East Kent Hospitals University NHS Foundation Trust

Quality Report

Kent and Canterbury Hospital
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Date of inspection visit: 4, 5, 6, 7, 19 and 20 March 2014
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The trust is a group of hospitals providing acute, specialist and community services to a population of 759,000 across all of East Kent. The trust has a total of 1,173 beds in its three acute hospitals: 476 at William Harvey Hospital based in Ashford; 410 at Queen Elizabeth The Queen Mother Hospital based in Margate and 287 at Kent & Canterbury Hospital based in Canterbury. It also has two community hospitals – Buckland which is based in Dover and Royal Victoria which is based in Folkestone. The trust directly employs over 7,000 staff.

The trust has a stable long-standing board with only one of the seven executive directors having been recently appointed in 2013. It became a foundation trust in March 2009. It was a teaching trust and has been a university hospital trust since 2007.

We inspected the three acute hospitals from 4 to 7 March 2014. We also carried out an unannounced inspection on 19 and 20 March 2014.

At Kent and Canterbury Hospital in Canterbury the Accident & Emergency department closed in 2005 and was replaced by an Emergency Care Centre (ECC) and a Minor Injuries Unit (MIU). We inspected the ECC and MIU, as well as both A&E departments at the other two hospitals. We also inspected the two maternity units at Queen Elizabeth The Queen Mother and William Harvey Hospitals.

We wrote to the trust in January 2014 to request information in advance of our inspection, but we did not receive this within the required time frame and received it one week before the inspection.

Before and during our inspection we heard from patients, relatives, senior managers, and other staff about some key issues that were having an impact on the service provided at these hospitals. We also held three listening events in Canterbury, Margate and Ashford.

An issue that dominated discussions was the trust's recent proposal to centralise surgical services to the Kent & Canterbury site. The staff we spoke with did not feel consulted in this decision and did not support the decision made by the board on 14 February 2014. Clinical staff raised detailed concerns with CQC and with executives in the trust.

We carried out this inspection because the East Kent trust had been identified as medium risk on CQC's Intelligent Monitoring system.

Our key findings were as follows:

Headline findings

This trust was rated as inadequate for providing safe care; requires improvement for providing effective care; good for providing caring services, requires improvement for responsive care and inadequate for being well-led. We rated this trust as inadequate overall.

Key findings

- There was a concerning divide between senior management and frontline staff.
- The governance assurance process and the papers received by the Board did not reflect our findings on the ground.
- The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years. It reflected behaviours such as bullying and harassment. The staff engagement score was amongst the worst 20% when compared with similar trusts.
- Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns about the care being delivered and the culture of the organisation.
- The number of staff who would recommend the hospital as a both a place to work or to be treated is significantly less than the England average.
- Risk to patients was not always identified across the organisation and when it was identified it was not consistently acted on or addressed in a timely manner.
- Throughout the trust there was a number of individual clinical services that were poorly led.
- There were insufficient numbers of appropriately trained staff across the three sites and in different areas of the trust. Specific staffing concerns were in the emergency departments, on wards at night and in areas across the trust where children were being treated.
- Staff were referring to a trust major incident plan that was out of date; the staff we spoke with were not

Summary of findings

trained and had not participated in a practice exercises, given the location of this trust and its proximity to the channel tunnel this is a significant concern.
- We had concerns in relation to the accuracy of the documentation of waiting times in the A&E department.
- An incident reporting system was in place, but patient safety incidents were not always identified and reported, and the staff use of the system varied considerably across the trust.
- Policies and procedures for children outside of the neonatal unit did not reflect to National Institute for Health and Care Excellence (NICE) quality standards and other best practice guidance for paediatrics.
- Children's care outside of recognised children's areas (such as the children's ward, the neonatal unit and the children's centre) fell below expected standards. Equipment in areas where children were being treated was identified as being out of date and not safe.
- There was a lack of evidence-based policies and procedures relating to safety practices across the three sites, and a number of out of date policies across the trust.
- In the areas we visited we saw limited evidence of how clinical audit was used to provide and improve patient care.
- We saw examples where audits had not been undertaken effectively and provided false assurance.
- We found examples of poorly maintained buildings and equipment. In some cases equipment was not adequately maintained and was out of date and unsafe.
- Patients had excessively long waits for follow-up appointments and then, when attending the outpatients department, they also experienced considerable delays waiting to be seen.
- Communication following the withdrawal of the Liverpool Care Pathway had been poor and resulted in confusion and misunderstanding about alternative tools to support patients at the end of their life.
- The complaints process was not clear or easy to access. The trust applied its own interpretation of the regulations and had two categories of complaints. A high a number of complaints were referred to the Ombudsman, and there were 16 open cases as of December 2013.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to East Kent Hospitals University NHS Foundation Trust

The trust is a group of hospitals providing acute, specialist and community services to a population of 759,000 across all of East Kent. The trust has a total of 1,173 beds in its three acute hospitals: 476 at William Harvey Hospital based in Ashford; 410 at Queen Elizabeth The Queen Mother Hospital based in Margate and 287 at Kent & Canterbury Hospital based in Canterbury. It also has two community hospitals – Buckland which is based in Dover and Royal Victoria which is based in Folkestone. The trust directly employs over 7,000 staff.

The trust has a stable long-standing board with only one of the seven executive directors having been recently appointed in 2013. It became a foundation trust in March 2009. It was a teaching trust and has been a university hospital trust since 2007.

Our inspection team

Chair: Diane Wake, Chief Executive at Barnsley Hospital Foundation Trust since November 2013, formerly Deputy Chief Executive, Chief Operating officer and Director of Nursing at the Royal Liverpool and Broad Green University Hospitals for six years.

Head of Hospital Inspection : Siobhan Jordan, Care Quality Commission (CQC)

The team of 57 included CQC senior managers, inspectors and analysts as well as doctors, nurses, a pharmacist, patients and public representatives, Experts by Experience and senior NHS managers.

How we carried out this inspection

We inspected the three acute hospitals from 4 to 7 March 2014. We also carried out an unannounced inspection on 19 and 20 March 2014.

At Kent and Canterbury Hospital in Canterbury the Accident & Emergency department closed in 2005 and was replaced by an Emergency Care Centre (ECC) and a Minor Injuries Unit (MIU). We inspected the ECC and MIU, as well as both A&E departments at the other two hospitals. We also inspected the two maternity units at Queen Elizabeth The Queen Mother and William Harvey Hospitals.

We wrote to the trust in January 2014 to request information in advance of our inspection, but we did not receive this within the required time frame and received it one week before the inspection.

Before and during our inspection we heard from patients, relatives, senior managers, and other staff about some key issues that were having an impact on the service provided at these hospitals. We also held three listening events in Canterbury, Margate and Ashford.

What people who use the trust's services say

What patients say, Friends and Family Test

For the NHS Inpatient Friends and Family Test, the trust's scores were below the England average in September and October 2013, but above the England average for November and December 2013. The response rate was below the England average for September to December 2013.

Summary of findings

For the A&E Friends and Family Test, the trust's score was above the England average in September 2013, but was below the England average from October to December 2013. The response rate was below the England average for September to December 2013.

Adult Inpatient Survey 2013

The trusts scored about the same as other acute trusts for the 10 areas of questioning. Of the 70 questions in the survey, the trust scored about the same as other acute trusts for 69 questions and better than average for one question.

2012/2013 Cancer Patient Experience Survey

The trust scored better than other trusts in 12 of the 69 survey questions. It did not score worse than other trusts for any questions.

Patient views during the inspection

We spoke with a number of patients across all three sites and patients also contacted CQC by telephone and wrote to us before, during and after our inspection.

We asked the trust to make comment cards available to patients and staff across its three acute hospital sites before and during our inspection. However, the trust did not do this. After the inspection the trust did make comment cards available across the three sites we visited, but CQC only received four completed comment cards.

Listening event

We held three listening events in Canterbury, Margate and Ashford. Attendance varied at each event and approximately 100 members of the public attended in total.

A total of 31 comments cards were completed at the listening events: 22 (71%) were negative and seven (23%) were positive. Nine comments were made about A&E services, seven covered medical care; 24 comments were made about the Kent and Canterbury hospital, five related to the William Harvey hospital and two related to Queen Elizabeth, the Queen Mother Hospital.

Kent and Canterbury Hospital received a total of 24 comments, of which 18 were negative. Themes included services not being accessible at different hospitals within the trust, which means they are not accessible to all patients (50% of the negative comments related to this theme). Inappropriate care, unhappiness with care received or care not being good was a theme for 30% of the negative comments received.

The feedback relating to William Harvey Hospital was across a number of services, however the common themes were poor care and outpatient appointment times.

There were two comment cards about Queen Elizabeth The Queen Mother hospital, which reported good care (as a positive) and communication (as a negative).

Facts and data about this trust

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Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Inadequate 

Systems and processes

Some staff do not use the recording and reporting systems as they do not have time to do so. Their responses varied. However, a number told us that they did not receive feedback from incidents that were reported and did not see any subsequent actions taken. We saw limited learning across the three sites.

Patient safety incidents were not always being appropriately identified and reported. Therefore this had an impact on the processes to review and to learn from incidents. This also increased the risk of further harm in future.

Staffing

Staffing was identified as an issue on all three sites across a number of services. It varied from area to area and we highlighted concerns with levels of nursing staff, medical staff, pharmaceutical staff and security staff. We noted this had a direct impact on patient safety and outcomes.

As well as substantive and frequent shortages of staff, staff were not appropriately skilled, which may compromise safety and effectiveness. This resulted in inappropriate practices.

Staff also commented on being afraid or discouraged from raising concerns as there was a blame culture. When staff shared concerns they had little or insufficient response.

We could not establish the level at which staff had received safeguarding training. Given children were treated by staff that were not specifically trained to care for children, we believe this to be important.

Never events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented.

The trust reported four never events between 1 December 2012 and 31 November 2013:

- Wrong site surgery on patient's eye requiring corrective surgery.
- Wrong site surgery performed on patient's incorrect lung.
- Retained swab following a caesarean section.

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- Unexpected death following a misread cortrack image resulting in the tube being inserted into the lung.

The audit to ensure compliance with the WHO (World Health Organisation) surgical safety check list is an audit put in place to support safe surgery. This was not robust or reliable as staff were completing it retrospectively.

The trust reported 38 serious incidents from December 2012 to November 2013. Only nine of them were grade 3 or 4 hospital acquired pressure ulcers. This is less than would be expected (for the period) in a trust of this size with 1,173 inpatient beds. It was not reporting hospital acquired pressure ulcers in line with others. Incidents noted on Datix and listed as complaints did not appear to be reported as serious incidents despite the severity of them meeting the national criteria.

Pressure ulcer prevalence was difficult to clarify due to possible under-reporting. Lack of equipment and concerns around the treatment of pressure sores were raised by staff throughout the inspection.

We raised our concern with the trust on 7 March and in April the trust reported 11 serious incidents on the STEIS (Strategic Executive Information System) – four of which were hospital acquired pressure ulcers. For full details, see the individual location reports for the inspection of this provider.

Are services at this trust effective?

Requires improvement

The trust had not responded to, and updated, policies, professional standards and guidelines and ensured changes were implemented. There was a lack of evidence-based policies and procedures across the trust and there did not appear to be a mechanism to identify and address polices that were out of date. We noted policies that hadn't been updated since 2008.

The staff referred to a trust major incident policy that was out of date. The staff we spoke with were not trained and had not participated in a practice exercise. The trust advised us the board of directors had endorsed the trusts incident response plan in November 2013 however staff we spoke to were not aware of this. The trust had initiated the use of internal major incident procedures in April 2013 due to high emergency demand.

Care and treatment did not reflect current requirements and was not delivered in line with recognised professional standards and guidelines. We noted this in children's services outside of the

Summary of findings

neonatal unit and also in the Emergency Care Centre (ECC). Anaphylaxis guidance on the ECC wall was dated 2001 and the pulmonary embolism guidance was dated 2003. NICE updated both in 2012 and there have been other updates in the last 10 years.

We saw good multi-disciplinary working and collaborative care across services. However, on occasion it relied on individuals rather than working arrangements being in place. For the critical care service at Kent and Canterbury Hospital, the intensive care medicine trained consultants were not available out of hours to ensure an appropriate standard of care – as defined by Intensive Care Society standards for consultant staffing. However, they were happy to be contacted at home out of hours while not working to provide support to colleagues if needed.

Staff were not always supported to participate in training and development due to issues with staffing levels in specific areas. This was raised by junior doctors across all three sites.

Some patients were transferred on multiple occasions while an inpatient in the trust. The trust did not appear to have a system in place to monitor this and the impact it was having on individual patients and their experience.

The trust stated it was only eligible for 37 of the 51 clinical audits. However, it did not participate in seven of those 37 audits, and data were not yet available for two of the audits – Joint Registry and Severe Trauma.

The trust was found to be performing worse than expected for four of the five National Bowel Cancer Audit Project indicators. However, it was performing better than expected in regards to the percentage of patients seen by a clinical nurse specialist.

The trust was found to be performing worse than expected for two of the Myocardial Ischemia National Audit Project indicators for the Kent & Canterbury Hospital and Queen Elizabeth The Queen Mother Hospital. The trust's performance is better than expected or tending towards better than expected for eight of the 19 Audit of Falls & Bone Health in Older People indicators. For the remaining 11, the trust's performance was found to be within expectations.

For full details, see the individual location reports for the inspection of this provider.

Are services at this trust caring?

Good

We noted that staff were kind and had a caring and compassionate attitude. They were committed to providing high quality care to patients.

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There was mixed feedback from people who use the service, their relatives and stakeholders about the way staff treat people.

Staff were aware of how to access interpreter services when required.

For full details, see the individual location reports for the inspection of this provider.

Are services at this trust responsive?
Meeting individual needs

Requires improvement

Services were not being delivered in a way that met the needs of children and we did not see evidence that the national service framework for children had been considered, and actions taken to ensure children's specific needs were being met when they were being treated outside of the children's areas.

We did see areas of good practice in relation to patients with dementia.

Nursing staff and lead dementia nursing staff supported patients with dementia in line with the dementia care pathway. Staff had attended dementia awareness training and the ward's dementia champion had produced a display of dementia information.

Staff told us that there was a focus on achieving the four-hour A&E target, which is that patients are seen, treated and discharged or admitted to hospital within four hours of attending. Staff suggested that this focus resulted in the high re-attendance rate. Between September 2012 and August 2013, the national average for the percentage of unplanned re-attendance within seven days of a previous attendance at A&E was 7%. During this period East Kent Hospitals University NHS Foundation Trust was continuously above the national average at 9-9.5%.

People were therefore being discharged when they were not ready. We noted that although they were removed from the A&E computer, they could still remain in the department. We also noted through incident reports, elderly patients being discharged late at night before their support needs were in place.

Services do not respond to meet the changing needs of patients. When patients are placed on a ward in the trust they are treated by the consultant who is on the ward – regardless of whether they specialise in the patient's condition. Patients told us about this practice and junior doctors also described the impact of this, and their concerns that when patients are admitted and transferred to a ward, there is a short period without a doctor being designated as responsible for their care.

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Waiting times

Patients described long waits for their follow-up outpatient appointments at the trust. They then described long waits in the clinic itself. Staff had undertaken audits which showed delays in outpatients clinics. However, no action had been taken to address the issue. We were not told about any actions in place to risk-assess the patients whose follow-up appointments were delayed. We also noted in some cases GPs were waiting six weeks to receive a letter from the trust advising them of the results of an outpatient attendance. Again, there had been no risk assessment on the impact of such delays.

Within the pre-assessment clinic we identified that children were being pre-assessed by nurses who were not children's nurses and had no specialist training. We were also made aware of excessive waits to see a doctor in this clinic. We spoke with a patient who had waited five hours.

Complaints

Most of the patients we spoke with reported that they did not know how to raise a complaint, or would not feel comfortable to raise issues as they had some concerns about the impact this may have on their treatment. We also noted an example when a patient did raise an issue and was challenged on it by a member of staff when they returned to hospital. The gentleman had a condition which meant he would be required to have regular inpatient stays at the trust.

We identified that the trust was aware of issues within the complaints department and had started taking action to address these. One issue was the delay in answering complaints. Of the 222 complaints made about Urgent Care between July 2013 and January 2014, 20% (45 complaints) took four months or more to respond to, with four complainants waiting more than 12 months for a response and two of those more than 18 months.

The trust had a new head of patient experience in post who had suggested the re-introduction of the Patient Advice and Liaison Service. The trust was aware of the areas that needed to be improved, which not only included the backlog, but the quality of the responses and being able to work more effectively with departments. The trust had published a plan to address the issues, which suggested complex cases could legitimately be delayed. This is contrary to recommendations in the Francis report, Francis' recommendations were presented to the Board in November 2013.

Summary of findings

The new policy being suggested by the trust distinguished between formal and informal complaints. This is not a distinction which is recognised by The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009.

The trust's guidelines for structured management of complaints refer to 'informal complaints' being resolved within five days. The trust needs to be very clear about whether it is dealing with concerns or complaints and recognise that complaints which are not resolved within 24 hours, in accordance with the Complaints Regulations, must automatically be dealt with as a 'formal' complaint. We were concerned to note that the trust's new policy had a two-tier system which meant that it is not in keeping with national complaints regulation.

At the time of our inspection there were a high number of complaints with the ombudsman, which was explained as a possible consequence of the backlog in responding to complaints.

Patients said the complaints process was not clear or easy to access. Complaints from patients are not handled appropriately and the learning from them is not shared. Patients and those close to them conveyed a lack of faith in the complaints system. There is a lack of openness and transparency.

We asked to review complaints about the A&E department and were provided with a list of complaints from all three emergency departments. This was not site-specific and had no analysis of site-specific themes. Therefore, it was difficult to determine what action had been taken and whether any action was site-specific or trust wide.

We were told incidents for the A&E departments and the ECC were all collated. However, staff at William Harvey Hospital told us of an action as a direct result of an incident there. When we asked why this had not been adopted at the other A&E or the ECC they could not tell us.

Mixed sex accommodation

We noted staff treating people with dignity and respect. However, we also noted areas where the trust was in breach of compliance with the mixed sex accommodation policy – the Government's requirement to eliminate mixed sex accommodation. This was another area where the trust had a specific local interpretation of national policy. Staff told us of numerous occasions when the policy was breached. The commissioners had also issued a contract query (highlighting failures) in November 2013. We observed a breach in compliance on our inspection, but the trust continues to declare compliance.

Summary of findings

For full details, see the individual location reports for the inspection of this provider.

Are services at this trust well-led?

Inadequate

Leadership and governance

There was a disconnect between the risks and issues described by staff and those reported to, and understood by leaders and the board. Risks and issues were not dealt with in a timely fashion and lessons were not being consistently learned across the whole trust. An example of this was in the William Harvey A&E department, where comfort rounds were introduced as a direct response to a complaint. However, we noted that this initiative had not been considered at Queen Elizabeth The Queen Mother Hospital or at the ECC in Canterbury.

In many departments we noted a divide between the senior management team and front line staff. Staff at the Queen Elizabeth The Queen Mother Hospital and the William Harvey hospital shared a view that the trust board were focused on the Kent and Canterbury site. However, we witnessed executives working across all three sites and executives confirmed they did this on various days of the week.

The comprehensive papers going to the board suggested strong governance within the trust. However, when we spoke with the executives they did not recognise the issues that the staff were describing.

When they were aware of current issues, their plans, such as recruitment to an administrative post to free up ward managers, or the development of the Assistant Practitioner role to address the junior doctor gaps, would not have an impact for some time. The plans were not effectively identifying and mitigating risk.

There was poor engagement with staff. For example, the recent proposal that surgical services would be centralised at Kent and Canterbury was out to consultation. Consultants expressed concern to us about the clinical consequences of this reconfiguration. They told us that there had been a lack of engagement on the matter. A meeting was planned, but it was only after the board had agreed the decision. The local clinical commissioning groups also expressed concerns in the way this proposal had been communicated.

The approach to service delivery and improvement to address the challenges to provide adequate surgical cover by centralising services is focused on the short term, and the clinicians spoken with were not aware of or involved in any longer term solution.

Summary of findings

The trust's 'Seasonal Pressures/Capacity plan for 2013/2104' involved the use of four escalation beds on one ward. It was clear that the use of these beds had been agreed at a corporate level and had not taken into account the pressure and impact on the ward where the beds were introduced. Staff told us that they had been in use for much of the winter and because there were no additional staff in place, this left them with less time to manage the other patients on the ward.

There was a limited approach to obtaining the views of patients who use the services. The trust had focused on improving the numbers of patients that completed the Friends and Family Test and was publishing a rating on where areas and wards ranked, but not specifically on the outcome of the test and the actions taken as direct result.

The Kent, Surrey & Sussex Deanery Report in April 2013 stated that the deanery had serious and considerable concerns about the effectiveness and safety of clinical service and felt it lacked leadership and direction. This remains a current high level concern for the deanery and is being investigated. An action plan is not yet in place to respond to the concerns raised.

This trust has been in financial balance for a number of years and it is not noted in the location reports that there was a financial driver for the poor staffing levels or the lack of equipment. We raised concerns about some of the equipment and whether it was fit for purpose. The trust agreed to address this with immediate effect. Financial and quality governance were not integrated to support decision-making.

Recruitment and staffing

The trust has significant recruitment issues and this was a driver to centralise services to ensure they could deliver services safely. As well as the challenges the trust faced with recruitment, the 2013 staff survey results raise concerns about staff retention. We identified a number of issues with recruitment and staffing;

- The midwife-to-mother ratio was at 1 to 33, the national standard is 1 to 28. The trust froze posts in July 2013 and then did not act to address this when the number of births increased. This demonstrates lack of awareness and recognition of the impact of this decision.
- Despite Francis' recommendation in March 2013 to strengthen nursing leadership and ward sisters to work in a supervisory capacity, this was not the case in the trust. Despite the additional recruitment and the additional funding being

agreed, no senior nurse could tell us when this recommendation would be in place. We noted senior nurses with only two days in four weeks where they were not counted in the establishment to provide direct patient care.

- We identified that there was at least one ward in the trust that had only one nurse on night duty. The Chief Nurse, Director of Quality and Operations was not aware at the time of the inspection that it had been ongoing.
- We identified unsafe practices as a result of poor staffing, such as the administration of controlled drugs with a single checker.
- There was a lack of clarity about who was responsible for nurse staffing levels in the trust as nurses escalated to their matrons or to the site managers. They were unsure how far their concerns were raised at, and if the board knew of the challenges they faced.
- The ECC staff expressed during the inspection and on incident reports the impact of the model and the staffing challenges. When we fed this back to the executives they referred to it as an exemplar model. We could not see or obtain any evidence to confirm when the model had last been reviewed. Staff confirmed that they did not record capacity issues and staffing issues on the incident reporting system. The ECC has subsequently been reviewed since our inspection.

NHS staff survey

In relation to bullying and harassment findings, before, during and since our inspection, staff have communicated directly with CQC about their concerns, and have expressed anxieties on the impact on them if they raise concerns internally. Staff have contacted us directly on numerous occasions, prior to, during and since the inspection to raise serious concerns regarding the care being delivered and the culture of the organisation.

Staff satisfaction was poor at the trust and had been for some years. We noted open honest caring front line staff, but a number of them stated that it was not a happy trust. Staff also stated that they would not “whistle blow” as they feared the consequences of this or that nothing would change if they did. They said that low morale had existed for some time at the trust.

The staff engagement score was amongst the worst 20% when compared with similar trusts. The number of staff who would recommend the hospital as a both a place to work or to be treated is significantly less than the England average.

The Director of Human Resources shared their concerns about the staff survey and the trust’s inability to improve its results over a number of years. The senior team stated that improvement in staff

satisfaction is a high priority, but we did not identify on inspection how the trust was engaging with staff to address concerns identified in recent and previous staff surveys. We were not made aware of interim surveys and actions to address the areas where the trust was in the bottom 20%.

The trust's results from 2013 also demonstrate an increase in the number of key findings that were worse than average since the 2012 staff survey. These results show that the trust's scores for 17 of the 28 key findings were worse than average for acute trusts, and of these 17, the trust scored in the worst 20% of acute trusts for nine key findings. The trust's bottom five scores compared with other acute trusts related to staff experiencing bullying and harassment from other staff, staff experiencing bullying and harassment from patients, relatives or the public, staff experiencing work-related stress, staff feeling able to contribute to improvements at work, and staff feeling pressure to attend work when feeling unwell.

The trust was found to be performing better than average for six of the 28 2013 NHS Staff Survey indicators. The trust is in the highest 20% of acute trusts for the percentage of staff who received appraisals within the last 12 months. Staff reported that they were experiencing less physical violence from patients, relatives and/or the public compared to the average, and are receiving job relevant training/development and equality and diversity training.

Culture

We observed a 'top down' and directive leadership style. There was an initiative in the trust called Dragon's Den, which has been specifically put in place to provide staff with an opportunity to present ideas to the senior managers, where if they were supported they would be funded. We heard that the red tray initiative went through this route to be funded, but we did not hear of other initiatives that had progressed through this initiative. We spoke with staff who did not feel able to come forward in this way.

The culture is not openness and transparent. Staff found it difficult to be honest when raising concerns. Staff contacted CQC directly to share concerns and spoke openly with CQC inspectors, acknowledging their responsibility to engage with the trust and challenge on behalf of the patients. However they then detailed a reluctance to do so, because of either nothing happening or what they believed may happen to them.

The lack of openness discouraged the identification of risk. Issues and concerns were being discouraged and repressed, which meant that leaders were unaware of significant issues threatening the

delivery of safe and effective care. There are low levels of staff satisfaction, high levels of stress, work overload, and conflict within the organisation. Staff do not feel respected, valued, supported, appreciated or cared for.

The trust did have an initiative in place where the chairman and the non-executive directors spent time visiting the services, and staff valued this. We interviewed the non-executive directors and they explained some of the pending financial issues the trust would face in coming years. However, they did not raise the issues that the inspectors or the frontline staff had identified on inspection.

Not all staff and departments across the organisation have clear objectives. Team work is poorly developed and implemented with a lack of clarity about team tasks, objectives, membership and roles across the wider organisation. There is limited collaboration and cooperation between teams and departments. The palliative care team is an exception to this, as we noted robust systems and strong communication in place across the three sites inspected.

Reporting incidents

The trust is known to be a low reporter of incidents. During our inspection, we recognised that staff did not have the time and were not being motivated to report incidents.

The trust has also applied its own criteria to never events and serious incidents, which raises concerns. The trust has had very few grade 3 or 4 hospital acquired pressure ulcers for a trust of its size, given the contingency beds, the staffing challenges and the shortage of equipment all identified on inspection. We raised this with the trust to attempt to understand why.

The trust published a quality bulletin which shared details of how it downgraded severe harm to moderate harm depending on the time it would take for a patient to recover. We did recognise the NPSA criteria, but we raised concerns that the trust could not determine this at the time of such incidents and by possibly downgrading incidents the opportunity to investigate and learn was being lost, and is the key to reporting.

The trust has a duty of candour to the patients and we reviewed the template used to review and investigate serious incidents within the trust. There was no detail or dedicated section within the template to inform the reader what communication had taken place with the patient and or their family regarding the incident nor any follow-up communication and updates in line with this duty of openness and transparency.

Overview of ratings

Our ratings for Queen Elizabeth The Queen Mother Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity & Family planning	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Children & young people	Good	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Our ratings for Kent & Canterbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency care centre	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Inadequate	Good	Good	Good	Inadequate	Inadequate
Critical care	Requires improvement	Good	Good	Good	Good	Good
Children & young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Overview of ratings

Outpatients	Inadequate	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for William Harvey Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
A&E	Inadequate	Not rated	Requires improvement	Inadequate	Inadequate	Inadequate
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Critical care	Good	Good	Good	Good	Good	Good
Maternity & Family planning	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Children & young people	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate

Our ratings for East Kent Hospitals University NHS Foundation Trust

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

Notes

1. We do not give a rating for A&E/Effective and Outpatients/ Effective.

Outstanding practice and areas for improvement

Outstanding practice

- Staff were kind and had a caring with a compassionate attitude. They were committed to providing high quality care to patients.
- The trust's Specialist Palliative Care team assessed all patients referred to them within 24 hours in week days and we noted that supporting documentation was comprehensive with evidence of effective care planning.
- An individual was recognised for standardising the resuscitation room and developing A&E documentation to have a positive impact and improve patient safety in the A&E departments at both William Harvey Hospital and at Queen Elizabeth The Queen Mother Hospital.

Areas for improvement

Action the trust MUST take to improve

- Actions are detailed in individual location reports

Action the trust COULD take to improve:

- Actions are detailed in individual location reports