changed to 10:00am to 8:00pm. Staff told us previous visiting hours were based on patients feedback and best evidence to offer patients rest time and protected personal care and meal times. Staff said they had raised this issue with their matron and were awaiting feedback.

The culture within the critical care services directorate was to encourage openness and honesty including staff and people who use services, to report incidents. Leaders and staff spoken to, all knew the importance and relevance of the duty of candour.

Leaders and staff understood the importance of being able to raise concerns without fear of retribution. Staff said they would raise concerns through team meetings and debriefs or with the lead nurse who would then provide information to the leadership team. We were told the matron held an open door policy and staff said they would felt comfortable to raise issues.

The trust told us there were six freedom to speak up guardians. Guardians have a key role in helping to promote the profile of raising concerns in the organisation. They also provide confidential advice and support staff in relation to concerns they may have about patient safety and the way their concern has been handled. However, three in every five staff questioned were not aware of the freedom to speak up guardian.

We saw evidence of development and appraisal opportunities to improve staff competence and further career development. Examples of this were the advanced critical care practitioner training programme and the ICU rotation post for medical high dependency unit nurses to develop skills in managing level 3 patients.
We saw evidence of cooperative and supportive relationships among staff and teams to work collaboratively to resolve conflict quickly. However we were told of a situation where recovery beds being used on the medical wards were an issue of contention due to the pressure this put on staff.

**Governance**

Senior managers of the critical care team attended a monthly planned care directorate governance and management board meeting. The last three months minutes showed discussion of serious incidents, complaints, patient feedback, mortality and morbidity rates, risk register and the directorate performance dashboard which monitored performance using a scorecard of quality measurements.

It was not clear on the governance structure for the trust where this group fed back to. However there was a quality improvement group feeding back directly to the Quality Assurance group which reported in turn to the board.

Within the critical care units there were regular monthly senior team meetings for the whole department as well as all staff meetings which were held three times a year. At these meeting the minutes of the governance board meeting were to be discussed with all staff. This gave assurance that governance issues were discussed with all unit staff.

Service leads reviewed a range of data including ICNARC and audit (trust wide and local) and used the results to improve the quality of the service. Recent audit results were displayed on noticeboards in the units and were easily accessible through the audit nurses. Where results fell below expectations, explanations had been recorded showing the outcomes had been investigated. Dissemination of the results was made via team meetings, huddles and handovers or during appraisals if these were relevant to the person.

Staff were aware of the financial measures put in place and were aware of cost saving measures. We were assured by leaders that the existing financial measures did not affect quality and there were currently no staffing restraints. However, staff told us they did not understand how finances were managed. As an example we were told that critical care staff did not believe charity and donations given to critical care services should be put in a general financial pot for the whole hospital.

We were told that the critical care services did not have any existing service level agreements with external partners.

**Management of risk, issues and performance**

The critical care managers monitored significant risk to the service through the use of a risk register for the critical care and perioperative programme. Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating.

We saw controls were identified to mitigate the level of risk and recorded with an action plan. Leaders were aware of the main risks and performance issues in the critical care services. The two main issues identified were medical staffing and patient flow. Risks were reviewed on a regular basis and discussed at the governance meeting and escalated according to risk status.

Leaders for critical care services identified that medical staffing was an issue with less than a third of registrar posts filled by the deanery. To mitigate this a new ST6-7 level post was created and provision of training was agreed. An F2 doctor was also encouraged to join and would be supported with research development. In addition, the acute care clinical practitioner post was added to the team and consultants gave training support with competency assessment.
Leaders told us how they were addressing performance issues such as flow. We were told that of the 32 concerns raised in critical care throughout March 2018, 30 were regarding flow. In addition to this the new organisational structure had impacted on flow and it had become more of a problem than before. This was particularly due to the management of surgical beds.

As a response to general flow issues within the hospital the trust established the Clinical co-ordination centre that carried out three daily meetings to manage patient flow. Part of this meeting was identifying critical care patients needs and organising available bed space and recovery beds. Leaders were also aware of general pressures such as seasonal peaks.

Additionally critical care services established a seven day consultant cover to alleviate flow issues. Leaders were confident these changes would have a positive impact on flow and ongoing auditing was being done with the use of monitoring processes such as the route cause analysis form for critical care admission completed by the acute response team.

Staff raised concerns about nurses being moved to areas outside of critical care to support understaffed wards. Leaders told us nursing staffing levels was an issue that was being addressed in several fronts. We were told an establishment review had led to more band six nursing posts being available and that the trust was organising recruitment evenings. Additionally, the trust was also trying to recruit to their nursing bank.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. On the critical care units, audit nurses were responsible for pulling data to run risk assessments. As an example we were able to ask the audit nurses to look into ongoing audits for venous thromboembolism risks and what actions were being taken to address these. The audit nurse was able to easily access this data and assured us that the outcomes from the audit were being monitored and reviewed. We were told data was regularly fed back to the governance meeting. Information and data relating to performance and safety was collated and shared with senior staff at monthly meetings.

We saw that there were effective arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. This was further supported on ICU and SHDU by the use of electronic systems were patients details and clinical data was uploaded immediately to the system and reviewed by the audit nurses to assess if any gaps in information existed. If any information was missing the audit nurses would escalate these issues to the relevant nurses or doctors so that data could be completed as soon and as accurately as possible.

The critical care units submitted data to ICNARC which supported monitoring of the units performance against national standards in comparison to similar critical care units.

Staff had access to relevant guidance and policies via the trust’s intranet and in policy folders kept on the units.

We saw that admission, discharge and transfer documentation was in line with best practice and NICE guidance. Staff were aware of the importance of data protection and policies were in place for this.

Staff in the critical care outreach team collected data on their activity and patient outcomes and were responsible for completing handovers to other teams when patients were deemed ward able.

**Engagement**
The critical care service engaged well with patients, staff and the public to plan and manage appropriate services and collaborated with partner organisations effectively. An example of this were the ongoing research trials that were occurring in the hospital.

Patients and their relatives views were valued and considered an essential part of running and developing the service. Staff used patient and relative interactions as a way of continual improvement to shape the service. Information was gathered through the patient feedback satisfaction questionnaire or documented informal talks.

We were not aware of any senior staff members required to regularly report on aspects of patients’ mental health or emotional wellbeing.

Leaders and senior staff told us they would try to resolve complaints and concerns immediately. As part of their engagement they would call complainants or talk to them directly to try and deescalate the raised issues. We were told that duty of candour was crucial to the services’ ethos and if complainants did not feel their issue was managed appropriately they would direct the complainant to the Patient advisory liaison group or a more senior member of staff.

We heard evidence of positive and collaborative relationships with external partners. As an example the trust engaged regularly with NHS England looking to develop the post of the acute critical care practitioner programme.

The trust was a part of the south east critical care network and had regular engagement with the network. Feedback from this network identified the critical care services as the best for rehabilitation and at a good standing for organ donation.

We also heard the critical care service had done an international presentation on the use of their electronic system for data collection.

**Learning, continuous improvement and innovation**

Leaders and staff strived for continuous learning and improvement. There were robust systems and processes for learning continuous improvement and innovation.

Leaders were sent daily database reports and monitoring trends from the audit nurses. We were told this helped leadership be more proactive with identifying and managing issues. An example of this was an internal audit looking at the quality of discharge data. The results of this audit helped realise that there was the need to have more information on the discharge report to support more effective discharges for the patients. Other ongoing audits included sedation and sepsis management. We were also told that an audit dashboard was being developed to support a more organised approach to auditing.

Critical care services showed examples of learning and competence training. We were told of the rotational nurse role in ICU where nurses normally working in the medical high dependency could develop competencies with level 3 patients.

Staff and leaders shared learning to make improvements. We were told multidisciplinary talks and huddles encouraged shared learning. Huddles were also used to disseminate the safety message of the week. Additionally leaders had identified the need for human factors training to be completed by staff.

Leaders and senior staff told us research was ongoing and highly encouraged by the trust. There had been a total of 65 clinical trials completed with 5 ongoing trials at the time of inspection. We were given insight and supporting evidence regarding the PRISM research trial and vasodilatory catheter guided thrombolysis.
Staff told us that they used their appraisals and supervision sessions to identify personal and competency based learning needs. We were also told that team meetings were used to disseminate learning as well as have an opportunity to discuss improvement and innovation.
### Outpatients

#### Facts and data about this service

Medway Maritime Hospital provides outpatient appointments for a variety of specialities where assessment, treatment, monitoring and follow up are required. The hospital has medical and surgical speciality clinics, as well as paediatric (children’s) and obstetric (women’s and maternity) clinics.

The outpatient clinics are located in different areas. Outpatient areas one to eight and the pharmacy are located in the main building. The phlebotomy department in an adjacent building. The trust runs a small number of clinics at other local hospitals.

Outpatient services are provided at a number of locations throughout the site. A small number of clinic are also run by the trust at other local hospitals. The main outpatient department is located just off the main entrance to the Medway Maritime Hospital and there are also individual outpatient areas located in specialty areas. The outpatient department is responsible for the facilitation of the clinics, although they are clinically managed by the specialties.

(Source: Routine Provider Information Request (RPIR) AC1 – Context - description of all acute services)

During the inspection we visited outpatient areas one to eight, phlebotomy and the pharmacy. We spoke with 20 members of staff including managers, consultants, nursing staff and administrative staff. We spoke with 21 patients and their relatives. We reviewed seven sets of patient records.

The outpatients department is part of the surgical services division, which is part of the planned care directorate.

Clinics ran Monday to Friday, 8am to 5pm, with some additional clinics running in the evenings and at weekends.

### Total number of appointments compared to England

The trust had 438,098 first and follow up outpatient appointments from November 2016 to October 2017. The graph below represents how this compares to other trusts.
Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from November 2016 to October 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway Maritime Hospital</td>
<td>407,221</td>
</tr>
<tr>
<td>Darent Valley Hospital</td>
<td>33,026</td>
</tr>
<tr>
<td>Sittingbourne Memorial Hospital</td>
<td>10,121</td>
</tr>
<tr>
<td>Gravesham Community Hospital</td>
<td>4,351</td>
</tr>
<tr>
<td>This Trust</td>
<td>607,952</td>
</tr>
<tr>
<td>England</td>
<td>103,843,026</td>
</tr>
</tbody>
</table>

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from November 2016 to October 2017.

Number of appointments at Medway NHS Foundation Trust from November 2016 to October 2017 by site and type of appointment.

Is the service safe?

Our rating of safe stayed the same. We rated it as good.

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 April 2017 to October 2017 for medical and dental staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>9</td>
<td>12</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>9</td>
<td>12</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>9</td>
<td>12</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>8</td>
<td>11</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>5</td>
<td>11</td>
<td>45%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the training target in any of the eight modules for medical staff in outpatients. The worst training compliance rate was in adult basic life support (45%). However, as medical staff were managed via their clinical specialities rather than by outpatient specifically, it was not possible to give an accurate estimation of how many medical staff working for outpatients had received an appropriate level of training.

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

Mandatory training data for outpatient staff could not be broken down to service level. The trust gave us the figures for the Women’s and Children’s division, of which outpatients were a part. The trust met the 85% target in 14 out of 17 modules. The three modules where the compliance was worse than the trust target were for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) (80%), paediatric basic life support (BLS) (81%) and safeguarding children level three (12.5%). However, as the outpatient department only treated adults, not all staff would need to be level three trained. It was unclear from the data provided by the service how many staff should have had safeguarding level three training in line with the intercollegiate guidance, “Working together to safeguard children- roles and responsibilities for healthcare staff” (2014).

The service kept records of training compliance for monitoring purposes. Senior staff told us about the Medway online learning environment. This was a web based application that allowed staff to access training from computer and mobile devices. However, senior staff told us that there was a delay with this system being updated in relation to training compliance rates and therefore an additional excel spreadsheet was kept by the team that was red, amber, green (RAG) rated depending on completion which we reviewed.

**Safeguarding**

There were safeguarding policies and procedures across the trust. We spoke with staff who understood their responsibilities regarding this and knew how to raise concerns.

The main outpatient department was intended for adults only, with children and young people attending the children’s outpatient departments. However, when checking patient notes, we saw that one child had attended a clinic in the adult dermatology clinic. We spoke to staff about this who advised us this was usually avoided, and would only be done if the patient could not be seen...
in the children’s outpatients department. Following the inspection the trust confirmed that nursing staff had appropriate levels of safeguarding training as a mitigation of this.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training. Seventy-four per cent of staff in outpatients had completed safeguarding training from April 2017 to October 2017, which was worse than the trust target.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for medical and dental staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (level two)</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults (level two)</td>
<td>8</td>
<td>12</td>
<td>67%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the target for the two eligible safeguarding courses for medical and dental staff in outpatients. However, as medical staff were managed via their clinical specialities rather than by outpatient specifically, it was not possible to give an accurate estimation of how many medical staff working for outpatients had received an appropriate level of safeguarding training.

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

Safeguarding training data for outpatient nursing staff could not be broken down to an outpatients level. We were given the figures for the Women’s and Children’s division, of which outpatients were a part. The division performed better than the target of 85% in safeguarding adults, and children levels one and two. The compliance rate for safeguarding children level three was worse than the target at 12%, however, the intercollegiate guidance states as long as staff are level two trained and have access to a level three trained member of staff, this is acceptable. Staff told us that the outpatient matron and senior sister were both level three trained.

We spoke with five members of staff who all knew the process for escalation of safeguarding concerns. All staff aware of contact details to escalate issues around safeguarding, mental health concerns or alcohol abuse. Cue cards with vital contact information had been issued to all staff. We also saw telephone numbers of all services in the matron’s office.

Cleanliness, infection control and hygiene

The service controlled infection risk well and the department appeared visibly clean.

The Patient Led Assessment of the Care Environment (PLACE) score for cleanliness in clinic areas one, two, three and six was 98%, which was the same as the national average of 98%. We did not receive the PLACE scores for the other areas of outpatients.

Staff completed infection control training as part of their mandatory training course. We saw data that confirmed that 100% of eligible nursing staff had completed this training. Of the two non-eligible members of staff who had not completed the training, one was a new starter and the second was a staff member who was on an extended career break.

We observed staff cleaning their hands before and after patient contact. This was in line with the National Institute for Care and Excellence (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.

We saw results from hand hygiene audits returned from the outpatients departments between April 2017 and March 2018. We saw hand hygiene audit results displayed in each area. These all had a result of 100%, indicating that hand hygiene protocols were consistently complied with in these areas.

We observed hand cleansing gel dispensers were available at the entrance to the clinic areas we visited with large, visible, red signs reminding staff and visitors to clean their hands upon entering and leaving the department. We saw staff and patients cleaning their hands on entry and exit.

All clinic areas we visited appeared visibly clean and tidy. There were cleaning schedules and checklists across the clinic areas and we observed these checklists to be completed daily and dated. This meant that the department had assurances of daily cleaning in line with the schedules. We observed that equipment was visibly clean and labelled with the date it had been cleaned. We saw a cleaning rota for each clinic room daily, and an overall checklist for clinic areas which was audited monthly.

The outpatient clinic areas were designated as “significant” risk areas and as such were audited for cleanliness every two months. The target for the audit was 85%, and we saw that between April 2017 and March 2018, the score for cleanliness only fell beneath this target once with a score of 83%. This meant that the majority of cleanliness audits in the outpatients areas met or were better than the target.

Clinical waste was separated and appropriately labelled in line with Health Technical Memorandum (HTM) 07-01. In the decontamination room, we saw a “tiger stripe” bag for offensive waste and a black bin bag for domestic (paper/wrappers) waste. There was also a “gritt bin” which was specifically used for the safe disposal of chemicals used during the decontamination process.

We saw Control of Substances Hazardous to Health (COSSH) assessments for the chemicals used for nasoendoscopes cleaning. A nasoendoscopy is a small, flexible tube fitted with a small camera, inserted via the nostril to enable a clinician to view the top of the mouth and throat. This meant the trust had assessed the risk of using these substances and had controls in place.

We were unable to observe nasoendoscopes procedures during our inspection. However, we spoke with staff that walked us through the process of cleaning the scopes in the ear, nose and throat (ENT) area of outpatients and saw that this process was in line with the Health Technical Memorandum (HTM) 01-06: Decontamination of flexible endoscopes guidance. The department had ten nasoendoscopes and these were processed for cleaning via an automated endoscope reprocessor (AER). When not in use, nasoendoscopes were kept in the drying cabinet and they could be stored for up to 72 days before they would need to be reprocessed, or up to three hours if stored outside of the cabinet.

The set-up of the decontamination room meant that clean and dirty equipment was processed in the same room, which presented an infection control risk. However, the department sister explained the flow through this room to ensure the dirty equipment remained segregated from the clean equipment, which meant the risk of contamination was minimised. There was a separate hand wash basin in the room with mixer taps which was compliant with Hospital Building Note (HBN) 00-09: Infection Control in the built environment.

However, within the decontamination room there was only one deep fill sink. This meant that when scopes were rinsed with detergent, the sink had to be emptied and refilled in order to rinse them. This was not compliant with Health Technical Memorandum (HTM) 01-06: Decontamination of
flexible endoscopes guidance, which recommends use of two sinks. We observed that the deep filled sink had “fill to” lines on which helped staff to ensure the correct concentration of water to detergent was used.

The automated endoscope reprocessor used a “track and trace” electronic system. This system monitored which scope was used on which patient by the scanning of equipment barcodes and the storing of these within the patient record. Information held on these barcodes also indicated the last time it was cleaned, and whether it had gone through a manual or AER cleaning process.

There was a decontamination folder available within the department which we saw. It held the contact details in the event of any issues or problems and gave a guide of what to do in the event of a fault with the decontamination equipment. We also saw a log book for when a scope was out of action or required repair. No scopes were out of action or quarantined at the time of our inspection.

Only trained staff could undertake the decontamination process and only then would they be issued with a bar code and fob for the drying cupboard room. We looked at four members of staff yearly competency check sheets, which had been completed and were within date. We saw in-date standard operating procedures were in place for staff. These included the manual wash and inspection of flexible nasoendoscopes; manually washing and leak testing the scope on the tracker system and removing a scope from drying cabinet on the tracker system.

**Environment and equipment**

The 2017 Patient Led Assessment of the Care Environment (PLACE) score for condition, appearance and maintenance in clinic area six was 100%, which was better than the national average of 94%. The score for clinic areas one, two and three was 90% which was slightly worse than the national average. We did not receive the PLACE scores for the other areas of outpatients.

We observed the outpatient department clinic areas had a range of adequate seating. Some waiting areas such as clinic areas one and two were busy and appeared cramped, but all patients we saw waiting had access to a chair. There were also a “quiet” room available on area one and two, if staff needed more privacy to talk to patients.

Staff had access to personal, protective equipment (PPE). Within the decontamination room, we observed that there were disposable gloves, aprons and protective eye visors available for staff to use. Staff told us they used gloves, aprons and visors while cleaning the dirty scope. When the scope was clean, they used gloves and apron, which was appropriate use of PPE as it avoided the nasoendoscopes becoming contaminated.

Sharps management complied with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. We saw sharps bins were appropriately dated and signed when used.

There were plastic covered trays available for transporting nasoendoscopes to and from the clinic rooms. This meant that the scopes remained clean during transportation. We observed a tray being prepared and saw that trays were wiped down with detergent wipes, and then a clear plastic liner was placed onto the base of the tray. The nasoendoscopes was then removed from the drying cupboard, and placed onto the tray. A green plastic cover was placed on top of this to indicate it was clean and ready for use. When the nasoendoscopes had been used in clinic, a red plastic cover was used before transporting back to be cleaned to indicate that it was dirty. This ensured that the instruments were clearly identifiable as clean or dirty.
Water testing was undertaken weekly and all results went through the surgical endoscopy department. In the event of any issues, the endoscopy department rang outpatients to inform them of this.

There was a chemical spill kit available and this was kept in a separate room to the chemicals. In the event of a chemical spill a third-party specialist company was called to safely remove the spill. We were given examples of when this had occurred.

Resuscitation trolleys were visible throughout the outpatient areas and checked daily. We saw completed logs indicating checks occurred daily. This provided assurances equipment on the trolley was safe and fit for use.

The phlebotomy department was outside of the main outpatients building, accessible via a ramp. Staff told us that previously the doors to the department were manually operated, and patients using wheelchairs had struggled to access the building. This issue had been raised and the doors to the department were now automatic, allowing ease of access to wheelchair users. The waiting area was small in this department, but was adequate for the number of patients we saw waiting.

**Assessing and responding to patient risk**

During our inspection, we observed that staffing levels were adequate with an appropriate mix of registered nurses, clinical support workers and reception staff.

Basic life support (BLS) training formed part of the mandatory training programme for outpatient nursing staff. We saw that 95% of staff had received this training, which was better than the trust target of 85%.

Paediatric life support training also formed part of the mandatory training programme for outpatient staff. Compliance for this training was 88%, which was slightly better than the trust target of 85%.

There was a system of safety huddles to ensure staff had access to current information to enable them to ensure patient’s safety. We observed the morning safety huddle for clinic area one in the outpatients department. This involved all the clinical staff who were working in the area that day, and the nurse in charge ran the session. A standard checklist was used including any staffing issues, who was responsible for the resuscitation equipment, who held the medicines cupboard keys, any missing notes, hand hygiene, double checking of patient identification, any safety issues and any clinic delays. Staff had an opportunity to raise issues and were required to sign a registration sheet to demonstrate their attendance. However, staff told us that not all areas of outpatient had access to safety huddles, such as the neurology unit. This meant that not all staff may have had access to important information prior to their shift starting.

There were also directorate safety huddles held each morning. This meeting was used to discuss any staffing issues and any other pressures or delays in patient flow. Senior staff told us this helped use clinical areas better, and the outcomes from this meeting fed back into the departments safety huddle.

Clinical oversight of patients waiting over 52 weeks was embedded in practice within the department. We spoke to the directorate lead who showed us that any patient waiting over 40 weeks for an appointment was flagged electronically on the system for pathway co-ordinators to follow up. Clinical harm reviews had been set up to assess whether patients waiting over 52 weeks for treatment or an appointment had come to further harm as a result of their wait.

We reviewed two clinical harm review documents. Both reviews resulted in no harm and had been reviewed by the relevant consultant. We reviewed data that showed the number of patients waiting over 52 weeks had gradually declined month on month since April 2017. We saw data for March
2018, there were no patients waiting over 52 weeks, which was the first time the department had achieved this since implementing 52 week clinical harm reviews. The below graph demonstrates the reduction in numbers of patients waiting over 52 weeks.

Staff told us they had specific major incident training and we saw a policy and plan in the department. There was also a major incident box which contained relevant materials and policies needed in the event of one occurring. Senior staff told us a table top exercise for a possible rail incident was due to take place later this year. However, we were not provided with an overview of how many staff had completed this training in the past or were scheduled to attend in the future.

We saw an in-date business continuity plan that linked with the major incident plan. It described how to manage business as usual in event of a major incident and included equipment locations and staff contacts.

**Nurse staffing**

There was no baseline national acuity tool for nursing staff in outpatients and staffing levels were based on the number of clinics that were run. During our inspection, we observed that clinic had an adequate number of staff and skill mix to run the clinics safely.

Since our last inspection, one of the band seven nurses had left and had not been replaced. Staff told us that although this role was missed, the workload was still manageable. There were two full-time band six nurse vacancies, and one band two part time vacancy. We spoke with staff, who told us this structure was manageable. Each clinic had a band five coordinator allocated to it, who was responsible for managing staffing levels, and dealing with clinic issues and queries.

There were over 40 bank staff available to outpatients and permanent staff told us they were able to fill staff shortages at short notice.

There was one senior administrator for the outpatient department. We spoke with senior staff, who told us this was a valued and demanding role and ideally, they would like an additional part time administrator to support this administrative function.

**Turnover rates**

From November 2016 to February 2018 a total of five staff have left the service within four months of starting.
In ten out of the 16 months, there was no turnover staff in the service. The turnover per month, based on full time equivalent staff ranged from 0% to 3.8%, which was better than the trust target of 4%.

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

Sickness rates

Between November 2016 and February 2018 there was an average of 13 staff absent per month. The highest number of staff absent was 21 in December 2016 and the lowest was six in July 2017.

Long term sickness absence ranged from 0% (November 2017) to 8.24% (February 2018). In four out of the last 12 months more than 5% of staff have been had a long term sickness absence.

Short term sickness absence ranged from 0.8% (July 2017) to 4.3% (March 2017). In three out of the last 12 months more than 3% of staff have been had a short term sickness absence.

Bank and agency staff usage

From January 2017 to December 2017 the trust reported a bank and agency fill rate of 20.7% in outpatients with a further 0.2% of shifts remaining unfilled. A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>67 (0.6%)</td>
<td>2,885 (26.3%)</td>
<td>39 (0.4%)</td>
<td>10,950</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>32 (0.6%)</td>
<td>415 (7.6%)</td>
<td>2 (0.0%)</td>
<td>5,475</td>
</tr>
</tbody>
</table>

Nursing shifts were mainly filled by bank staff with only 0.6% of shifts filled by agency staff for both nursing assistants and qualified nurses. This meant that staff who were filling shifts were familiar with the hospitals processes and procedures.

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

Medical staffing

The reported their medical staffing numbers as below for December 2017. The trust had a medical staffing fill rate of 87.1%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental - Hospital</td>
<td>10.1</td>
<td>8.8</td>
</tr>
</tbody>
</table>

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

Vacancy rates

The trust reported an annual vacancy rate of 13.3% from January 2017 to December 2017 for medical and dental staff in outpatients. This was worse than the trust’s target of 12%.

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

The trust reported an annual turnover rate from January 2017 to December 2017 of 25.9% for medical and dental staff in outpatients. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate, which is the data that has been provided by the trust.

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

Sickness rates

The trust reported an annual sickness rate from January 2017 to December 2017 of 0% for medical and dental staff in outpatients. This was better than the trust target of 4%. This either meant there was no sickness, or that there was an error in the system that meant sickness in this staff groups went unreported.

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

Bank and locum staff usage

There was no data reported for outpatients in the bank and locum data provided by the trust.

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

Records

Staff we spoke with told us that the availability of notes for clinic was good. Medical records were stored off site. Staff confirmed having notes stored off site did not usually cause problems or delays to the service.

An availability of patient case notes audit was carried out in April 2018. This detailed that the current patient administration system (PAS) used in outpatients did not have the facility to capture whether the patient notes were available for their consultation. Therefore, a snapshot audit was undertaken with randomly selected specialties, using the paper outcome form that had a tick box to indicate whether the patient notes were available. The audit identified that the patient outcome forms were not being completed fully following the clinic, and an action taken as a result of this was for clinic coordinators to collect outcome forms at the end of each clinic, and to transfer these manually onto the PAS system to enable a report or audit trail to be completed.

However, we were also given data showing the percentage of appointments where patient notes were not available for 2017. This demonstrated that, on average, 94% of notes were available in clinic. Therefore, it was not clear whether the data was captured on the patient administration system or not.

Staff told us incident reports were completed when notes were not available in clinic and we saw that there were seven incidents reported where patients could not be seen in clinic due to unavailable notes/referrals or results, and 36 incidents were reported where a patient was seen without their full record being available. There were also 53 incidents reported where patients’ notes had been misfiled, and one incident where a patient’s notes were found by a member of the public outside of the hospital building. Between January and March 2018, two outpatient appointments had to be cancelled due to notes not being available.
The matron for outpatients had devised a “super preparation room” for records preparation in their clinics. This was implemented by the matron as a result of poor preparation of notes in the past when delivered from the medical records site. As part of the super preparation, the nurses and clinical support workers were responsible for the preparation for clinic and the matron told us this reduced the number of staff handling the notes prior to the clinic, reducing the risk of lost and misfiled notes. Upon delivery of the notes by the porter, a band three clinical support worker was allocated to ensure that the notes contained the correct paperwork and clinic letters, and that any relevant test request forms and outcome forms were attached and ready for use.

The matron told us that the number of reported incidents regarding notes had reduced since the super preparation clinic had been introduced and the feedback had been positive. We spoke with staff who thought the new system worked well.

We checked eight sets of patient notes and found that all were in appropriate state of repair and filed correctly. Where appropriate, we saw that World Health Organisation (WHO) checklists and consent forms were correctly documented and complete. However, we also found that one set of notes did not contain a referral letter, and one did not have their consultation notes dated.

Patient records were kept in a locked room before clinics, and notes kept face down at reception desk before being moved to patient rooms to protect confidential patient data.

We observed nine patient consultations during our inspection, and all of these had notes available which were adequately prepared for the clinic.

Information governance training was part of the mandatory training programme provided by the trust. We saw data that confirmed 100% of nursing staff in outpatients had completed this training.

**Medicines**

The outpatients department reported 35 medication incidents between 1 April 2017 and 29 March 2018. The majority (34) incidents were reported as no harm, with one incident reported as low harm.

In November 2017, the hospital stopped routinely using FP10 (a type of prescription that can be used at any pharmacy) prescription pads, moving towards hospital prescriptions only. Prescribers issued hospital-only prescriptions, except for some evening clinics where a patient may need to access their medication outside of the hospital pharmacy working hours. FP10s were locked away and recorded on a log when used which was in line with best practice and legislation.

The lead registered nurse on shift held the key for the clinic medicines cupboard, which was in line with guidance. We observed that medicines were stored in locked cupboards or designated locked fridges. We saw checklists were completed for fridge temperatures. This showed medicines were stored appropriately to preserve their function and safety.

**Incidents**

The outpatients department reported 297 incidents between 1 April 2017 and 29 March 2018. The majority of these (105 or 35%) were categorised as patient information incidents, which included any misfiled or unavailable notes, or information governance breaches.

The majority of incidents were classified as no harm (264 or 89%), 31 (10%) low harm, one moderate (0.3%) and one incident reported as a death (0.3%). The high proportion of no and low harm incidents demonstrated a good incident reporting culture. We reviewed the incident reported as a death and the incident description referred to two separate patients, both referred on 62-day cancer patient pathways, who were both referred to tertiary centre hospitals as part of their...
pathway. The incident was reported in January 2018 and at the time of our inspection was awaiting approval.

Of the 297 incidents reported, the majority (213 or 72%) had a final review, and 10 (3%) incidents were awaiting final review approval. The remaining 45 (15%) were in the process of being reviewed and 29 (10%) were in the holding area awaiting review. This demonstrated that overall, incidents were reviewed and responded to promptly.

We spoke with staff about incidents and they were able to give us examples of incidents they had reported and learning as a result of these. One example of learning was following a chemical spill and the relevant control of substances hazardous to health (COSHH) documents were inside the room, which meant staff would have to be exposed to harmful chemicals to retrieve important information. The learning from this was that COSHH documentation was kept outside of the room, and we saw this had been implemented. Staff told us they got feedback by email following an incident.

**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 January 2017 to December 2017, the trust reported no incidents classified as never events for outpatients.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SI) in outpatients which met the reporting criteria set by NHS England from January 2017 to December 2017. This was a treatment delay meeting SI criteria.

*(Source: Strategic Executive Information System (STEIS))*

Before the inspection we were told that there was only one serious incident reported. Following the inspection, the trust clarified that there have been two.

We reviewed the details of the serious incident relating to the chemical spill serious incident and saw that the patient had an uneventful recovery and was able to go home as planned following the procedure. The treatment room was sealed off following the incident and two further procedures planned in the treatment room that day were cancelled. The fire and rescue service removed the substance and the room was deep cleaned. Learning outcomes detailed with the root cause analysis, included the production of a standard operating procedure for the chemical involved, which we saw, greater provision of spill kits, and staff training to accompany the standard operating procedure. While we saw the standard operating procedure, there was no approval date, no ID number, no review date and no document owner. It was also not clear whether staff had received training on this. This meant there were no assurances that that it was the latest version of the standard operating procedure had been ratified by the trust's governance committee or contained the most up to date guidance. The second serious incident we reviewed had a set of recommendations following the root cause analysis, however there were no dates for completion or way of identifying whether these recommendations had been actioned.
Safety thermometer

The safety thermometer is a tool used to measure patient harm and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Data from the safety thermometer records new pressure ulcers, falls with harm and new catheter-acquired urinary tract infections from any given department. This data would not routinely be displayed in outpatient departments due to their nature and in the areas we visited, none were on display. Staff told us that any safety incidents such as a fall, would be reported through the electronic reporting system and feedback received in order to improve safety.

Is the service effective?

We do not rate effectiveness in outpatients.

Evidence-based care and treatment

The trust had policies and procedures that were based on the National Institute for Health and Care Excellence (NICE) or other nationally recognised guidelines. For example, in the dermatology department, we saw a local version of the British Association of Dermatology (BAD) guidelines available for staff.

The trust policies and guidelines were easily accessible for staff via the trust intranet. Staff could use the local search engine to easily access policies or guidelines, which we observed.

The pathology department based at the hospital was in the process of merging with a nearby NHS trust to form an integrated pathology service. Because of the merger, the hospital had not applied for United Kingdom Accreditation Service (UKAS) status, and once the merger had been completed, were looking to extend the scope of the hub UKAS status to the on-site pathology department.

The trust participated in local and national audits. The trust’s UK Parkinson’s audit data had been submitted and was awaiting publication at the time of our inspection.

Nutrition and hydration

Lunch boxes were available for patients who were delayed in clinic. These were also made available for patients if they were diabetic or had other nutritional needs. We spoke with staff who told us that a full range of diets were catered for.

We saw in waiting areas a hot drinks and snacks trolley that was run by a volunteer. There was also a café and restaurant on site that patients used.

Pain relief

Staff could give patients a prescription, which they took to the pharmacy department in the hospital for dispensing, if pain relief was required in the outpatient department. However, we observed long waiting times in the pharmacy which meant there may be a delay in patients receiving their pain relief.

We spoke with staff about pain relief and the use of an assessment tool that can be used to assess pain and distress in patients who cannot verbalise pain, either due to illness or dementia. Not all staff were familiar with this type of pain scale.

Patient outcomes

All outpatients seen in clinic had a dynamic outcome form which was completed at the end of their consultation. This indicated whether the patient needed further tests, a follow up
appointment or could be discharged. The information on this form was inputted onto the electronic patient administration system (PAS) by administrative staff at the end of the clinic, known as “caching” the clinic.

The senior team recognised that there was sometimes a delay in the caching of the clinics and that this could impact patient outcomes. They had therefore recently begun auditing this process. There was a process and agreed back up plan if outcomes were not cached at the end of a clinic, so that patients outcomes would not be lost or delayed. This involved the team leaders collecting any un-cached forms at the end of the clinic and prioritising them for entry on the system by other administration staff.

The patient access team audited the quality of new referrals that had been entered onto the patient administration system (PAS). This was a random spot check to ensure that all relevant patient information such as address, telephone contact details, surname and GP details were included when the referral was entered. We saw that between two and six patient records were audited each month and that between March 2017 and November 2017, all relevant information was correctly entered on the records audited which demonstrated

The hospital participated in the UK Parkinson Audit which had been submitted and was awaiting publication.

The senior sister for outpatients ran a micropigmentation clinic for patients who had mastectomies or other invasive surgery to the breast, which resulted in the nipple being scarred or completely removed. Micropigmentation is the process of tattooing the nipple and areola to best match the skin tone. As part of the clinic process, and with the patient’s consent, photographs were taken before and after the micropigmentation. The photographs were taken from the shoulder to the waist only, protecting patient’s privacy and dignity. We observed the before and after photographs and observed that the natural appearance of the nipple had improved. However, there was no formal way of auditing this process, which meant that the clinic could be missing out on documented patient outcomes for this clinic.

Follow-up to new rate

From November 2016 to October 2017 the follow-up to new rate was generally below the England average at all sites except at Darent Valley Hospital where the rate was above the England average. There was an increase in follow-up to new rate appointments reported at Sittingbourne Memorial Hospital in February 2017. From March to June 2017 the follow up to new rate showed zero as there were no first appointments from March to May 2017 and no activity in June 2017.

Follow-up to new rate, Medway NHS Foundation Trust.
Competent staff

Appraisal rates

From April 2017 to December 2017, 97.6% of staff within outpatients at the trust had received an appraisal, which was better than the trust target of 85%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target (%)</th>
<th>Appraisal completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>4</td>
<td>4</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>11</td>
<td>11</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>17</td>
<td>17</td>
<td>85%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Other Non-Medical Staff</td>
<td>9</td>
<td>8</td>
<td>85%</td>
<td>88.9%</td>
</tr>
</tbody>
</table>

The nursing staff from outpatients had 40 members of staff who were eligible for a yearly appraisal, of these, 39 had received one. There were seven new members of staff who had not yet been a full year in employment and therefore were not counted as part of the appraisal cycle. This meant the outpatient nursing staff were meeting their appraisal target of 85%. The senior sister told us that there was a new appraisal system being introduced and that there was an event scheduled the week of our visit to disseminate the process for this. We were told that a wellbeing aspect had been added to the process, which she told us was welcomed by staff.

We saw orientation and induction forms for bank and those staff new to the department. This included a checklist which had to be signed and completed by the new member of staff and their supervisor. Examples of the orientation included introductions to the senior staff, to all of the department and how to read the application for the day. We observed ten signed induction sheets that had been completed for bank staff new to the department.
New members of staff had a competency package which covered all aspects of training including medical devices. Mentorship was provided by the sister in charge of the clinic team. We saw there were completed competency assessments for staff including in dermatology for patch testing and tele dermatology, and in the ear, nose and throat department for decontamination of nasoendoscopes. These provided assurances that staff were skilled and competent to carry out specific tasks related to their role.

**Multidisciplinary working**

We observed one-stop clinics in operation during our inspection. These were clinics where patients could attend and have diagnostic tests and consultations in one appointment slot, rather than having to attend multiple times. The fracture clinic was a combined clinic with consultant and administrator, with a dedicated x-ray room staffed by radiographers, and plaster rooms and orthotics staffed by technicians. On the trust website, there was information about one-stop clinics and patients were advised to allow extra time for these kinds of appointments.

We spoke with the senior sister who was responsible for the running of the micropigmentation clinic. They told us about working closely with the plastic surgery consultant. When the consultant had a patient in their clinic that they felt may benefit from micropigmentation, with the patient’s consent, they would take them to a quiet room to discuss whether they would like to be seen in the micropigmentation clinic by the micropigmentation clinic nurse.

There was a psychiatric liaison service that the matron was aware of, but had never needed to use it.

We spoke with staff in the ear, nose and throat (ENT) department who told us that they were working with the community services and referring some work to GPs with special interests to help patients be treated in the community.

**Seven-day services**

The outpatient department did not provide seven-day services, which is in line with outpatient departments nationally. The service offered appointments Monday to Friday, with some weekend and evening clinics.

**Health promotion**

Smoking cessation, healthy eating and other self-care information leaflets were readily available in waiting areas. Doctors and staff took responsibility for giving patients further information when required. We observed patients being encouraged by staff to self-care in the dermatology clinic.

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

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

The trust provided training in mental capacity act (MCA) level two, which included MCA and deprivation of liberty safeguards (DoLS) training. The trust reported that from April 2017 to December 2017, MCA training has been completed by 56.3% of staff within outpatients. This was worse than the trust target of 85%.

A breakdown by medical staff is shown in the table below (there were no nursing staff reported under outpatients in the training data provided by the trust):
<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental - hospital</td>
<td>9</td>
<td>12</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Nursing staff completed MCA training and we saw that 93% of staff had completed this training, which was better than the trust target of 85%.

We spoke with staff about the micropigmentation clinic and saw blank consent forms for both the photographs and the procedure itself. Patients consented to a before and after photograph (from shoulders to just below the breast to maintain anonymity), and to whether they consented for the photograph to be used to show other patients who may be considering a similar procedure. Patients were also shown the photograph taken, and if they were unhappy with this they could request it to be deleted and re-taken.

Is the service caring?

Compassionate care

Staff provided treatment and care in a kind and compassionate way and treated people with respect. We observed consultations where staff were patient, considerate and empathetic. Patients we spoke with were generally positive about the care and treatment that they received.

The Patient Led Assessment of the Care Environment (PLACE) score for privacy and dignity in clinic areas six was 100%, which was better than the national average of 83%. The score for areas one, two and three was 85%, which was marginally better than the national average. Both of these scores had improved since our last inspection. We were not given PLACE scores for the other outpatient areas.

Friends and family test – outpatient response (% recommended) from August 2017 to February 2018

The average response rate for outpatients was between 10% and 15%. The percentage of patients who would recommend the trust was between 89% and 91%, which was slightly worse than the England average of 94%.
In addition to the friends and family test, the department also ran a “comments on our service” (COOS) card, and these were available in all outpatient areas we visited. These were slips of paper with three simple boxes on that patients and relatives could record what they liked, disliked and any suggestions. There was a separate form aimed at children and young people and their parents, which had a teddy bear picture on it to differentiate it from the standard version. Patients did not have to record their names or details on the form, unless they would like a response to their comments. Two band six nurses collected the COOS cards and collated the responses, and these were shared at the patient experience meetings. We observed that the majority of responses were positive.

We observed a member of staff showing compassion and supporting a patient who appeared out of breath on their way to an outpatient appointment. The staff offered a wheelchair and to accompany the patient to their clinic destination to ensure their safety.

There was a chaperone system. When a chaperone was present, this was documented in the patient notes and was signed and dated by the chaperone. As well as offering the patient support during the consultation, this also supported staff should an allegation be made about an event during a consultation and staff told us that this had been invaluable in the past.

Clinic doors had “knock and wait” signs to ensure privacy and dignity for patients and we observed staff knocking and waiting before entering a clinic room.

We spoke with 21 patients and relatives during our inspection. The majority of these patients told us they felt they received positive care, describing staff as “patient”, “kind”, “understanding”, “welcoming”, “friendly” and “fantastic”.

**Emotional support**

We saw that clinics had access to clinical nurse specialists (CNS) for a range of specialities, including cancer, Parkinson’s disease and multiple sclerosis. CNS’s formed part of multi-disciplinary teams to provide support to patients who have a long-term illness or cancer diagnosis, as well as their families and carers. We spoke to CNSs who had advanced communication skills training and psychological welfare training, which meant they were equipped to be able to support patients who may require emotional support.

We spoke with patients about the emotional support they received, and were told in the majority that patients felt well supported. We spoke with one patient who felt their diagnosis had been delivered in a matter of fact way by the consultant and the CNS was not available for their clinic. However, the following day the CNS contacted the patient who told us they were “brilliant”.

We observed two consultations where emotional support was given to patients. We observed staff handle difficult topics such as suicidal ideation sensitively and patiently.

**Understanding and involvement of patients and those close to them**

The cancer care unit held a Macmillan Quality Environment Mark (MQEM). This is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. This demonstrated that the unit was welcoming and accessible to all; respectful of people's privacy and dignity; supportive to users' comfort and well-being and listened to the voice of the user.

We observed three patient consultations. We observed that good explanations of options available were given, and time was given to enable patients to make decisions. A patient told us that they had a good dialogue in their consultation, with a full and honest decision. Another patient told us
they fed back to their consultant regarding discomfort they experienced with a medical device. The consultant took this on board and worked with the patient to make this more comfortable.

The micropigmentation clinic had developed an image library of before and after photographs. These were photographs taken with the patient’s consent, that helped demonstrate to other patients what their results may be like. The senior sister we spoke with was keen on making sure there were a range of different body types and results in the image library, so that if a slim, elderly patient came to the service, they would have a patient of a similar body type to show them. Similarly, patients with a lot of scar tissue compared with those with minimal scar tissue to give patients realistic expectations about what the clinic could offer them. We spoke with staff who ran the clinic, who told us they felt the patients that they saw in clinic felt empowered; they had a choice about whether to have the treatment done, along with choice in the size and colour of work, provided the end result resembled a natural appearance.

There was a micropigmentation clinic patient information leaflet, which explained the risks and benefits of the treatment. It also clearly defined the aim of the treatment was to “improve the cosmetic appearance of breast by recreating as closely as possible a nipple that matches the existing nipple (if applicable)”. The outcome of successful treatment was listed as a “positive effect of improving and body image and self-esteem”. It also provided after care information, including the risk of using laser hair removal on a treated area, as it could permanently affect the pigmentation.

In some cases where patients requested, friends or relatives were allowed to attend the treatment part of the patient’s consultation to provide support and to be part of the recovery process.

We observed staff encouraging patients to self-care, such as a dermatologist showing their patient how to correctly examine their skin at home.

**Is the service responsive?**

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

The outpatients department operated mainly from Medway Maritime Hospital, but other clinics also ran from other local NHS sites which meant that patients could choose to attend a local site that suited them.

The hospital was currently introducing automated check-in for outpatients. This is where patients could check into their appointment via a touch screen at the entrance to the hospital. We observed several patients using the automated check in, and there were two members of staff allocated to assist with this process. We spoke with patients who had used the system, and there was a mixed response to this, with some patients stating they would rather speak to someone rather than using a touch screen, and others saying the touch screen process was effective.

The main outpatient clinics ran from Monday to Friday 8am to 5pm, with some additional clinics running in the evenings and at weekends. This allowed patients who worked during the week some flexibility to attend at times that suited them. The phlebotomy department was open Monday to Friday, 7am to 4.45pm. This meant that patients who attended clinics later in the day between 4pm and 5pm might not be able to get their blood sample taken on the same day and would have to return to the hospital or attend their GP surgery for this.

The hospital car park was situated close to the main entrance but was very busy and oversubscribed. We observed cars queueing for parking spaces. The car parks operated a “pay on exit” scheme, but if a clinic was overrunning, the extra time in the car park would have to be paid for, rather than a one-off appointment charge. This meant patients who arrived on time for their
appointment but were delayed by clinic was running late were penalised for a delay. There was a designated free taxi phone at the front of the hospital that patients could use to contact taxis to take them home.

The main clinic areas for outpatients were well signposted and there were volunteers posted at various stations throughout the hospital to provide assistance. We observed the volunteers were an invaluable and friendly resource to the hospital, with many visitors grateful of their support.

However, when we tried to locate the outpatient pharmacy department, members of our inspection team were unable to locate the department without the help of volunteers’ due to very poor signage. We also observed patients and relatives asking for directions to it. The pharmacy was situated off a corridor, and was signposted at either end of the corridor, but the actual pharmacy was within the X-ray north wing, and there was no signposting to indicate this. We spoke with a member of staff who helped us locate the pharmacy, and they told us that the poor signage had been escalated to their manager but that nothing had happened regarding this.

There were water coolers available for patients to access water. There was also a hot drinks trolley managed by a volunteer. Patients could pay as much or as little as they wanted for their chosen item.

The pharmacy was open Monday to Friday 9am to 5pm, and 11am to 3pm on weekends and bank holidays. We visited the outpatient pharmacy waiting area where there were 13 patients waiting. The time they had each been waiting ranged between one hour ten minutes and two hours and ten minutes. There were also two patients who had come back on a different day to collect their prescription because of the wait, but their prescriptions still were not ready and they had been waiting in excess of one and a half hours. One of them had rung to ask whether their prescription was ready and was told it was, but had still been waiting one hour. When we previously inspected the hospital, there was a target of dispensing prescriptions within 30 minutes. This was not being met on the day of the inspection.

The pharmacy had a poster in the waiting room advising that the trust was implementing a new electronic system for outpatient prescriptions and that this may result in a delay. However, there was a manual paper ticketing system in place on the day of our inspection. We spoke with the chief pharmacist about this, who advised that the electronic system (that was able to show on a screen where a patient’s prescription was in the queue and estimated wait time), had been turned off due to an unknown technical fault. The system used for tracking wait times of prescriptions had also been stopped. We were advised that since the hospital had stopped using FP10s (a type of prescription that could be used in any pharmacy) in November 2017, the workload in the outpatient pharmacy had increased, and the tracking system took too long and became stressful for staff to input data. The chief pharmacist told us that they would look into a manual reporting system in the interim to be able to track prescription turnaround times. Following the inspection, we were provided with some turnaround times for outpatient prescriptions, however these figures came with a caveat that these were not likely to be accurate due to a problem with the tracking system.

The website signposted where patients could get help with changing, cancelling or confirming outpatient appointments. The patient service centre was open from Monday to Friday, 8am to 5pm. Calls regarding appointments came to the patient access centre, where a team of staff manned the telephone lines. We reviewed the call data for 2017. Out of a total of 115,917 calls, 95,536 (82%) were answered, and 20,379 (17%) were abandoned. Of the calls answered, the average wait times were between one minute and four seconds and two minutes and 14 seconds.

The trust ran some telemedicine and virtual clinics as an alternative to face to face appointments. As part of the dermatology telemedicine clinic, following a dermatoscopy (examination of the skin
with a microscope) and photograph of the lesion, the nurse completed a proforma, passed to the consultant who then informed the patient of the outcome. The virtual fracture clinic was where an x-ray was reviewed by the relevant clinician, and the patient was then contacted and advised whether or not they needed to be seen in clinic again. These types of clinics meant patients did not have to be on site to receive advice. Virtual clinics may therefore have helped with issues such as car parking by reducing the number of patients in the department at any given time.

We visited the pathology department that was currently undergoing a merger with another local NHS trust to form an integrated pathology partnership that covered the North Kent locality. This meant that representatives from both trusts would oversee the management and governance of the service and turnaround times. The last 12 months turnaround times were overseen by this trust.

There were three timed streams for blood sample turnaround. Urgent or ward requests within one hour, four hours for outpatient blood samples, and 24 hours for GP blood samples. The hospital target for these was 90%, and the four-hour stream consistently met this target between April 2017 and March 2018. The one hour and 24 hour streams were at 75% and 76% respectively, which were worse than the hospital set target.

Histology turnaround time was measured by the percentage reported within ten days. The target was 90%, and we saw that between March 2017 and February 2018, 94% of urgent cancer biopsies were reported within ten days which was better than the target. Of all histology cases, the compliance over the reporting period was 77% which was worse than the trust target.

We spoke with the patient access manager, who told us they had audited the reception areas in outpatients to ensure there were enough staff on the reception to man the desks. Now they have two receptionists on area five, two on area seven, two in dermatology on busy days, and two on busy days in maxillo-facial.

**Did not attend rate**

From November 2016 to October 2017, the did not attend rate was generally better than the England average at Medway Maritime Hospital and Darent Valley Hospital but worse than the England average at Sittingbourne Memorial Hospital and Gravesham Community Hospital. There was no activity recorded for Sittingbourne Hospital in June 2017.

**Proportion of patients who did not attend appointment, Medway NHS Foundation Trust.**

(Source: Hospital Episode Statistics)
We saw the trust did not attend policy, which was in date. This detailed the procedure to follow in the event of a patient not attending their appointment whether this was a new, follow up or two week wait appointment.

There was an appointment reminder service that patients could sign up for. This would trigger a text and voice reminder seven days prior to the appointment time, and then again three days before the appointment time. The message also left contact details for patients to ring if they needed to change or cancel their appointment. We spoke with patients who told us they had received the reminders and found them useful.

**Meeting people’s individual needs**

The PLACE assessment for dementia was included for the first time in 2015, and focused on key issues such as flooring, decoration (for example contrasting colours on walls), signage, along with seating and availability of handrails, which can prove helpful to people living with dementia. The outpatient clinic area six scored 83% for 2017, which was better than the national average score of 75%, and was an improvement from the previous year. However, areas one, two and three scored 46%, which was worse than the national average and had deteriorated since the 2016 score, indicating that services for patients living with dementia in this area could have worsened in the last year.

The PLACE assessment for disability was included for the first time in 2016. Clinic area six scored 88% which was better than the national average of 78% and an improvement from the previous year’s score. However, areas one, two and three scored 58%, which was both worse than the national average and a deterioration from the previous year.

There were learning difficulties and dementia links and champions within outpatient staff. The outpatients’ department had developed their own local competency document for dementia for staff to complete to help raise their awareness and ability to assess a patient who may have dementia. Staff showed us dementia and learning difficulties resource boxes were available in the department, with tools for supporting and managing patients with learning difficulties or dementia.

The outpatients’ department used the national “butterfly” scheme for patients living with dementia, and a local “smiley face” scheme for patients with learning difficulties. The butterfly scheme was a way of making staff aware the patient was living with dementia and was indicated by a small purple butterfly sticker placed on the notes. The smiley face scheme was to indicate to staff that a patient may have learning difficulties and was indicated by a small smiley face sticker placed on the notes.

There was no specific training for staff on dementia, however there were five dementia champions in post in the outpatients department, and a patients with learning difficulties and dementia group, which met quarterly. We saw minutes from one of the meetings that took place in October 2017, that discussed issues or any concerns identified in any of the department areas.

The trust offered face to face, telephone and written interpreting and translation services. We spoke with staff who knew how to access these services and were told that these were usually booked at the time of the appointment. If they were not booked but needed, staff told us that they would use the telephone translation service, or in the worst-case scenario, use staff to interpret. The hospital website gave advice to patients who may need an interpreter that they needed to inform the trust at least seven days in advance by phoning the number on the appointment letter.
We saw patient information leaflets available in other languages and staff knew how to access leaflets in a different language if they were not immediately available.

There were quiet rooms available in outpatient areas for patients, relative and staff to use if they needed space for reflection.

There was a detailed section on the website for outpatients which gave patients information on what they could expect during their visit. This was broken down into five sections: before your appointment, when you arrive, at your appointment, if you are having surgery and after your appointment. Each section had advice for what to expect such as ‘what you may need for your appointment’. There was also a contact number for patients who may be eligible for patient transport services. Patients were advised to allow two to three hours for an appointment or longer if waiting for tests, and if they did not attend without informing the hospital, they may be referred back to their GP.

In the “After your appointment” section there was a sub-section titled “prescriptions”, however this did not contain information about prescriptions and repeated information regarding taxis from the hospital.

The hospital had a chaplaincy and spiritual care team that was on site from Sunday to Friday and on call at all times. The chapel was located on level two in the blue zone of the hospital and was open to staff, patients and visitors. It was open to all faiths and those who had no faith. There were details of how to contact the team by phone or email on the website.

Access and flow

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From February 2017 to January 2018 the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently worse than the England average. The latest figures for January 2018 show that 79.4% of non-admitted patients were treated within 18 weeks compared to the England average of 88.8%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Medway NHS Foundation Trust.

![Graph showing referral to treatment rates over time](image)
The following two specialties were better than the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>92.9%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Neurology</td>
<td>87.5%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

The following 13 specialties were worse than the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>92.4%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>91.8%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>87.6%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Other</td>
<td>86.7%</td>
<td>91.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>84.7%</td>
<td>87.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.2%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Total</td>
<td>80.1%</td>
<td>89.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>76.0%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>73.7%</td>
<td>87.9%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>72.0%</td>
<td>92.3%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>70.9%</td>
<td>85.4%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>65.3%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>59.9%</td>
<td>89.1%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From February 2017 to January 2018, the trust’s referral to treatment time (RTT) for incomplete pathways was consistently worse than the England average. The latest figures for November 2017 show that 82% of incomplete patients were treated within 18 weeks compared to the England average of 89%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Medway NHS Foundation Trust.
Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

The following four specialties were better than the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology</td>
<td>96.7%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>93.0%</td>
<td>90.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>91.5%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>91.3%</td>
<td>91.2%</td>
</tr>
</tbody>
</table>

The following 11 specialties were worse than the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Trust</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>95.6%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>87.0%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.7%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>84.7%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Other</td>
<td>82.5%</td>
<td>91.3%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>82.1%</td>
<td>94.0%</td>
</tr>
<tr>
<td>ENT</td>
<td>79.5%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>74.5%</td>
<td>84.3%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>71.7%</td>
<td>91.6%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>57.0%</td>
<td>86.1%</td>
</tr>
</tbody>
</table>

(Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

In the last four quarters, the trust performed better than the 93% standard for people being seen within two weeks of an urgent GP referral in just one quarter (Q3 2017/18). The performance over time is shown in the graph below.
Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Medway NHS Foundation Trust

![Graph showing percentage of people seen by specialist within 2 weeks of urgent GP referral.](image)

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (all cancers), Medway NHS Foundation Trust

The trust performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in three out of the last four quarters with an improvement in performance over time. The performance over time is shown in the graph below.

![Graph showing cancer waiting times.](image)

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral in all of the last four quarters. There had been no improvement in performance over time. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Medway NHS Foundation Trust
The trust had an in-date elective access policy which set out processes to ensure national waiting time guidance was followed.

We reviewed the data recorded from the amount of cancelled clinics. Between April 2017 and March 2018, 2,325 appointments were cancelled with less than six weeks’ notice. This was not in line with the trust’s elective access policy, which stated a minimum of six weeks’ notice is required for cancelling clinics.

Waiting times and delays for clinics were displayed in the clinic waiting areas but on some occasions these were inaccurate and there was no oversight of average waiting times. We spoke with a patient who was waiting in the rheumatology clinic. The waiting time board stated that there was a 15-minute delay to the clinic. However, when we spoke with the patient they had been waiting 20 minutes. The patient approached a member of staff who advised them that they would be seen soon. The patient, however, was still waiting an hour later, but told us that staff had apologised and assured them that they would be seen next. We observed staff apologising and promising to look into what had gone wrong.

Access to the micropigmentation clinic was through two main routes; from a GP referral, or from referral at a local specialist plastics hospital. Patients could also be referred from the plastic surgery clinic where a consultant could facilitate an informal chat with the clinic nurse and, if happy, the consultant could make a formal referral to the service.

As a new patient in the micropigmentation clinic, appointment duration was dependent on whether the patient was new, a follow up or the complexity or amount of work undertaken. For example, an appointment for a double mastectomy would be allowed a longer duration that a one sided mastectomy. This meant that patients were allowed sufficient time to ask questions about their treatment, and staff had sufficient time for their assessment.

**Learning from complaints and concerns**

**Summary of complaints**

From January 2017 to December 2017, there were 154 complaints about outpatients. At the time of reporting, 134 of these complaints had been closed. The trust took an average of 28 days to close these complaints. The trust has a target to close complaints within 30 days and complex complaints within 60 days. Only 61.9% of complaints were closed within 30 days and 91.0% of all complaints were closed within 60 days. This meant the service was not meeting their complaint response target.

The majority of complaints had more than one theme. The most common themes of complaints were:

(Source: NHS England – Cancer Waits)
Appointments - 40
Attitude of staff – 39
All aspects of clinical treatment – 33
Delay/cancellation (outpatient including A&E) – 29
Communication/information to patients – 28
Delay in outpatient appointment – 17
Verbal communication to patient – 13
Written communication to patient/family – 12

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

Information on the trust’s complaints policies and procedure was available on the trust’s website. None of the complaints reported in 2017 were referred to the Parliamentary and Health Service Ombudsman (PHSO).

Is the service well-led?

Leadership

There were two directorates within the trust incorporating different programmes of care. Each directorate was overseen by a management triumvirate.

The management and directorate structure had undergone significant changes since our last inspection. The outpatients’ department was part of the women’s and children’s programme, which sat in the planned care directorate. The directorate was overseen by an executive director of operations, a deputy medical director and a deputy director of nursing. The children and women’s health programme was overseen by two clinical directors, a head of operational performance and speciality leads. At the time of our inspection, one of the clinical director posts was vacant, and the head of operational performance was also acting up to the executive director of operations role. Senior staff told us the triumvirate was invaluable for decision making at a high level, and gave the right knowledge base to be able to make decisions.

Nursing staff in outpatients were managed by two matrons covering the different clinic areas, and medical staff in the outpatient department were managed by their own specialities. The patient service centre had one service manager, who oversaw one senior team lead, and four team leads.

There were clear lines of local management responsibility within the department. We spoke with staff at all levels who told us they felt supported in their roles, they told us they had regular one to ones and felt able to raise issues if they needed to. Managers were described as accessible and approachable.

Vision and strategy

The trust’s values were be bold, every person counts, sharing and open; and together (BEST). We saw the trust values displayed throughout the hospital. Staff we spoke with knew the values and were able to tell us about them.

We spoke with the executive director of operations regarding the strategy or vision for the outpatient department. At a previous inspection, we were told that a draft strategy was under development but at this inspection we were told that the outpatient’s department did not need its own strategy as it acted as a support to the other programmes and acted as a service provider to other programmes. We were told that the purpose of the outpatient’s department was to follow the
trust’s elective access policy and to support the other programmes in the completion of their objectives. Senior staff we spoke with echoed this to us and were aware that they as a department worked from the elective access policy. We spoke with staff who told us that they were aware of there not being an outpatient-specific strategy and told us that they worked to the elective access policy. However, with no formal document detailing this, it was unclear whether the department as a whole knew the direction or role it played within the hospital. It was also not possible to monitor progress of this informal objective.

Whilst there was no formal strategy, we saw detailed trajectories and data dashboards that fed into the development and monitoring of the outpatient department’s performance. Senior staff told us that there was a national requirement to meet the 18 week target this year, but again, this was not documented within a formal strategy or objective for the department.

There was a children and women’s operational programme plan 2018-19, which we reviewed. This covered areas such as finance, quality and performance and the outpatient department performance.

We saw that a referral to treatment (RTT) web-based application had been produced by the outpatient department, which allowed a detailed overview of an individual specialty’s performance. The application could ‘drill’ down as far as to an individual patient, consultant or specialty.

**Culture**

We spoke to staff who told us that they were happy and well-supported. We spoke with staff who had been at the hospital for a number of years and they felt they got recognition from the matron and other staff. We were told there was a bigger focus on pastoral care, and gave examples of the rota being flexible to support staff who had outside commitments such as personal appointments or family members to care for.

We saw a card from a member of staff who expressed their gratitude to the matron and senior sister for support during a difficult time. Senior nursing staff talked about nurturing new staff and there were several examples of staff who have gone through the ranks and been developed since they joined the trust. We were given examples where student nurses had come back to work on the bank as clinical support workers because they liked the environment, demonstrating the positive culture in the department.

There were five freedom to speak up guardians within the trust. This role had developed since our last inspection, when there was only one. Freedom to speak up guardians have a key role in helping to raise the profile of raising concerns in their organisation and to provide confidential advice and support to staff in relation to concerns they had about patient safety or about a way their concern had been handled. The majority of staff knew about this role but there were some staff who did not. This indicated that while the profile of the freedom to speak up guardians had been raised, it was still not fully embedded amongst all staff.

We saw a leaflet for staff on how to deal with psychosocial reactions to a major incident. This included practical hints and tips for how staff could use self-help and how they may be affected. There was a further section on getting further help including contact details for NHS direct, the occupational health department at the hospital and support groups and caring organisations that may be able to help and offer support.

Staff told us about recent changes to working patterns and hours to accommodate longer clinic days. This was made with open discussion and agreement with staff, and there was no need for further consultation.
We spoke with senior leaders, who were proud of their teams, and staff who told us about where they had raised issues and these were listened to and acted upon.

Senior staff told us about creating a good impression on the shop floor more, for example, ensuring that staff took pride in their appearance and followed the uniform and infection control policy.

Phlebotomy staff told us about an issue raised with clinical director that was listened to and resolved.

**Governance, risk management and quality management**

Governance of the outpatients department was monitored in a variety of ways.

Most of the outpatient areas held daily huddles, where any risks or incidents could be discussed before clinics started. There were also divisional and executive level huddles that representatives from outpatients and the women and children’s division attended.

Monthly governance meetings were held where incidents, risks and complaints were discussed. Weekly RTT meetings were held where all issues and action points were raised and addressed. Representatives from all specialities attended these. We saw minutes from these meetings.

The pathology department sat in the unplanned and integrated care directorate under the cancer and clinical support service division. The pathology department was about to merge with another NHS hospital to become a regional hub, but governance arrangements had been set up. For example, if Medway staff reported an incident through the electronic reporting system, the pathology hub would investigate and feedback.

Since our previous inspection, we saw that the outpatients department had identified risks on the risk register and senior staff were aware of these risks. The divisional risk register, had two risks for outpatients listed. One was the thoroughfare through clinic areas one and two, and the other was regarding low hanging lamps in one of the clinic rooms. We spoke with staff who were aware of the risks on the risk register.

We saw a copy of the RTT recovery update and 2018 plan. This was split into trust level actions, performance and speciality, and individual trajectory, all of which was red, amber, green (RAG) rated. This included a number of different possible trajectories that were dependant on when elective surgery was re-started. This meant that the service was taking into account possible factors that may impact the RTT performance in the future.

Senior staff were aware of where the problem areas were in terms of capacity and the impact this had on RTT. Dermatology was listed as one of the biggest factors in RTT capacity, and told us how they were working with commissioners to try and reduce wait times.

Staff also recognise that with the pause on elective surgery from December 2017, there would be capacity issues when this pause was lifted and the pathways were started again. Staff were assured by the embedment of the clinical harm reviews in place for patients waiting over 52 weeks.

**Engagement**

The outpatient department participated in the national friends and family test and in local comment on our service surveys to help monitor the quality of the service.
Staff in the outpatients’ department attended twice monthly staff meetings and we saw that bank staff also joined these meetings. Minutes were shared with staff that could not attend by placing copies in their pigeon holes. We spoke to staff about these meetings who told us that they started with an open session for staff to share any issues or questions, and then moved onto standard agenda items such as incidents, complaints and friends and family results.

The trust website had a vast array of information available for patients and visitors to the outpatient department. This included information regarding before the visit, during their visit and after the visit. The text message reminder system that was in place also gave a number to contact for any questions prior to a patient’s appointment. This meant that patients were engaged with prior to their appointment.

**Learning, continuous improvement and innovation**

There were several nurse-led clinics within the outpatients department. This included venesection (removal of blood by needle in the vein), plastics and a micropigmentation clinic. The venesection clinic involved the training and assessment of a clinical support worker to complete venesection, and once competent, running the clinic. The plastic surgery clinic was a wound clinic supported by a plastic surgeon. The clinic was available following surgery at a local plastic surgery specialist hospital, and involved the removal of sutures and monitoring of the wound and the appropriate dressings. This clinic could also accommodate patients with pressure damage and district nurses could refer into the clinic patients that could access the hospital clinic. During the clinics, patients were taught and encourage self-care to help reduce the need for hospital visits and admissions.

There was an automated check-in project in progress in the outpatients department, which we saw. The project was currently testing the automated check-in, in areas one to three with an interim test system, with an intention to roll out to the whole department once the testing phase had been evaluated.

An e-referral project was underway and ready to roll out. This was a project that would mean all referrals that came to the outpatient department (with some exceptions) would be received electronically. The hospital had been ready for this process for a number of months, but external parties were delaying this process. There had now been a final deadline for full switch to e-referrals by October 2018, but the staff on this project were hopeful that this would be rolled out by May 2018.

A new tele dermatology clinic had been initiated by the dermatology department. This was a new clinic where a dermatoscopy and photograph of a skin lesion would be examined by a nurse who completed a proforma and gave to the consultant, who would then review the images and patient would be informed of the treatment options and outcome by telephone.

The matron for outpatients was trialling a pre-assessment outpatients project. This project was working towards triaging patients who were being put forward for surgery in outpatients following their appointment, and carrying out the pre-assessment there and then. This meant patients would not have to attend for a separate pre-assessment clinic prior to their surgery. This would only be completed if the patient was assessed to be low risk -patients that had any moderate to high risk would still have their pre-assessment in a dedicated pre-assessment clinic.
Diagnostic imaging

Facts and data about this service

The trust provides a diagnostic, interventional and therapeutic service for the local population, seeing patients from GP surgeries, hospital clinics, inpatient wards and the Emergency Department. The diagnostic and imaging department carries out routine x-rays, as well as more complex tests such as Magnetic-Resonance Imaging (MRI) and Computerised Tomography (CT) scans. The department also provides nuclear medicine, osteoporosis and the management of bone and thyroid clinics aligned to these services. Most imaging services are provided at Medway Maritime Hospital. A range of services are also provided at a local community hospital in Swale and a plain film x-ray service at two local prisons.

The department had been re-accredited with the Imaging Service Accreditation Scheme (ISAS) in November 2017.

Total activity compared to England

The trust undertook 258,740 diagnostic tests from January 2017 to December 2017. The graph below represents how this compares to other trusts.

![Graph showing total activity compared to England](Source: NHS England)

Activity by modality

A breakdown of diagnostic test activity by modality at Medway NHS Foundation Trust from January 2017 to December 2017 is shown below:

<table>
<thead>
<tr>
<th>Test</th>
<th>Total activity</th>
<th>% of all activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computerized Axial Tomography</td>
<td>31,280</td>
<td>12.1%</td>
</tr>
<tr>
<td>Diagnostic Ultrasonography</td>
<td>39,035</td>
<td>15.1%</td>
</tr>
<tr>
<td>Plain Radiography</td>
<td>150,865</td>
<td>58.3%</td>
</tr>
</tbody>
</table>
Single Photon Emission Computerized Tomography | 170 | 0.1%
Magnetic Resonance Imaging | 21,735 | 8.4%
Fluoroscopy | 7,550 | 2.9%
Nuclear | 8,105 | 3.1%
(Source: NHS England)

The department was situated within the main outpatient area of the hospital, with an additional x-ray facility situated in area seven of the outpatient clinic area. During our inspection we visited x-ray, MRI, CT, osteoporosis dexascanning, interventional radiology and ultrasound. We spoke with 18 staff including managers, consultant radiologists, sonographers, radiographers, nursing staff and administrative staff. We also spoke with seven patients and three relatives.

As part of our inspection, we looked at hospital policies and procedures, staff training records and competency assessments, audits, performance dashboards, meeting minutes and governance records.

(Source: Acute Provider Information Request – Context acute tab)

**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 and had processes to ensure all staff completed mandatory training that was required to their role. However, compliance with mandatory training did not always meet the trust target, this meant that not all staff had completed mandatory training that was required for their role.

**Mandatory training completion rates**

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for medical and dental staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>20</td>
<td>22</td>
<td>91%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>18</td>
<td>21</td>
<td>86%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>18</td>
<td>22</td>
<td>82%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>17</td>
<td>22</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>17</td>
<td>22</td>
<td>77%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>16</td>
<td>21</td>
<td>76%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>15</td>
<td>21</td>
<td>71%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>3</td>
<td>10</td>
<td>30%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the training target in six out of the nine modules for medical staff in
diagnostic imaging. The lowest training compliance rate was in resuscitation (30% compliance). The data for resuscitation training was provided by the trust; however, staff within the imaging department were unable to differentiate between resuscitation training and basic life support. Adult basic life support training was lower than the trust target at 77%.

A breakdown of compliance for mandatory courses from April 2017 to October 2017 for qualified nursing and midwifery staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>17</td>
<td>19</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Level 2</td>
<td>16</td>
<td>18</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>16</td>
<td>19</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>16</td>
<td>19</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>15</td>
<td>19</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>1</td>
<td>8</td>
<td>13%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met the training target in six out of ten eligible training modules for qualified nursing and midwifery staff in diagnostic imaging. The lowest training compliance rate was for resuscitation with 13% compliance. The data for resuscitation training was provided by the trust; however, staff within the imaging department were unable to differentiate between resuscitation training and basic life support. Adult basic life support training was marginally lower than the trust target at 84%.

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory courses from April 2017 to October 2017 for allied health professional staff including radiographers and sonographers in diagnostic imaging is shown below:
The trust had not met the training target in eight out of ten eligible training modules for allied health professional staff in diagnostic imaging. The lowest training compliance rate was for resuscitation with 5% compliance. The data for resuscitation training was provided by the trust; however, staff within the imaging department were unable to differentiate between resuscitation training and basic life support. Adult basic life support training was lower than the trust target at 72%. Information provided by the trust showed an overall mandatory training compliance across all staff groups of 82.75%.

Following inspection, the trust submitted additional data, which indicated the overall completion of mandatory training was above the trust target.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>85%</th>
<th>87%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>129</td>
<td>149</td>
<td>87%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>128</td>
<td>149</td>
<td>86%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>122</td>
<td>148</td>
<td>82%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>123</td>
<td>151</td>
<td>81%</td>
</tr>
<tr>
<td>Moving and Handling</td>
<td>118</td>
<td>145</td>
<td>81%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>112</td>
<td>148</td>
<td>76%</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>93</td>
<td>130</td>
<td>72%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>102</td>
<td>148</td>
<td>69%</td>
</tr>
<tr>
<td>Prevent</td>
<td>100</td>
<td>149</td>
<td>67%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>2</td>
<td>37</td>
<td>5%</td>
</tr>
</tbody>
</table>

The trust had not met the training target in eight out of ten eligible training modules for allied health professional staff in diagnostic imaging. The lowest training compliance rate was for resuscitation with 5% compliance. The data for resuscitation training was provided by the trust; however, staff within the imaging department were unable to differentiate between resuscitation training and basic life support. Adult basic life support training was lower than the trust target at 72%. Information provided by the trust showed an overall mandatory training compliance across all staff groups of 82.75%.

Following inspection, the trust submitted additional data, which indicated the overall completion of mandatory training was above the trust target.

<table>
<thead>
<tr>
<th>Organisation Overall Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>275 CT Suite - CG240</td>
</tr>
<tr>
<td>275 Diagnostic &amp; OP Dr Management - CG130</td>
</tr>
<tr>
<td>275 General Imaging - CG120</td>
</tr>
<tr>
<td>275 X-ray Administration - CG130</td>
</tr>
<tr>
<td>275 Imaging Management &amp; Administration - CG140</td>
</tr>
<tr>
<td>275 Imaging Medical - CG430</td>
</tr>
<tr>
<td>275 Imaging Nursing - CG140</td>
</tr>
<tr>
<td>275 Imaging PACS - CG150</td>
</tr>
<tr>
<td>275 Imaging Ultrasound - CG250</td>
</tr>
<tr>
<td>275 Imaging Vascular Services - CG260</td>
</tr>
<tr>
<td>275 Imaging Swale - CG120</td>
</tr>
<tr>
<td>275 MRI - CG230</td>
</tr>
<tr>
<td>Nuclear Medicine Department - CG320</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OVERALL SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance %</td>
</tr>
<tr>
<td>87.42%</td>
</tr>
</tbody>
</table>

Staff received and had opportunities to complete mandatory training via face to face and online e-learning training sessions and modules. Staff told us they received the range of mandatory subjects as well as refresher sessions and ongoing discussions around these subjects as part of their day to day work. For example, staff discussed health and safety and infection control as part of their daily huddle meeting.

There was a system to track and monitor staff training. A training matrix was held by the head of imaging that monitored mandatory training and took steps to ensure this was undertaken within the department. Managers received reports and followed up on issues affecting compliance.

Staff knew how to access online training and the process for booking face to face sessions. They...
could access up to date information on their own training and received reminders of when training was due.

Staff reported that they didn’t always have time to complete mandatory training and that this had been affected by staff shortages. Managers acknowledged that there were some areas of lower compliance and had plans to support improvement, including reminding staff via the ‘Big 4’ weekly communication and via staff meetings.

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

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. Seventy percent of staff in diagnostic imaging had completed safeguarding training from April 2017 to October 2017.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for medical and dental staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>19</td>
<td>21</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>16</td>
<td>20</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>1</td>
<td>3</td>
<td>33%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust did not meet the target for two of the three eligible safeguarding courses for medical and dental staff in diagnostic imaging.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for qualified nursing and midwifery staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>17</td>
<td>19</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>15</td>
<td>19</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust met the target for one of the two eligible safeguarding courses for qualified nursing and midwifery staff in diagnostic imaging.

A breakdown of compliance for safeguarding training courses from April 2017 to October 2017 for allied health professional staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>17</td>
<td>19</td>
<td>89%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>15</td>
<td>19</td>
<td>79%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Cleanliness, infection control and hygiene

There were systems and processes to prevent and control infection. Staff kept the environment and premises clean. With the exception of cleaning of ultrasound probes, standards of cleanliness across the department were maintained, with systems to prevent healthcare associated infections.

Infection control policies were available on the intranet. Policies and procedures had all been reviewed by the trust and included areas of infection control such as decontamination, hand hygiene, cross infection, universal precautions and cleaning of equipment. The policy was in date and available on the intranet, in addition, the infection control lead kept a folder with information on policies and infection control audits.

We observed cleaning schedules in place throughout the department. General cleaning schedules were clearly displayed and schedules relating to clinical rooms and equipment were kept within those rooms. All areas we visited were visibly clean and tidy and there were clear infection prevention and control processes. Cleaning schedules were signed by domestic staff when completed in each area. Clinic rooms included records of completed cleaning checks by staff as well as audits of the availability of sanitising hand gel.

We observed staff following trust policy on infection control. For example, staff with long hair had tied it back and all staff were ‘bare below the elbows’ at all times to enable effective hand washing and minimise the risk of contamination. We observed staff following National Institute of Health and Care Excellence (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. We saw the results of hand hygiene audits displayed in clinics completed in March 2018, which all showed 100% compliance. General cleaning audit results were between 96% and 98%.

Alcohol hand sanitiser was seen throughout the department and at all entrances. There were clear instructions for patients, staff and visitors to use the sanitiser in order to reduce the risk and spread of infection. Posters, encouraged people to use the hand sanitiser and we observed staff using this when entering and exiting the department.

There was sufficient personal protective equipment (PPE) available in line with trust policy. There were sufficient hand washing facilities in place with sinks with lever arch taps available in clinical/treatment areas. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap, hand towels and hot water were available next to hand basins to facilitate effective hand washing. Information was displayed by hand washing sinks, demonstrating the World Health Organisation (WHO) guidance (2009) ‘Five moments for hand hygiene’.

We observed that all disposable curtains in treatment areas had been changed in the last six months in line with trust policy.
Staff in the ultrasound department described the process of decontamination of reusable ultrasound probes. They told us that a number of options had been reviewed and that this had been subject to input from the infection control team and a recorded risk assessment. The ultrasound local rules detailed the process of cleaning transducers including the use of a wipe clean method with paper towels and cleansing wipes and the use of transeptic spray. Probe covers were also used where there was a risk of contamination. Health and Safety Executive (HSE) guidance on the cleaning of semi-critical ultrasound probes QPSD-GL-028-1 states the a multi-wipe method of cleaning ultrasound probes is the least preferred option for disinfecting semi-critical ultrasound probes. It also recommends that a local risk assessment is performed if this option is to be used as an interim measure prior to implementation of an automated system. We requested a copy of the local risk assessment but this was not provided by the trust. We did not see any copies in the imaging department. Staff told us that testing of automated systems had been carried out within the department but they were not aware of plans or changes to the current multi-wipe system.

Waste was seen to be handled in the correct way with separate colour coded systems for clinical waste, general waste and sharps bins. Waste bins were emptied regularly and not overfilled. Sharps bins had completed labels with the date they were assembled and relevant staff signatures. Sharps bins were available in treatment rooms and areas where sharps may be used. Sharps bins were not overfilled and were managed in line with Health and Safety Regulations 2013 (the sharps regulations), 5 (1) d. This requires that secure, fit for purpose containers are used for the safe disposal of medical sharps, be placed close to the work area where sharps are being used. The diagnostic imaging service had processes in place for the treatment of patients who were considered a potential infection risk. For example, in general imaging they had a room that was used for this purpose and staff were aware of the procedures in place for shutting down the room for decontamination purposes following the procedures.

Environment and equipment

There was clear signage within the department warning where radiation exposure was taking place.

Equipment within diagnostic imaging was registered on an equipment maintenance log with asset numbers clearly recorded on the equipment. Planned and preventative maintenance systems were in place and records were maintained linked to the asset register to ensure quality assurance checks were undertaken regularly.

All diagnostic equipment was subject to annual quality assurance testing. We viewed the most recent radiation physics report dated September 2017 that showed regular checks of equipment such as the scanners were carried out. During 2016 and 2017, the trust had installed two new replacement CT scanners. In 2017 five new ultrasound scanning machines had been introduced to help improve quality and performance. Staff told us that a number of items of equipment were ageing; therefore a business case had been developed to provide options for replacement. The business case was in the process of review by the board.

The radiation protection advisor report stated that no controlled areas within the department gave rise to doses greater than the public dose limit except for one area. This had resulted in a recommendation to improve the controlled area designation and the shielding provided was upgraded.

Lead aprons used in x-ray were subject to daily visual checks and weekly and annual quality assurance checks. We viewed records of these checks regular monitoring occurred and aprons
were withdrawn from operation based on these checks. MRI equipment was labelled in line with MHRA recommendations.

Resuscitation trolleys were available in the department. These were subject to daily checks in line with the trust policy. However, the resuscitation trolley and paediatric paediatric resuscitation equipment in the interventional radiotherapy department was not checked at weekends, despite it potentially being needed for use by other areas of the department. The resuscitation trolley in CT did not include a paediatric grab bag and at the time of our inspection there were boxes on the floor in front of the trolley potentially restricting the ability of staff to access it quickly in an emergency.

A variety of disposable items of equipment were available in treatment rooms and all items we checked were seen to be in date. However, staff told us that they had experienced some difficulty getting approval for stock ordering and that this had resulted in stock levels of some consumable equipment becoming low. There was no evidence of incidents relating to this impacting on patient care.

There were radiation risk assessments that and had been reviewed by the radiation protection advisor (RPA). Risk assessments addressed occupational risks as well as those to patients and the public. Control systems were in place to restrict access to imaging areas, including signage, overdoor indicators and the use of locked doors to high risk areas. Radiation exposure was monitored for both patients and staff. Patient dose data was reviewed by the RPA with diagnostic reference levels issued accordingly and action taken to address occurrences of staff exposure to excel levels. Control of substances hazardous to health (COSHH) risk assessments were in place for substances used throughout the department.

Assessing and responding to patient risk

The diagnostic imaging department had systems and processes to assess and respond to patient risk. For examples of assessing and responding to patient risk included, following a cardiac arrest incident involving an in-patient within the department, all in-patients attending the department had a copy of their medical notes so staff had access to current medical information in the event of an emergency.

At the previous inspection in November 2016 it was identified patients who had been taken for CT scans from the emergency department were sometimes left in the CT clinical preparation room that was used as an inpatients waiting area without a designated member of staff looking after them. At the time, staff told us that this was a regular occurrence. Since then, the trust had told us that this issue had been discussed as part of the emergency department audit and board meetings. As a result the trust had developed a standard operating protocol for patient transport from the emergency department to CT. This was in draft form at the time of inspection, having been approved at the imaging governance meeting and while awaiting approval at the emergency department governance meeting. The standard operating procedure stated that all patients with identified high risk clinical issues or who were receiving interventions such as intravenous fluids or oxygen therapy were to be escorted to CT by a member of the emergency department team. The trust told us that the standard operating procedure was subject to regular monitoring and audit, however there were no records of available.

We did not observe safety huddles as part of our inspection. However staff told us that these occurred on a daily basis in some modalities and weekly in others. Issues such as health and safety, infection control and incidents were discussed. For example, one particular concern that
staff consistently told us they had discussed related to the transport of patients to and from the department. This had become an issue since the dissolution of dedicated porters for diagnostic imaging to a pooled portering service. Staff told us this had consistently resulted in patients having to be transferred by radiography staff to ensure that the service operated as efficiently as possible. The head of imaging told us they had arranged a meeting with the portering supervisor to identify and address issues relating to this.

A radiation protection supervisor was on site for each diagnostic test and there was a contract with a local NHS trust for the provision of a radiation protection adviser. This was in line with the Ionising Regulations 1999 (IR99) and the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. We were told that the radiation protection adviser was normally on site at the trust twice a month. A number of trust policies and procedures such as local rules, risk assessments and IR(ME)R procedures were reviewed by the radiation protection adviser throughout the year.

Local rules were in place within each modality within the department. These rules indicated specific safety measures for each modality and included issues such as access, action to take in an emergency, radiation protection and safety control measures. We viewed local rules on the wall in each modality and these were also available on the staff intranet.

Pathways were in place for emergency admissions with imaging reporting available out of hours for emergencies. There was clear guidance and protocols in place for which staff could make imaging requests and these were monitored and audited routinely.

Risk assessments were undertaken for each patient prior to their scan, including the identification of potential allergies prior to the use of contrast. Emergency equipment was in place, including medicines for use in anaphylaxis.

Unexpected or significant findings were escalated to the referring clinical teams by the radiologists.

**Nurse Staffing**

The trust reported their registered nursing staff numbers as lower than planned for December 2017. The trust had a nursing fill rate of 83.3%. Staffing needs were calculated based on activities within each modality within the diagnostic imaging department.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>38.2</td>
<td>31.8</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

The trust reported an annual vacancy rate from January 2017 to December 2017 of 15.9% for qualified nursing and health visiting staff in diagnostic imaging. This was worse than the trust’s target of 12%.

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

**Turnover rates**

The trust reported an annual turnover rate from January 2017 to December 2017 of 20.6% for qualified nursing and health visiting staff in diagnostic imaging which was higher than the trust voluntary target. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate which is the data that has been provided by the trust.
Sickness rates
The trust reported an annual sickness rate from January 2017 to December 2017 of 5.7% for qualified nursing and health visiting staff in diagnostic imaging. This was worse than the trust target of 4%.

Bank and agency staff usage
From January 2017 to December 2017 the trust reported a bank and agency fill rate of 38.8% in diagnostic imaging with a further 3.6% of shift remaining unfilled. A breakdown by staff type is shown below:

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Filled by agency staff</th>
<th>Filled by bank staff</th>
<th>Shifts not filled</th>
<th>Total shifts available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing assistants</td>
<td>9 (0.2%)</td>
<td>2,486 (61.9%)</td>
<td>66 (1.6%)</td>
<td>4,015</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>172 (5.2%)</td>
<td>163 (5.0%)</td>
<td>200 (6.1%)</td>
<td>3,285</td>
</tr>
</tbody>
</table>

Nursing assistant shifts were mainly filled by bank staff whilst around a third of shifts for qualified nurses remained unfilled. Induction arrangement for bank and agency staff were in place, including competency assessments.

Allied Health Professionals
The trust reported their allied health professional staffing within diagnostic imaging numbers as lower than planned for December 2017. The trust had an allied health professional staffing establishment of 83.9%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified allied health professionals (Qualified AHPs)</td>
<td>165.1</td>
<td>138.6</td>
</tr>
</tbody>
</table>

Vacancy rates
The trust reported an annual vacancy rate from January 2017 to December 2017 of 13.8% for qualified allied health professionals in diagnostic imaging. This was above the trust’s target of 12%.

Managers and staff told us they had experienced difficulties with recruitment and staffing of radiographers and sonographers. Reasons for this had been explored and managers told us this was in part due to the age of the equipment within the department as newly qualified allied health professionals generally wanted to work with more modern equipment.

Staff told us that the volume of vacant posts within the department had impacted negatively on the service. For example, there were a number of section head posts currently vacant. This included in MRI, general imaging, CT and ultrasound. Staff told us that some aspects of the section head roles had been shared out across junior staff, with the support of the head of imaging. In addition, the radiation protection coordinator role within the department was also currently vacant and the duties of this role had been shared out across the remaining radiation
protection supervisors (RPSs).

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

**Turnover rates**

The trust reported an annual turnover rate from January 2017 to December 2017 of 13.8% for qualified allied health professionals in diagnostic imaging which was higher than the trust voluntary target. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate which is the data that has been provided by the trust.

Managers informed us that they had implemented ANNEX 20 to improve recruitment and retention. ANNEX 20 is a system that is part of the NHS job evaluation scheme. A radiographer employed at a band 5 level has the opportunity to have their job role evaluated to progress to the next pay band irrespective of whether or not there is a vacant post available at that level. Managers told us that by providing better career progression they hoped to retain more staff and reduce their turnover rates.

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

**Sickness rates**

The trust reported an annual sickness rate from January 2017 to December 2017 of 2.3% for qualified allied health professionals in diagnostic imaging. This was better than the trust target of 4%.

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

**Bank and agency staff usage**

The trust did not provide us with bank and agency staff usage data for allied health professionals. Staff told us there was a high usage of bank and agency allied health professionals, however a high proportion of this was their own staff undertaking additional shifts or bank and agency staff who worked in the department regularly. Induction for bank and agency was in place, with competency records and safety information shared.

**Medical staffing**

The reported their medical staffing numbers as below for December 2017. The trust had a medical staffing establishment of 88.5%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>WTE Staff</th>
<th>Number in post, December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental – Hospital</td>
<td>22.7</td>
<td>20.1</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

The trust reported an annual vacancy rate of 12.6% from January 2017 to December 2017 for
medical and dental staff in diagnostic imaging. This was above the trust’s target of 12%.

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

Turnover rates

The trust reported an annual turnover rate from January 2017 to December 2017 of 9.7% for medical and dental staff in diagnostic imaging. Although the trust has a voluntary turnover target of 8% (which excludes fixed term contracts, junior doctors, retirements, dismissals, etc.) there is no set target for the overall turnover rate which is the data that has been provided by the trust.

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

Sickness rates

The trust reported an annual sickness rate from January 2017 to December 2017 of 0.2% for medical and dental staff in diagnostic imaging. This was better than the trust target of 4%.

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

Bank and locum staff usage

There was no medical bank and locum and locum staff used in diagnostic imaging from January 2017 to December 2017.

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

Records

The diagnostic imaging service used a Picture Archive and Communication System (PACS) to store standard 2D and 3D image files. This meant that all images from scans such as CT and MRI scans and x-rays were stored electronically and accessible to staff across the system. The PACS was a web based system that stored all patients’ radiology imaging and allowed clinicians to view images and radiological reports remotely. Radiologists told us that the system enabled them to report on images from home where this was supported by securely encrypted computer equipment that was of suitable quality to view the images. The system allowed for offsite reporting, for example, overnight and at weekends where reporting was outsourced using teleradiology providers. Managers told us that outsourced tele radiology providers followed the Royal College of Radiology guidelines and were subject to regular service review meetings.

A Radiology Information System (RIS) was in operation across the imaging service to support workflow. The system enabled the creation of appointments, generation of letters, report dictation and storage, and the recording of procedure related information as required by the Ionising Radiation Medical Exposures Regulations 2000 (IRMER). In addition a Patient Administration System (PAS) was in use across the department for recording patient demographic information. Staff told us that the RIS and PAS systems were not interfaced and use of systems was sometimes difficult. For example, information about capacity and demand on the service was difficult to access and correlate.

Imaging requests were not yet digitalised, with requests being made via post, fax or email. Staff told us that there were a number of issues relating to paper imaging requests. For example, they were not always completed correctly which could lead to delays in scans which in turn had the potential to impact on waiting time targets. Managers told us that a business case has recently
been developed to fully digitalise the service including imaging requests. The trust told us that a trial of electronic remote imaging requests involving GP pilot sites was underway. However, staff told us they believed this had been put on hold due to problems with the process.

Business continuity plans were in place for all of the electronic record systems. The plans included impact assessments and contingencies. For example, the PACS system had access to a second server so that a back-up was in place should one server fail. In addition, other contingencies were in place for a number of different scenarios.

Patients transported from inpatient areas or the Emergency Department (ED) to the imaging department did so with their health records. Radiology staff phoned inpatient areas to request the patient and their health records, at the same time they asked about any issues they should be aware of before the patient arrived in the department.

GPs were advised of results via the electronic reporting system with the timeliness of reports audited.

**Medicines**

The trust had a current medicines management policy last been reviewed in May 2017 and due for a further review in May 2018.

We saw that medicines used for injection of contrast during imaging procedures was stored securely in a locked cupboard and in date.

A medicines fridge was in use within the MRI department for the storage of anaesthetic medicines. We reviewed monitoring records of fridge temperatures and saw that these had not been recorded since 2017. Staff told us they had been told they no longer had to record the temperature of the fridge but were unable to explain why this was. Following our inspection the trust told us that the fridge temperature had stopped being monitored manually in error and that in response to our findings the temperature was being monitored manually and centrally via the electronic system and that the fridge temperatures were in range.

The medicines management policy states that all intravenous drugs must be checked by a second registered person (or student nurse). However, we were told that overnight in CT this was not possible as there was only one radiographer available. Following our inspection the trust sent us a flowchart produced by the imaging department in response to our findings. The flow chart described the process to be followed when contrast medium is needed to perform a scan out of hours and included checking the contrast with the general radiographer on site overnight. The trust had plans to audit this process to ensure compliance.

Annual competency assessments were in place for staff, including checking their competence in administering medicines. Medicines were administered via patient group directions (PGDs). These were available on the intranet and paper copies were seen. In particular, we saw one PGD for a contrast agent in MRI that was out of date. We were told that the PGD was an old paper copy that had been printed by a member of staff but that up to date PGDs were accessible on the electronic record system. We were also told that the contrast agent was no longer in use following a Medications and Healthcare products Regulatory Agency (MHRA) alert in December 2017 restricting its use. Staff told us that the agent was scheduled to be returned to pharmacy but that had not had time to do this and they were unsure of the pharmacy input available for monitoring of the stock medicines. There were no pharmacist monitoring records visible. There had not been any specific medicines incidents.
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 January 2017 to December 2017, the trust reported no incidents classified as never events for diagnostic imaging.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in diagnostic imaging which met the reporting criteria set by NHS England from January 2017 to December 2017.

(Source: Strategic Executive Information System (STEIS))

Of the five serious incidents reported, three related to a delay in treatment, for example where abnormalities were not acted upon and resulted in actual and/or potential complications for the patient.

Records of serious incidents demonstrated investigations were carried out, with actions identified to address quality improvements. However, investigation reports did not always include a responsible person or a completion date for specific actions. For example, we reviewed an investigation report relating to a delay in treatment and found none of the actions included a responsible person, and a number of actions had passed their completion date but not recorded as completed. This included action relating to establishing a multi-specialty task and finish group to review and develop a pathway for the escalation of critical results; a review of guidelines on stack reporting; and an audit of generic email to ensure critical findings from imaging were being escalated in the correct manner. These actions were all due to be completed by the end of 2017.
We reviewed a second investigation report relating to a delay in diagnosis and saw that actions relevant to both incidents had been taken. For example the development of a task and finish group to review and develop a pathways for the escalation of critical results had begun to be addressed with an identified responsible person, the development of terms of reference for the group and a request for nominated participants in the group. In addition, regular updates to the directorate risk register relating to a lack of an electronic alert system included actions that were relevant to the incidents we reviewed and we saw that these were being regularly reviewed as part of the risk review and governance processes. We saw that the root cause of incidents was raised with staff and cascaded through the trust’s ‘theme of the week’ message to staff.

We viewed an annual Radiation Protection Adviser (RPA) report dated September 2017 and saw that 30 radiation incidents had been reported between January 2017 and September 2017, compared with 36 incidents that had been reported in 2016. It had not been necessary to report any of the 2017 incidents to the CQC under IR(ME)R Regulation 4(5). There had been 244 incidents in total reported relating to diagnostic imaging in the 12 months preceding our inspection. We saw incidents were reviewed and actions taken. For example, communication with other departments had been a focus where incidents regarding delayed scanning times were recorded. This had been a particular focus where inpatients were delayed as a result of issues affecting collecting them from the wards.

The trust had a duty of candour policy and there had been 11 times in 2017 where the duty of candour had been applied across diagnostics. We saw a record relating to a patient being informed when they had received an x-ray of their chest, in error, instead of their pelvis in line with the duty of candour regulation.

The trust had an electronic incident reporting system that all staff could access. Incidents were reviewed daily across the Unplanned and Integrated Care Directorate. Staff were aware of how to report incidents using the electronic reporting system. One example of where this had been used was to report incidents of portering staff not collecting patients from wards for their scans. This had resulted in radiographers having to collect patients themselves. As part of the action taken as a result, the head of imaging had arranged to meet with the portering supervisor to address these concerns. However, some staff told us they did not always report incidents that had not resulted in harm via the reporting system due to the length of time it took to complete the record. This meant that opportunities to learn and improve services may not have always been taken.

We were told that lessons were shared at the programme quality summits and patient safety seminars. Immediate learning was shared via the Big Four (‘Big 4’) message changes (a newly implemented method of sharing the four main learning points) each week. We saw one notice relating to the ‘Big 4’ but this did not detail any learning from incidents. We were told that learning was shared via huddles and team meetings; however staff in some modalities of diagnostics told us they did not have regular meetings and had not done so because of vacant section head posts. The head of imaging told us they held regular ‘open door’ meetings as a way of sharing information and learning across the team and different modalities. This meant that opportunities to share lessons were available outside of the usual meeting structure.

There were processes to checking that the right person got the right procedure at the right time, with measures in place to verify the patient identification against the procedure request.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harm 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 harm and
their elimination. Data from the Patient Safety Thermometer records new pressure ulcers falls with
harm and new catheter urinary tract infections. We did not see Safety Thermometer data on
display within the diagnostics service and were told that any safety information would be reported
under each Programme structure. However, falls and other safety incidents were reported through
the electronic reporting system and feedback received in order to improve safety.

**Is the service effective?**

**Evidence-based care and treatment**

National diagnostic reference levels (DRLs) were used as an aid to optimisation of patient
protection in diagnostic radiology. These levels were routinely audited and analysed and the
results monitored by the trust radiation protection advisor (RPA). The RPA report included some
areas of audit where information was not complete, however there was evidence that the trust
were taking a risk based approach pending the outcome of a business case for the upgrade
upgrade or replacement of equipment and the likely impact of this on patient doses and DRLs.
Annual RPA reports were provided, the most recent dated September 2017. Bi-monthly Radiation
Protection Group (RPG) meetings were held and action plans were produced and monitored by
the group.

The service identified and implemented relevant best practice and guidance, such as The National
Institute for Health and Care Excellence (NICE) guidance and recommendations from the National
Patient Safety Agency (NPSA). Managers told us that relevant NICE guidance was reviewed and
discussed at monthly audit meetings. We viewed minutes of these meetings and saw evidence of
NICE guidance being reviewed. For example, we viewed records of discussions around the
implementation of NG12 NICE guidance for suspected cancer: recognition and referral. Minutes of
meetings showed that diagnostic imaging staff were involved in the meetings and discussions
around the implementation of the guidance.

Audits of practice were undertaken locally against guidelines. For example, an annual audit of
nasogastric tube positioning and requesting was undertaken. This was against a National Patient
Safety Agency (2011) patient safety alert where x-ray is to be used only as a second line test
when no aspirate could be obtained or the pH indicator paper had failed to confirm the position of
the tube. Teaching had been carried out for radiographers to only accept an x-ray request when it
had been confirmed that an inconclusive aspiration test had been carried out.

The service ensured that NICE guidelines for acting on an image report/radiologist report were
followed through the use of audit and cross checking of images. A system of quarterly peer review
was in place for all radiologists and reporting radiographers. Incidents of errors and discrepancies
were reported via the trust electronic incident reporting system and reviewed at discrepancy
meetings.

Not all staff we spoke with during inspection were aware of NICE guidance and some were
unclear about how this information was shared.

**Pain relief**

Staff within diagnostic imaging identified patients who may be vulnerable or need additional
support and implemented measures to support them. For example, action would be taken to
minimise the waiting time for a patient experiencing pain. In a situation where an inpatient was
experiencing pain, staff contacted the ward and returned the patient as soon as possible so that they could be given pain relieving medicines. In addition, diagnostic imaging staff would advise ward staff to administer pain relief prior to a procedure for patients experiencing pain that would likely be exacerbated by movement.

Nutrition and hydration

Patients were informed of the requirements of their imaging procedure in relation to nutrition or hydration, for example if they needed to drink more fluids prior to an ultrasound scan or if they needed to fast. Reception staff were trained to identify patients with additional support needs in relation to eating and drinking and they monitored the waiting areas during extended waiting times. They would escalate any concerns to clinical staff.

A water machine was available in the main waiting area. Patients who were diabetic were given information about fasting prior to their appointment and advised about how to manage this.

Patient outcomes

Diagnostic imaging services participated in the Imaging Services Accreditation Scheme (ISAS) and the department was last assessed and re-accredited in September 2017. The next assessment was due in June 2018.

There were monthly audit meetings and all staff were invited to attend. Audits were reviewed at this meeting and learning identified to ensure improvements. For example, an audit of rejected lumbar spine imaging showed an increased number of rejections. Following this, reporting radiographers carried out teaching on the correct positioning for the procedure. A repeat audit showed an improvement and subsequent reduction in the number of rejected images.

The trust had participated in NHS radiology benchmarking in 2017 where they performed well in comparison to other trusts in areas such as waiting times for inpatients to receive x-rays and CT scans.

There was active participation in quality improvement projects. For example, the head of imaging told us they were in the process for signing up for a research project around the use of MRI in colitis.

The service undertook regular error and discrepancy meetings (where errors in reporting have been made or where peer review identifies inconsistencies in reporting) as per the Royal College of Radiologists (RCR) guidance. These were carried out monthly and attended by radiologists and reporting radiographers where a log of actions and learning were detailed and reviewed at subsequent meetings.

The department did not participate in the Improving Quality in Physiological Services (IQIPS) accreditation scheme. This scheme is a professionally-led assessment and accreditation scheme designed to help healthcare organisations ensure that patients receive consistently high quality services in safe environments.

Competent staff

Appraisal rates

From April 2017 to December 2017 82.8% of staff within diagnostic imaging at the trust had
received an appraisal compared to a trust target of 85%.

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

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total staff required to complete appraisal</th>
<th>Total staff who have received an appraisal</th>
<th>Trust Target (%)</th>
<th>Appraisal completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff – Hospital</td>
<td>21</td>
<td>20</td>
<td>85%</td>
<td>95.2%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>144</td>
<td>127</td>
<td>85%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Support to Scientific, Therapeutic and Technical Staff</td>
<td>58</td>
<td>48</td>
<td>85%</td>
<td>82.8%</td>
</tr>
<tr>
<td>Qualified Nursing Midwifery Staff</td>
<td>17</td>
<td>14</td>
<td>85%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Support to Doctors and Nursing Staff</td>
<td>123</td>
<td>100</td>
<td>85%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Other Non-Medical Staff</td>
<td>88</td>
<td>67</td>
<td>85%</td>
<td>76.1%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>24</td>
<td>18</td>
<td>85%</td>
<td>75.0%</td>
</tr>
<tr>
<td>NHS Infrastructure Support Staff</td>
<td>3</td>
<td>2</td>
<td>85%</td>
<td>66.7%</td>
</tr>
</tbody>
</table>

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

We viewed information on a noticeboard in x-ray, identifying performance reviews as one of the ‘Big 4’ messages in relation to completion targets. All allied health staff we spoke with told us they had received an appraisal in the last year and the trust told us that appraisal rates at the time of the inspection were at 90%. We viewed an appraisal structure chart that showed a cascade method of appraisal where the head of imaging would appraise the advanced practitioners and the advanced practitioners would appraise the band 6 staff.

Competency assessments were in place for all staff new to the department. We viewed completed competency assessments for staff in x-ray for each room and each piece of equipment. In addition, all staff completed annual competency assessments for each item of scanning equipment. We viewed completed assessment forms for a range of staff in CT, MRI, dexa and ultrasound.

Training opportunities were available for staff to support them in upskilling and advancing their careers. For example, nursing staff working in dexa had been supported to achieve the bone densitometry diploma. The trust supported staff to achieve post graduate diplomas, for example two staff working in MRI had recently completed these. The head of imaging worked with the human resources department to maintain records of when registration checks were due for registered staff and ensure that checks had been carried out.

**Multidisciplinary working**

We saw good multidisciplinary working across the diagnostic imaging department where health care professionals, medical, nursing and administrative staff worked together to provide the service for patients.

There were examples of good team working across modalities and with other departments across the trust. For example, we were told of theatre liaison meetings where a representative from the department would meet with a theatre representative to ensure that needs in relation to imaging requests and patient treatment was met.
Radiologists participated in cancer pathway and oncology meetings where multidisciplinary staff would meet to discuss patient care and treatment options. There were one stop clinics for breast cancer where multidisciplinary working enabled patients to receive an examination and various diagnostic tests in one visit.

Throughout our inspection we observed staff working together to provide an efficient service and a high quality patient experience.

**Seven-day services**

The diagnostic imaging department provided a seven day a week service. This was in line with NHS services, seven days a week, priority clinical standard 5, 2016 and the Royal College of Radiologists standards for providing a seven-day acute care diagnostic radiology service.

Hospital inpatients had access to a scheduled seven-day diagnostic services such as x-ray, ultrasound, CT and MRI. Radiology consultants were available, seven days a week, on a rotational basis, to provide consultant-led diagnostic tests and completed reports. Trust radiologists were on-call until 9pm then consultant cover was provided overnight via an external company on an on-call basis for CT and MRI for the emergency department and inpatients.

There was seven day radiographer cover where both imaging and reporting functions were provided between 8am and 8pm. An overnight service was also provided, with two radiographers and an assistant practitioner providing cover in the department for the emergency department and urgent inpatient requests.

**Health promotion**

There was educational literature for patients, placed around the diagnostic imaging department including clinical and waiting areas. Information based on national guidance and best practice was provided in interventional radiology.

Smoking cessation leaflets and details of related support services available locally were available in the main x-ray waiting area. We also saw infection control information leaflets for patients, including a guide for patients, hand washing and clostridium difficile.

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

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

The trust provides training in mental capacity act (MCA) level 2 which includes MCA training and deprivation of liberty safeguards (DoLS) training. The trust reported that from April 2017 to December 2017 MCA training has been completed by 65% of staff within diagnostic imaging. For qualified clinical staff this figure was 78%.

A breakdown by nursing and medical staff is shown in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental – hospital</td>
<td>16</td>
<td>22</td>
<td>73%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>
Staff we spoke with had a good understanding of consent. For example, in relation to informing patients of risks and benefits of procedures and treatment in order to obtain informed consent. Assessment processes within each modality included records of consent. For example, in MRI a consent form contained a section where patients could indicate their consent to the procedure and also their consent to the use of an injection of contrast or an anti-spasmodic to help enhance the detail of the images. Patients told us they were informed of the procedure they were having and that staff checked they were happy to proceed. One patient told us that staff continually monitored how they felt during their scan and was told to alert staff if they wished to stop.

Staff demonstrated understanding of the issues relating to patients who do not have mental capacity. Staff we spoke with told us that patients who did not have mental capacity would sometimes be accompanied by someone acting as their advocate. However, staff told us that they would always take their cues from the person receiving the scan to ensure that they were supported through the process.

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

Is the service caring?

Compassionate care

Patients told us that they were treated with dignity and respect and staff had been kind. Staff demonstrated a good understanding of the support needs of patients and we observed staff communicating with patients in a compassionate and caring manner. We spoke with two relatives of patients using the service who told us that staff had treated them with kindness and respect.

Reception staff were welcoming and friendly and showed patience and understanding when communicating with patients. Staff showed compassion and a non-judgemental approach when talking about how they supported patients with a learning disability, dementia or those who were particularly anxious. We also witnessed staff identifying themselves, asking patients if they were okay and if they needed help with anything when being collected from waiting areas.

Staff told us that patients always had the option of a chaperone and that this role would be undertaken by clinical support workers in the first instance, or that radiographers would double up on an appointment if necessary. We were told that where a patient made a request for a same sex health professional, this would be respected where possible and staff would swap duties to make sure the patient request was met. There were no visible chaperone signs within the department, although staff told us they would verbally offer this if the patient requested it or appeared uncomfortable.

Volunteers were available to provide help, support and guidance to patients. We observed volunteers guiding patients to the right department and they did so with patience and kindness.

The NHS friends and family test is a nationwide initiative to gain feedback from patients about the care and treatment they receive in hospital. Patients were asked whether they would recommend NHS services to their friends and family if they needed similar care or treatment. We did not see Friends and Family test survey results for diagnostic imaging services. However the diagnostic imaging department conducted their own patient satisfaction survey every six months. Results
from the most recent survey showed that 99% of patients felt that their privacy and dignity was respected.

**Emotional support**

Staff told us that if patients become distressed or anxious they were able to take them to a quiet area away from other patients. Reception staff also told us that if a patient wanted to speak privately they could do so.

Patients reported they felt the received information to help them understand the procedure they were having as well as their treatment plans. They had time and the opportunity to talk to staff about any concerns or treatment options. This was in line with NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Staff spent time talking to patients or those close to them before, during and after consultation. They asked if any further information was required and provided leaflets and further advice and information if requested or needed. Where patients were identified as having any additional support needs, they were invited to attend the department to have a look around and view the equipment or experience their appointment would entail. Staff identified patients with additional support needs through information shared at the point of request or by contacting wards to identify any issues.

Where patients were given life changing news they were referred to other support services, for example clinical nurse specialists.

Reception staff told us they regularly scanned the waiting areas to identify if anyone appeared unwell or upset. This was escalated to clinical staff so they could assess the patient’s wellbeing.

**Understanding and involvement of patients and those close to them**

Patients, family and friends were enabled to manage health and care when they could. People received the support they need to cope with care, treatment or condition needs. This is in line with NICE QS15 Statement 10): Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.

Staff working in diagnostic services said that potentially complex appointments were made during times when staff were able to provide extra support. For example, longer appointments were given for patients with a learning disability or those who were particularly anxious about their scan. Time was allowed to explain to patients and families the processes that would be followed, enabling them to have clearer expectations and an understanding of the scanning procedure.

Information was given to patients in leaflet format to support the information shared with them during their appointment. For example, in the interventional radiology department a range of leaflets were available to support patients in their aftercare.
Patients consistently told us that staff took the time to explain things to them and involve them in their care and treatment. For example one patient told us that on a previous visit to the department staff had taken the time to talk through the equipment and what they could expect. They also talked through any concerns the patient had about how they might feel after the scan.

Patients said they received copies of letters between the hospital and their GP’s. Patients told us they had been given information to prepare for their scans and contact numbers to call if they had questions.

Is the service responsive?

Service delivery to meet the needs of local people

The diagnostic imaging department provided a walk in service for general x-ray between 8am and 5pm. This allowed patients to attend at a time that suited them up until 5pm. The opening times for the general x-ray department were not clearly signposted and were not available on the trust website. Patients could receive x-rays outside of the general opening times if they arrived after 5pm but this was dependent on the discretion of staff and the workload of the department at the time. Patients arriving after 5pm were warned that they may have to wait for their x-ray. After 4pm there was no reception cover in main x-ray. There was a sign on the reception desk informing patients to go to the ultrasound reception, however this sign was only visible once patients had approached the desk and did not provide clarity on where the ultrasound reception was based.

Patients who required imaging in the emergency department (ED) had access 24 hours a day, seven days a week. Portable x-rays were available for inpatients that were too unwell to be transported to the department. Scans such as CT, MRI, ultrasound and dexta scans were by appointment only.

Staff we spoke with told us the department had a number of capacity issues, in particular relating to limited staffing and availability of equipment within the department. Specific action taken to address capacity issues had included the purchase of new equipment and the development of a business case to secure future sustainability in relation to equipment. One example of action taken to meet the needs of patients waiting for MRI scans was the periodic use of a mobile MRI scanner to assist with capacity issues. Staff told us that the mobile MRI scanner was used on a regular bi-monthly basis.

Patients and relatives told us that a lack of available parking was an issue for them. One relative told us they had tried to park for approximately 20 minutes and as a result they had been later for their appointment. However, staff had been able to accommodate them in spite of this. We also saw signage that informed patients that parking concessions were available where patients had been waiting a long time and faced the potential of escalating parking costs because of departmental delays. There was also information available about public transport in the main entrance of the hospital and patients would be signposted to this by reception staff.

Changing rooms were available in separate areas of the department. However, these were sometimes screened off curtain areas in public corridors that did not appear offer enough privacy. One patient with a disability told us that the changing area they had been signposted to lacked space and made it difficult for them to get changed. Disabled toilet facilities were available in the department. All areas of the department were wheelchair accessible; however some waiting areas had limited space so that when more than one wheelchair user was waiting, space was an issue. For example, in the dexta scan waiting area.
Toys were available in a screened off section of the main x-ray waiting area to provide activities for children who were waiting.

Reception staff informed patients of any delays in appointment times when they arrived and in the general x-ray waiting area there were signs in place informing patients of the length of time they could expect to wait. At the time of our inspection the waiting time was between 30 and 45 minutes long.

**Meeting people’s individual needs**

The diagnostic imaging team ensured that appointments allowed time for patients to ask questions and receive an explanation of the procedure and the equipment used. Patients were asked to attend 10 minutes ahead of their appointment time to allow for questions and to go through safety procedures.

Support with transport was available to service users with mobility issues. The department was accessible to patients in wheelchairs. However, some areas had limited space and we observed patients in wheelchairs needing assistance to navigate their way around. There were automatic doors available in public areas of the department. However, in CT, the automatic doors were not working and staff told us this had been the case for quite some time. Staff we spoke with told us they believed that the issue had been reported and would report it again. This meant that patients with disabilities were not able to gain access to the department without assistance.

Larger chairs were available in the waiting areas for patients who needed them. Bariatric patients had access to a wide bore MRI scanner which was in general use to improve comfort for patients during their scan.

There was a system in place which enabled staff to identify patients living with dementia through the use of a discrete sticker placed on their records. An assistant practitioner within the department had been identified as a dementia buddy and regularly attended meetings that helped the department to be aware of issues relating to patients with dementia.

Patients who were vulnerable were able to bypass queues at reception and were ‘fast tracked’ to their appointment in order to minimise any distress. All children, patients with learning disabilities and those with dementia had their appointments processed via this ‘fast track’ method. Staff we spoke with told us that they planned appointments for patients with learning disabilities or dementia and could involve the specialist nurses (learning disabilities and dementia) to support the process and the patient.

Where a patient was anxious or phobic, or had additional support needs, was booked to attend an appointment they could be offered the opportunity to attend the department beforehand. This enabled staff to go through equipment with them, as well as the process for what would happen. For example, patients could lie down in the scanner to experience what it would feel like. Where patients were unable to stay still during a scan due to vulnerabilities or additional needs they could be assessed and added to the sedation or anaesthetic list so that they would not be awake during the procedure.

Guidance for staff was available and visible in reception areas on how to book interpreters and translators. This included for face to face and telephone support, and outside of usual working hours. Interpreters were available across a broad range of languages and included sign language interpreters. Reception staff told us they knew how to access this support and would do so in response to information received at the point of referral.
Patients were asked about any communication difficulties in line with the Accessible Information Standard as part of the appointment booking process. Administration staff were dedicated to each modality within the imaging department and took responsibility for booking appointments and communicating with patients as necessary.

**Access and flow**

**Diagnostic waiting times**

From January 2017 to December 2017 the percentage of patients who waited over 6 weeks for diagnostic tests was consistently above the England average. The trust’s performance has improved over time but remains worse than the England average.

**Diagnostic waiting times - % of patients waiting over 6 weeks January 2017 to December 2017**

(Source: NHS England)

From February 2017 to January 2018 the highest proportion of patients waiting over 6 weeks was for MRI tests with 7.3% of patients waiting over 6 weeks, which was worse than the England average of 1.1%.

Five out of 13 modalities at the trust had a higher percentage of patients waiting over 6 weeks compared to the England average: MRI, audiology assessments, non-obstetric ultrasound, dexam scan and CT. The remaining eight modalities showed better performance compared to the England average.

**Diagnostic wait times - % of patients waiting over 6 weeks by modality (test) February 2017 to January 2018**
MRI waiting times were consistently higher than the England average over the course of the year with the monthly breakdown averaging waiting times of between 2.5% and 13.5%. The trust had made use of a mobile MRI scanner to help reduce the waiting times and this was reflected in the monthly waiting time figures. For example, in December 2017 13.5% of patients had waited for six weeks or more, whereas in January 2018 this figure had reduced to 2.5%. The average figure over the course of the year was 7.3% compared with the England average of 1.1%.

Dexa scan waiting times over six weeks averaged 3.4% over the course of the year compared with the England average of 1.1%. However, for nine out of twelve months the figure was below the England average, with two months in 2017 where the waiting time was between 13% and 20%. Since October 2017 no patient had waited six weeks or more for their Dexa scan.

Non-obstetric ultrasound scan waiting times over six weeks averaged 4% over the course of the year compared with the England average of 0.7%. The monthly breakdown averaged between 1.1% and 7.5%. Figures from the trust showed that two particular areas that had breached the six week waiting time were paediatric (nine weeks wait) and musculoskeletal (seven weeks and six days) scans.

CT scan waiting times were similar to the England average for patients waiting six weeks or more. The monthly breakdown averaged between 0.2% and 2.8% and for six months out of 12 the trust was performing better than the England average.

Managers told us that they had been focusing on reducing the MRI waiting times and that they were currently working on improvement plans to address the ultrasound waiting times. However, there were no documented plans in place at the time of inspection.

At our inspection in 2017 on average, across all diagnostic modalities within the trust the percentage of patients waiting for six weeks or more was 6.6% which was an improvement on the previous year. At this inspection the percentage of patients waiting for six weeks or more across all modalities was 3.2%, demonstrating further improvement. Across all diagnostic imaging modalities, the average was 3.8%.

The trust had developed a new diagnostics and waiting times activity (DMO1) dashboard that was more user friendly for administration staff to monitor patients and pathways. The trust was in the process of reviewing and implementing processes to improve the response to inpatient diagnostic demand. They were developing new models of working to support the processing of scanning appointments for patients in the emergency department, the management of demand, criteria led discharge and consultant request discharge diagnostics.
Urgent cancer appointments were marked with an orange dot to highlight that the request was urgent. The trust was in the process of implementing software to ensure that patients marked as urgent were on the cancer pathway. Radiologists participated in the weekly cancer patient tracking list (PTL).

Waiting times for interventional procedures and musculoskeletal injections were monitored through the referral to treatment patient pathways and we were told these were discussed and reviewed with the imaging department as part of these pathways as needed.

**Diagnostic reporting times and report turnaround targets**

The trust had an imaging report turnaround standard operating protocol. The target for reporting turnaround times for plain film was between 24 hours and five days depending on the source of the referral. Non-urgent ward turnaround times were between three and five days with urgent inpatient reports between 0-5 hours. Data provided by the trust was not based on referral sources and showed that the average plain film report turnaround for GP, emergency department (ED) and inpatient wards averaged seven days between October 2017 and March 2018.

Scanning and reporting times for CT were between one hour and six weeks depending on the referral source and urgency. For example, for patients on the cancer pathway the report turnaround time was two weeks, routine scans were within six weeks, inpatients were within four hours and acute admissions within one hour. Data provided by the trust was not based on referral sources and showed that the average report turnaround time for patients on the cancer pathway was seven days, urgent scans were 6.3 days and routine were 28 days.

Scanning and reporting times for MRI were between four hours and six weeks depending on the referral source and the urgency. For example, emergency patients such as those with a suspected metastatic cord compression would be scanned and reported on within four hours. Routine scans would be carried out and reported on within six weeks and urgent scans and those for patients on the cancer pathway would be carried out and reported on within two weeks. Data provided by the trust was not based on referral sources and showed that the average report turnaround time for patients on the cancer pathway and urgent referrals was seven days and that routine turnaround times was 16 days.

Scanning and reporting times for ultrasound were not provided by the trust.

**Learning from complaints and concerns**

**Summary of complaints**

From January 2017 to December 2017 there were 33 complaints about diagnostic imaging services. At the time of reporting all 33 complaints had been closed. The trust took an average of 28 days to close these complaints. The trust has a target to close complaints within 30 days and complex complaints within 60 days. Only 66.7% of complaints were closed within 30 days and 90.9% of all complaints were closed within 60 days.

The majority of complaints had more than one theme. The most common themes of complaints were:

- Communication/information to patients – nine
- All aspects of clinical treatment - eight
- Attitude of staff – seven
- Appointments – six
- Delay/cancellation (outpatient including A&E) – six
Verbal communication to patient - six

Of the 33 complaints about diagnostic imaging, 21 had been upheld or partially upheld by the trust. Complaints were discussed in team and governance meetings and learning identified. For example, nursing staff working in the dexa scan modality told us they had identified and shared learning as a result of a patient’s complaint following a fall within the service. Records of complaints and action taken demonstrated that learning had been identified. For example, additional training had been provided for staff in relation to customer care and conflict resolution and, information leaflets for patients about procedures sent out prior to the appointment.

Patients we spoke with were unsure how to complain. However there were signs in waiting areas informing patients on the Patient Advice and Liaison Service (PALS).

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

Is the service well-led?

Leadership

The organisation was structured into two directorates, planned care; and unplanned and integrated care. Each directorate was split into programmes. Diagnostic imaging sat within the cancer and clinical support services programme of the unplanned and integrated care directorate. The programme was led by a triumvirate that included two clinical co-directors and a head of operational performance. Diagnostic imaging was led by a triumvirate that included a clinical lead for imaging, a head of imaging and a service manager. There were seven modalities within the department; the breast unit, CT, MRI, ultrasound, general imaging, nuclear medicine, and osteoporosis. Each modality was led by a section head. In addition, the service had leads for imaging quality, radiation protection and imaging administration.

Overall, we found that services were not consistently well-led. The imaging department leads were visible, approachable and motivated to deliver a high quality service. However, we found that a number of senior posts within the department were vacant. For example, data from the trust showed that actual whole time equivalent management posts were 3.67 compared with the planned number of 7.67. We were told there were no section heads in CT, MRI, ultrasound or general imaging. The head of imaging who was new in post took overall responsibility for these sections and band seven radiographers had been acting up into the roles taking on some of the responsibilities of the section heads in parallel with their normal duties. In addition, the radiation protection coordinator post was also vacant, with the role being spread out among the existing radiation protection supervisors with other staff providing support around the administration of essential audits.

Staff told us they felt supported by the leads within the department, however they felt under pressure because of the vacant section head roles and the higher than average vacancy rates within the department. Staff working within a range of modalities told us that they did not always have time to undertake non-clinical duties and that monthly modality meetings were infrequent. For example, in one modality we were told that meetings had not occurred for a few months since the section head had left.

Staff consistently told us that senior trust and directorate leaders were not visible within the department and that they felt isolated from the rest of the trust as a result. There were limited formal meetings with programme managers and staff told us they felt like they were ‘firefighting’ a lot of the time with limited support. There had been recent changes to the structure of the
management team within the imaging department. While staff told us that service managers were approachable and supportive, they felt that the structure was not clear and there was potential crossover of roles. Senior staff within the imaging department told us that the roles were new and that clear objectives had not yet been set.

**Vision and strategy**

The trust had worked with staff to establish the values of the organisation. These centred on striving to be the best, sharing and open, respectful and supportive and inclusive and responsible. The vision and values were displayed throughout the trust and staff had a good understanding of them.

The trust strategy focused on the 13 programmes across the trust through their ‘Better, Best, Brilliant’ improvement plan. The improvement plan focused on two outcomes; to create capability, structure and a common language for continuous improvement; and, to deliver tangible financial and quality improvement across the trust.

There was no overarching strategy for the imaging service. At our last inspection in 2016 we were told that a draft strategy was being developed to be submitted to the programme board for ratification. However, when we viewed minutes of the programme board meeting where we had been told the strategy was being reviewed we saw that a diagnostic imaging strategy had not been presented. Since then staff told us that the focus had been on creating a more stable leadership structure rather than on the development of the strategy. However, there had been a focus on specific improvement and development initiatives such as improving staff retention and developing business cases for the upgrade of equipment and digitalisation of the imaging service.

Managers told us they had worked on plans to address staffing issues by implementing initiatives to provide better career progression with the aim of retaining more staff and reducing their turnover rates. However, they also told us they believed that a particular difficulty in staff recruitment related to the ageing equipment within the department and that they thought that newly qualified staff preferred to work within a more modern department. This had been a factor in the development of the business case to improve equipment within the department.

Managers told us that IT systems did not always interface with each other and this had impacted on their ability to use information to monitor capacity in relation to the demand on the service. This had been a factor in the development of the business case to improve the IT infrastructure and digitalisation of the service.

**Culture**

The staff within the diagnostic imaging department told us they felt valued by managers within the department; however they did not always feel valued by senior leaders who were not visible within the department.

Staff we spoke with told us of examples where they felt change was being implemented without their active involvement or their concerns adequately considered. For example, staff in ultrasound told us they had been asked by senior managers to scan patients on wards rather than them being taken to the department on beds. Staff didn’t feel that the additional pressures on staffing had been fully considered.

Other staff told us they had been instructed by senior managers to implement new performance indicators in cancer pathways to ensure that reports on scans were turned around in one week from the request being made. Staff within the department told us the decision had been made
without their input. They felt that consideration had not been fully made for issues such as the paper referral system resulting in an initial delay or the potential impact on the quality of reporting. Staff told us they felt there should be greater consultation with staff working within the department including senior staff and radiologists, as senior managers did not have adequate knowledge of or involvement with the department. We were also told that other pathways such as the ambulatory care and accident and emergency head pathways had turnaround times applied to them without consultation with diagnostic imaging staff including radiologists.

Managers within the department told us they did not have formal meetings with programme managers outside of governance meetings. They said that the leadership structure of the programme was relatively new and that communication was largely via email or reactive.

Staff told us they felt proud of the work they did and described a positive team approach within the department. We observed colleagues working collaboratively together and managers supporting staff to ensure their wellbeing and the smooth running of the service.

**Governance**

The diagnostic imaging department held monthly governance meetings. These were attended by one of the programme co-directors and priorities and actions from these meetings were fed back through the organisation via programme level governance meetings. Likewise, priorities and actions from programme level governance meetings were cascaded through the departmental meetings. We viewed minutes of monthly nuclear medicine clinical governance meeting where issues such as the risk register, quality assurance, incidents, complaints, staffing concerns and equipment were discussed.

Imaging management meetings were held on a monthly basis and feedback from directorate and governance meetings was included on the agenda. Also included on the agenda were issues such as equipment, report turnaround times, significant incidents, business continuity, complaints, training and staffing. Monthly imaging staff meetings and nursing meetings were also held. Minutes viewed indicated that information was cascaded from management meetings and that regular agenda items included complaints, incidents, risk, staffing and equipment.

The trust had a service level agreement with a neighbouring NHS trust for the provision of a medical physics expert (MPE), a radiation protection advisor (RPA) and a radioactive waste advisor (RWA). This service level agreement covered the provision of areas such as advice, training, audits, environmental monitoring and quality assurance testing of equipment.

Radiation protection committee meetings were held quarterly. RPA attendance was provided at these meetings with RPA and MPE advice given, as well as updates on any legislative changes. A medical physics report was also provided at each meeting. In addition an annual RPA report was provided, covering areas such as audits, governance, training provision undertaken and a review of any radiation incidents. We viewed minutes of the Radiation Protection Group meetings and saw that areas such as equipment quality assurance, training and teaching, personal dosimetry results, and dosage reference levels were discussed for each modality and area.

A number of trust policies and procedures were reviewed by the RPA throughout the year, for example; local rules, risk assessments, and Ionising Radiation Medical Exposure (IRMER) regulations 2000 procedures.

Imaging management meetings had been held on a monthly basis. However, the head of imaging told us that with so many vacant section head posts this had been difficult recently. They told us that more general meetings were held during this time and that they had an ‘open door’ policy where staff could raise concerns and issues as they needed to. Staff we spoke with confirmed that
they would address any issues to the head of imaging as they needed to. However, staff and managers we spoke with told us that they would like to have the capacity to be more proactive but that this was difficult with the staffing issues they were experiencing.

**Management of risk, issues and performance**

We viewed the corporate and directorate risk registers and saw that a number of risks relating to diagnostic imaging had been identified. For example; nursing vacancies impacting on the ability to provide the on-call interventional radiology service, a lack of allied health professionals in diagnostic imaging and the impact of a lower than planned number of sonographers within ultrasound affecting cover at weekends. Mitigating actions included recruiting from overseas, which we saw had been successfully implemented with the employment of three radiographers from overseas in recent months.

Diagnostic imaging risks were included on the directorate risk register. The risks identified were reviewed in department governance meetings on a monthly basis, as well as mitigating actions taken. We viewed a risk relating to a lack of an alert system on the electronic radiogy information system (RIS) that had been elevated on the risk register due to incidents relating to delays in diagnosis and treatment. Mitigating action had been taken including monthly audits of the current manual escalation pathway and the development of a task and finish group to look at a longer term solution and procurement of an system that was fit for purpose. Results of audits undertaken in April 2018 showed that 95.7% (22 out of 23) of the alerts had complied with the manual escalation process.

We were told that close monitoring of performance was carried out in relation to the quality of imaging reports both internally and those that were reported on via external contracts for out of hours reporting. For example, we were told that a number of delegated agreements were in place, where images were reported on by the referring clinician rather than by the radiologists. The head of imaging told us that an audit of this had shown poor compliance in relating to noting image interpretations. This was being re-audited at the time of inspection. We were told that improvements had been made to monitoring the quality of performance in relation to diagnostic imaging activities that had been outsourced to external companies for the provision of out of hours services. The head of imaging told us that regular service review meetings had been undertaken and that more regular contact with the companies had been established for monitoring purposes.

Learning and discrepancy meetings were held regularly to monitor performance and any incidents relating to this were flagged on the electronic reporting system for incidents. We viewed minutes of meetings and action taken as a result of discrepancy discussions. We saw there was an emphasis on learning and that where errors or discrepancies were observed, findings were shared with referring teams and records kept.

The trust had taken action to improve performance in relation to diagnostic waiting times. This had seen ongoing improvement to performance over time and we saw that action continued to be taken to improve. However, diagnostic waiting times in a number of areas such as MRI, Ultrasound and Dexa were still higher than the England average.

**Engagement**

The diagnostic imaging department conducted their own patient satisfaction survey every six months. Results from the most recent survey showed that 99% of patients felt that their privacy and dignity was respected. An annual waiting room survey had been undertaken, showing an
improvement from 92% to 95% of patients feeling satisfied with the waiting areas, against a target of 96%. There was a comments box placed in the main waiting area for patients to make suggestions or comments on the service.

Regular imaging department meetings, clinical governance and some modality meetings were held, although some staff we spoke with told us the frequency of the modality meetings was affected by vacant section head posts. A trust survey had been carried out, although managers could not identify specific results relating to the diagnostic imaging department. An internal survey into safety measures within the department and staff satisfaction with this showed that 97% of staff were satisfied with measures taken to improve their safety.

Staff told us they did not feel that they always received feedback and a number of staff told us they did not feel engaged with the trust as a whole.

**Learning, continuous improvement and innovation**

We observed a culture of learning and continuous improvement within the diagnostic imaging department. Staff told us of a number of audits that had been undertaken to improve waiting times, the quality of images and the quality of reporting. We viewed a department audit plan and saw that this included audits of clinical procedures, waste, adherence to pregnancy checks and the performance of equipment in use beyond its recommended lifespan.

The trust continued to have higher than average waiting times in some modalities within the department but this had improved over time. Issues affecting the department’s ability to innovate included the ageing equipment and aspects of patient pathways continuing to be in paper form. The department had developed business cases for both the upgrade of equipment and the digitalisation of plain film imaging.

The trust had implemented a new governance framework, with the ‘big four’ weekly message where four key messages were cascaded from information such as incident reports and complaints, so that staff meetings had a key learning theme.

Examples of developing innovation within the diagnostic imaging department had been shared with us during inspection. The trust had recently implemented new cancer software that ensured all patients had the correct code and where necessary, patients were placed on the cancer pathway. This had been implemented to support improved turnaround within seven days from request to report.

Staff told us that information required to make improvements was not always available. For example, aspects of the patient information system and other workflow systems did not always interface effectively together. This meant that it was difficult for staff to monitor capacity and demand for the service and taken proactive action to make improvements. However, the trust told us that new dashboards were in development to ensure they were more user friendly and enabled administrative staff to monitor patients and pathways.

The diagnostic imaging department participated in research projects, clinical trials and recognised accreditation schemes such as the Imaging Service Accreditation Scheme (ISAS). Staff working within the breast screening team had been finalists in the British Medical Journal (BMJ) Awards 2018.