Maidstone and Tunbridge Wells NHS Trust

The Tunbridge Wells Hospital at Pembury

Quality report

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14-16 October 2014

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This report describes our judgement of the quality of care at this hospital. 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.

Overall rating for this hospital	**Requires improvement**
Emergency & urgent care	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Inadequate
Maternity & gynaecology	Requires improvement
Services for children & young people	Requires improvement
End of life care	Requires improvement
Outpatients & diagnostic imaging	Requires improvement

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Letter from the Chief Inspector of Hospitals

Tunbridge Wells Hospital, Pembury, is part of Maidstone and Tunbridge Wells NHS Trust and provides acute services to a population of approximately 500,000 living in the south of west Kent and parts of north-east Sussex. Maidstone and Tunbridge Wells NHS Trust employs around 4,710 whole time equivalent members of staff.

We carried out an announced inspection of Tunbridge Wells hospital between 14 and 16 October 2014. We also undertook two unannounced visits of the hospital on 23 and 28 October 2014.

Overall, this hospital requires improvement. We found that each of the eight core services required at least some improvement with the exception of the critical care service which we rated as inadequate with significant improvement required in this core service.

The hospital requires improvement in ensuring that it provides safe and effective care which is caring and responsive to the needs of patients. The hospital requires improvement to ensure that it is being well-led.

Our key findings were as follows:

Safe:

- The concept of learning from incidents varied from service to service. Whilst some departments had grasped the important role that incident reporting and investigation had in improving patient safety, this ethos was not replicated throughout the hospital.
- The anaesthetic department utilised an independent incident reporting tool which fell outside the auspices of the trust's quality and risk strategy; there was a lack of robust oversight of this reporting tool into the overarching trust-wide governance structure.
- The hospital was found to be visibly clean. Infection rates across the hospital were noted to be falling when compared to previous years. There was however, some localised poor performance of hand hygiene practices.
- Performance for surgical site infection rates for those undergoing total hop replacements was worse than the national benchmark standard.
- Medicines management required improvement in some areas including, but not limited to the provisions for the storage and administration of medicines.
- Medical cover within the Intensive Care unit was not consistent with national core standards.
- The application of early warning systems to assist staff in the early recognition of a deteriorating patient was varied. The use of early warning systems was embedded within the medicines directorate, whilst in A&E and the children's and young people's service, its use was inconsistent.
- Nursing levels were generally found to be good. This was not always the case for the children's and young person's service, which had a nursing establishment based on historical activity. However, every mother in active labour could expect to receive 1:1 support from a qualified midwife.
- Patient records were not always found to be kept securely, nor were they always well organised or accessible.

Effective:

- The use of national clinical guidelines was evident throughout the majority of services. The Specialist Palliative Care Team had introduced an end of life pathway to replace the existing Liverpool Care Pathway. However, there was lack of clinical guidelines within the ICU setting and staff were not routinely using national guidance for the care and treatment of critically ill patients.

- The pre-operative management of children and adults was not consistent with national guidance. There were inconsistencies in the advice patients were offered with regards to nil-by-mouth times, with some patients experiencing excessively long fasting periods.

- Whilst staff were afforded training in understanding the concepts of, and the application of the Mental Capacity Act (MCA), we found that staff were not routinely implementing the MCA policy into their practice.

Caring:

- Staff were caring and compassionate and treated patients with dignity and respect.
- Maternity services scored better than the national average in the Friends and Family test. Responses to the friends and family test for patients undergoing surgery was varied, however, it was noted that overall, the hospital scored better than the national average.
- Patients considered that they had been given sufficient information and counselling by qualified healthcare professionals to enable them to make informed decisions about their care and treatment.

Responsive:

- Patient flow across the hospital was poor. Patients deemed fit to be discharged from intensive care units frequently experienced significant delays in being transferred to a ward and elective surgical patients were cancelled due to a lack of available beds.
- The provision of interpreting services across the hospital was poor.
- Capacity issues within the hospital led to a high proportion of medical "outliers". The result of this included patients being moved from ward to ward on more than one occasion, alongside late night transfers.
- All medical specialities were meeting national standards for referral-to-treatment times, including all national cancer care waiting time standards. However, some surgical patients were experiencing delays of more than 18 weeks from referral to treatment. The hospital had responded to this by introducing additional surgical lists on Saturday mornings.

Well-led:

- The hospital values "Pride" were known by some staff, but not all. The majority of directorates lacked a clear vision or strategy which led some staff to being frustrated. Whilst staff were keen to develop clinical services, initiatives were hampered by financial restraints and cost improvement plans which were not aligned with quality governance measures.
- The ability of the senior directorate management teams to effectively lead their respective service was varied. Whilst the directorates of medicine, maternity and end of life were rated to be well-led, the same could not be said for the remaining five services.
- The application of clinical governance was varied, with some services lacking any formal, robust oversight.
- Staff engagement was varied throughout the eight core services; some staff spoke positively whilst others reported examples of departmental silo working, favouritism and poor visibility amongst the senior management team.
- Risk registers were poorly applied in some clinical areas which led to some risks not being escalated to the executive board. However, where risks were escalated, there was evidence that the trust was taking action to try and resolve issues.

We saw several areas of outstanding practice including:

- On Ward 20 there was a focus on dementia care. Staff had bid and won funds from the Dementia Challenge fund to create a Dementia Café for use by people living with dementia, their friends and families. This area was designed using current guidance to be dementia friendly and was equipped to meet the special needs of people living with dementia.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that care and treatment provided to service users has due regard to their cultural and linguistic background and any disability they may have. This should include ensuring that patients have access to translator services are required.
- Ensure that people who use the service are protected against the risks associated with unsafe or unsuitable premises.
- Improve the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients.
- Have adequate intensivist consultant cover at all times to ensure cover is consistent with national core standards
- Ensure patients are not delayed more than 4 hours once a decision has been made to admit or discharge them to or from the intensive care unit (ICU).
- Ensure that where possible, patients are not discharged from the ICU during the night.
- Ensure outreach service meets current guidelines. (NCEPOD (2011)
- Ensure that level 3 intensive care patients are observed in line with their needs.
- Make arrangements to ensure that contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- Make suitable arrangements to ensure the dignity and privacy of patients accommodated in the Clinical Decisions Unit.
- Ensure that patient records are maintained, include appropriate information relating to individual care needs, and are fit for purpose.
- Review the process for incident reporting to ensure that staff are aware of and act in accordance with the trust quality and risk policy.
- Review the clinical governance strategy within children's services to ensure there is engagement and involvement with the surgical directorate.
- Review the arrangement for the management and administration of topical anaesthetics
- Review the children's directorate risk register to ensure that risks are recorded and resolved in a timely manner.
- Review the current PEWS system to ensure that it has been appropriately validated, is supported by a robust escalation protocol and is fit for purpose. Its use must be standardised across the children's directorate (excluding neonates).

In addition the trust should:

- Consider collating performance information on individual consultants. Where exceptions are identified these should be investigated and recorded.
- Provide written information in a format that is accessible to people with learning difficulties or learning disabilities.
- Ensure the protocol for monitoring patients at risk is embedded and used effectively to make sure patients are escalated in a timely manner if their condition deteriorates.
- Ensure that all medical staff in the ED have completed training in safeguarding children at the level appropriate to their grade.
- Make appropriate arrangements for recording and storing patients' own medicines in the CDU to minimise the risk of medicine misuse.
- Respond to the outcome of their own audits and CEM audits to improve outcomes for patients using the service.
- Review the arrangements for meeting the needs of patients presenting with mental ill health so they are seen in a timely manner.
- Review the management of patient flow in the ED to improve the number of patients who are treated and admitted or discharged within timescales which meet national targets.
- Review the systems in place in the ED for developing, implementing and reviewing plans on quality, risk and improvement.

- Review the way complaints are managed in the ED to improve the response time for closing complaints.
- Ensure there is strategic oversight and plan for driving improvement.
- Review the quality of root cause analysis investigations and action plans following a serious incident or complaint and improve systems for the dissemination of learning from incidents and complaints.
- On the Medical Assessment unit the trust should ensure that point of care blood glucose monitoring equipment is checked. It should also consider how this checking should be managed to be integrated as part of an overall policy that forms part of a pathology quality assurance system.
- Develop systems to ensure the competence of medical staff is assessed for key procedures.
- Develop systems to ensure that medicines are stored at temperatures that keep them in optimal condition.
- Ensure that patients' clinical records are stored securely in ward areas.
- Review the ways in which staff can refer to current clinical guidance to ensure that it is easily accessible and from a reputable source.
- Review current nil-by-mouth guidance to ensure that it is consistent with national standards; patient information leaflets should be standardised and reflect national guidance.
- Review the process for the management of patients presenting with febrile neutropenia to ensure they are managed in a timely and effective manner.
- Standardise the post-operative management and guidance of children undergoing urology surgery.
- Review the process for the hand-over of pre-operative children to ensure they have support from a health care professional with whom the child and family are familiar with.
- Ensure that all staff introduce themselves and wear name badges at appropriate times.
- Review the location of the vending machine currently located between Hedgehog ward and the Woodlands Unit.
- Review the managerial oversight of staff working in children's outpatients.
- Review the current clinic provision to ensure that women who have recently miscarried or who are under review for ante-natal complications are seen in a separate area to children who are also awaiting their appointment.
- Review the facilities and admission process for elective surgical patients.
- Monitor the transfers between sites, for both clinical and non-clinical reasons. The monitoring process should include the age of the patients transferring and the time they arrived after transfer.
- Have clarity about the definition of what constitutes an Serious Incident Requiring Investigation (SIRI) or Never Event in relation to the retained swabs.
- Ensure policies that have not been reviewed and impact on current evidenced-based knowledge/care are updated.
- Address staffing levels and recruitment on the gynaecology ward/unit
- Ensure appropriate reporting and recording of incidents on the trust system on the gynaecology ward.
- Implement actions for the findings of the gynaecology ward audit undertaken in June 2014.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Our judgements about each of the main services

Service	Rating		Why have we given this rating?
Urgent & emergency	Requires improvement	●	There was a multidisciplinary collaborative approach to care and treatment that involved a range of health and

services			social care professionals. There was adequate access to both medical and clinical leads to support a seven day service. Medical and nursing staff had good access to education to develop their skills and competencies. The ED provided a caring and compassionate service. Staff treated patients with respect and kept patients, their relatives and carers well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background. However the protocol for monitoring patients at risk was not used effectively and the department did not have enough medical staff trained at the appropriate levels for safeguarding children, which increased the risk of oversight for vulnerable children attending the ED. There was no protocol for managing patients' own medicines in the CDU, which increases the risk of misuse of medicines. Security staff were trained in control and restraint under their Security Industry Authority (SIA) licences only and had not completed patient specific training courses to improve their awareness when they supervised patients presenting with challenging behaviours, including patients with mental ill health and dementia needs. Patient flow was poor and waiting times were above the national average due to capacity. Male and female patients were accommodated in the CDU overnight and shared bathroom facilities, which compromised the privacy and dignity of patients and did not meet the standard for mixed sex accommodation. The department was failing to meet their target for closing complaints within an agreed response date.
Medical care	Requires improvement	●	Overall, medical care services required improvement. Staff provided kind, compassionate care that preserved patients' dignity. Patients were supported emotionally and received enough information to be involved in their care and treatment. Staff felt supported by their leaders and managers to provide high quality care and there was a culture that was focussed on meeting the needs of individual patients and their families. Service leaders at all levels had systems in place so they knew how well they were doing and were aware of the service needs. However; Policies in relation to the checking of blood glucose monitors were not being followed and the temperature of storage of medicines was not robust. Patient records were not always stored securely. Current clinical guidance was not always easily accessible for staff. Staff sometimes used inappropriate source of guidance that led to ineffective care. National audits showed patients with stroke or diabetes were receiving below average quality care.

			Medical care services were not responsive to people's needs as there was insufficient capacity in the service to meet demand. Arrangements for the provision of translation services required improvement.
Surgery	Requires improvement	●	Patients found the staff to be caring but improvements are required to ensure the service is safe, effective, and responsive. Improvements are required in the well led domain. Whilst most people admitted to Tunbridge Wells Hospital were happy with the quality of care they received and patient outcomes were, generally, in line with national averages, there remained significant shortfalls in the way services were provided. The Surgical Assessment Unit provided real benefits to patients and increased the effectiveness of surgical services at the Trust. The operating theatre department was well managed and demonstrated improving efficiency and effectiveness. Patients received safe peri-operative care and all appropriate measures were taken to ensure optimal outcomes for during and immediately after their operation. Where there were patients that were complimentary about the care they received there were others who reported negative experiences with the level of care they received. The Trust had good resuscitation provision and staff understanding of the safeguarding policies was good. However, the level of falls seen and the impact of these on patient wellbeing were unacceptable. Falls prevention work was ongoing but had not been embedded in the surgical patient pathways. Record keeping was poor; individual patient's records were disorganised and incomplete. Risk assessment and care planning for patients was not always adequate. The Trust had reduced the number of hospital acquired infections and the latest recorded level showed performance below the national benchmark but there was still work to be done improving compliance with hand hygiene policies as this was well below the target of 100%. Team working within the surgical directorate meant patients were not admitted under a named consultant and were frequently passed between teams. This resulted in a lack of continuity of care, indecisiveness over the plan of care and mixed messages to the patients.

			High bed occupancy levels led to ineffectiveness in the service provision. Operations were frequently cancelled, patients experienced unexpected delays and were cared for in unsuitable environments. Surgical patients were cared for on non-specialist wards and received sub-optimal care; this was of particular concern for patients with spinal problems. It also resulted in frequent transfers between sites for non-clinical reasons. There were concerns about 'out of hours transfers' and The Trust was unaware how frequently patients were being transferred between sites for non-clinical reasons. There was a lack of access to a translation service with staff relying on relatives, sign language and staff who spoke another language. Leadership was very variable. Some staff felt supported whilst others felt disempowered and "Cut adrift". Where we saw good leadership it was at a local ward or department level and reliant on the personalities and managerial skills of the individual. There was no sense that the staff working directly with patients understood what was happening at board level; the reverse was also true with little sense that the executive team and board really understood what was happening operationally across the Trust. There was little evidence of effective trust wide learning from incidents and complaints.
Critical care	Inadequate	●	Staff were caring but improvements were required to make the service safe, effective, responsive and well led. There were no apparent admission guidelines in use to show the criteria for admission to the ICU and we observed a lack of direct supervision of Level 3 patients. Medicines management systems were safe. The unit was clean however patients that were being source isolated because of an infection had their room doors left open. Governance systems were inadequate, for example at mortality and morbidity meetings, not all deaths were discussed and there was no record of the meetings that had taken place. Improvements were required to ensure that all incidents were reported through the same Trust wide system and were acted on promptly. Although the ICU was obtaining mostly good quality outcomes, there was some lack of compliance with national guidelines. For example, at weekends, there

			was only one ICU Consultant led ward round per day and the consultants were often more than 30 minutes away as they were shared between the Trust's two ICUs. Staff cared for patients in a compassionate manner with dignity and respect. Both patients and their relatives were very satisfied with the care provided. However, patients who were ready to be discharged to a ward environment were often delayed for up to a week due to lack of ward beds, and in many instances were discharged home directly from ICU. There were inadequate facilities for these patients. The patients were all in single rooms but there were no en-suite facilities or separate male/female toilet or bathroom facilities. Improvements were required to the leadership of the ITU to ensure that national best practice guidelines were followed.
Maternity and gynaecology	Requires improvement	●	The maternity services at Tunbridge Wells Hospital were well planned and organised. There were systems in place that ensured that safety was a priority. Women and their babies were treated in a well-equipped environment. Women's care and treatment followed national evidenced-based guidelines. Staff involved women who use the service as partners in their own care and in making decisions, with support where needed. Risks were effectively assessed and managed, there was a process for reporting incidents and any areas of learning were shared with staff in the maternity service. However, the gynaecology service did not mirror the same robust approach to the recording of incidents on the electronic recording system. The maternity service demonstrated the trusts vision, being proud of the service they offered to women. Investigations and internal reviews to look at interpersonal relationships within obstetrics and gynaecology consultants needed to be commissioned and completed and the findings fed-back to staff in order that longstanding cultural and behavioural issues amongst staff groups could be resolved.
Services for children and young people	Requires improvement	●	There was a collaborative approach to ensuring the nursing and medical needs of children were met. However, the relationship, engagement and management of children requiring surgical intervention required significant improvement. The children's directorate lacked any formal governance framework which incorporated the surgical directorate; this led to some surgical patients not being offered pre-assessment appointments, the post-operative management of patients was inconsistent and written information was neither age specific or appropriate.

			The directorate used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. However, there were discrepancies with the pre-operative management of children undergoing surgery with regards to nil-by-mouth guidance. Performance against national audits was varied. The NNU performed well when compared nationally and although the NNU did not always meet national benchmark standards, action plans had been generated to improve services. However, children admitted for suspected febrile neutropenia could not always expect to receive antibiotics within an hour of arrival. Parents and children were generally complimentary about the care and treatment provided. However, there were mixed reviews about the attitudes and behaviours of some surgical teams. Where children and/or parents/carers had cause to complain, these complaints had been acknowledged, investigated and action plans generated to help improve services for the future. The children's directorate lacked a formal vision or strategy and some staff were unaware of the trust's values. Day to day leadership within the directorate was good although the visibility of some senior managers needed to be improved. Whilst the directorate operated a risk register, we found this to be heavily underutilised. Whilst directorate leaders were aware of the issues which posed a potential risk to the operational effectiveness of the service, these risks were not always escalated to the trust board, nor were there any robust action plans in place to resolve the issues.
End of life care	Requires improvement	●	The SPCT were available five days a week for face to face contact and a local hospice provided telephone out-of-hours and weekend cover. Medicines were provided in line with guidelines for EoLC, but DNACPR forms were not consistently completed in accordance with trust policy. There were no standardised processes for completing mental capacity assessments. The SPCT provided four study days per year for trained nurses And staff were able access palliative care study days provided by the Hospice in the Weald. Medical end of life training was delivered as part of the doctors formal education programme.This was delivered by the palliative care consultant and the trust clinical ethicist. Palliative care link nurses were present on the wards we visited but training had reduced recently due to staff shortages in the SPCT. Leadership of the specialist palliative care team was good and quality and patient experience was seen as a priority. All patients requiring EoLC were referred to the SPCT, but often no input was required by the team. Referrals

			to the team supported audit processes within the trust. There was a multidisciplinary team (MDT) approach to facilitate the rapid discharge of patients to their preferred place of care. Patients were cared for with dignity and respect and received compassionate care. Relatives of patients receiving end of life care were provided with free car parking.
Outpatients & Diagnostic Imaging	Requires improvement	●	All the patients we spoke with told us that they had been treated with dignity and their privacy protected. They spoke highly of the staff in outpatients and radiology. They found staff polite and caring. However, many patients complained to us about the waiting times in the outpatient clinics. Staff were reporting incidents and these were discussed at the clinical governance meetings within the directorates. There were systems in place to reduce the risk and spread of infection. Medicines were stored and administered safely. The department held its own training records which were up to date and demonstrated that most staff had attended mandatory training. The trust had met their national targets and consistently performed higher than the national average in regard to radiology waiting times. There had been a backlog in reporting CT and MRI scans for several months but there was evidence at the visit that these were reaching resolution. There was an ongoing backlog in clinic letters being sent out that was not resolved. There was risk to patients receiving delayed or inappropriate treatment and considerable stress caused to the staff. Staff demonstrated a commitment to patient centred care and we found many examples of such care and attention to patient conditions and preferences.

The Tunbridge Wells Hospital at Pembury

Detailed findings

Requires improvement ●

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

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Summary of this inspection Page

Background to The Tunbridge Wells Hospital at Pembury

The Tunbridge Wells Hospital at Pembury is a general acute hospital and part of Maidstone and Tunbridge Wells NHS Trust. The hospital has 502 beds. This CQC inspection was not part of an application for Foundation Trust status.

The Tunbridge Wells Hospital at Pembury is in the borough of Tunbridge Wells, Kent, and serves the population living in South West Kent. The population of Tunbridge Wells is mainly White (95.1%) and the highest ethnic minority is Asian making up 1.4% of the local population. Maidstone ranks 190th out of 326 local authorities for deprivation. The local authority that ranks first is the most deprived and the one ranked 326th is the least deprived. Life expectancy for both men and women is slightly higher (better) than the England average.

The Tunbridge Wells Hospital at Pembury is one of two locations of Maidstone and Tunbridge Wells NHS Trust. The trust also provides services from Maidstone Hospital.

Our inspection team

Our inspection team was led by:
Chair: Professor Edward Baker, Deputy Chief Inspector (CQC)
Head of Hospital Inspections: Heidi Smoult, Care Quality Commission (CQC)

The team of 41 included CQC inspectors and analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics, palliative care medicine; consultant surgeon, anaesthetist, physician and junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses' a student nurse; and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Urgent & emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity & gynaecology
- Services for children and young People
- End of life care
- Outpatients & diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group; NHS Trust Development Authority; Health Education England; General Medical Council; Nursing and Midwifery Council; Royal College of Nursing; NHS Litigation Authority and the local Healthwatch.

We carried out an announced visit between 14 and 16 October 2014 and unannounced visits on 23 and 28 October 2014. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held focus groups with a range of staff in the hospital including doctors, nurses, allied health professionals, administration staff and pharmacists. We also interviewed senior members of staff at the hospital.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Tunbridge Wells on 9 October 2014, when people shared their views and experiences of Maidstone Hospital.

Facts and data about The Tunbridge Wells Hospital at Pembury

Key facts about The Tunbridge Wells Hospital at Pembury

The Tunbridge Wells Hospital at Pembury is one of two registered acute hospital locations of Maidstone and Tunbridge Wells NHS Trust.

Context

- Around 502 beds
- Serves a population of around 500,000
- Employs around 1,519 whole time equivalent (WTE) members of staff

Activity

- Around 150,778 outpatient attendances per annum
- Around 66,846 urgent and emergency care attendances per annum

Key Intelligence Indicators

Safety (Trust level data- Not broken down by location)

- Two never events in last 12 months (one in surgery, one in radiology)
- STEIS: 118 Serious Untoward Incidents (April 2013 - March 2014)
- Elevated risk for the percentage of CAS alerts with closing dates during the preceding 12 months which the trust has closed late
- C-difficile: 35 overall - target of 42
- MRSA: 3 overall - target of 0

Effective

- Hospital Standardised Mortality Ratio (HSMR) indicator – No evidence of risk
- Summary Hospital-level Mortality Indicator (SHMI) - No evidence of risk

Caring

- NHS Friends and Family Test (July 2014) – average score for urgent and emergency care was 60, which was better than the national average of 53. The response rate was 22.6%, which was better than the national average of 20.2%.
- The average score for inpatients was 77 which was better than the national average of 73. The response rate was 50.7%, which was better than the national average of 38%.
- The average score for maternity (antenatal) was 71, which was better than the England average of 62. The average score for maternity (birth) was 91, which was better than the England average of 77. The average score for maternity (postnatal) was 85, which was better than the England average of 65.
- Cancer Patient Experience Survey – the trust as a whole had a 90% rating for *'Patient`s rating of care `excellent`/ `very good.* This was higher than the threshold for the lowest 20% of trusts (86%) but lower than the threshold for the highest 20% of trusts (92%).
- CQC Adult Inpatient Survey – no risks were identified in the trust as a whole in the nine questions asked.

Responsive

- A&E, four-hour target – met the 95% target in the previous 12 months
- Referral to treatment times – met the admitted and non-admitted pathways target times
- Cancer: two-week wait – met the national target
- Cancer: 31-day wait – met the national target
- Cancer: 62-day wait – met the national target

Well-led

- Staff survey 2013 (trust as a whole): 3.73. Slightly worse than the England average of 3.74.
- The results of the 2013 NHS Staff Survey demonstrated that Maidstone and Tunbridge Wells NHS Trust performance showed that the majority of scores were as expected in line with the national average over the 28 key areas covered in the survey, which included:
  - as expected in 24 key areas
  - better than average in 2 key areas
  - worse than average in 2 key areas
- The response rate for the staff survey was higher than the national average with a response rate of 55% compared to 49% national average.

Inspection history

- The Tunbridge Wells Hospital at Pembury previous CQC inspection before this comprehensive review was carried out on 23 November 2013. They were found to be non-compliant with outcomes 9 (medicines management) and 13 (staffing).

Overview of ratings

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Maternity & Gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Children & young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Outpatients &Diagnostic Imaging	Good	Inspected but not rated[1]	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Notes:

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent & emergency services

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

Information about the service

The accident, emergency and trauma department at Tunbridge Wells Hospital, Pembury is also known as the accident and emergency (A&E) department. It is a designated trauma unit. The department saw 66, 846 patients between 1 April 2013 and 31 March 2014. 77.3% of patients were aged over 17 and 22.7% of patients were aged 0-17 years old.

The A&E is divided into areas depending on the acuity of patients. The resuscitation area has six bays including one designated bay for paediatrics. There are 13 active bays and four ambulatory care spaces for treating major cases ('majors'). There are eight examination rooms for treating minor cases ('minors'). In addition, there is a Clinical Decision Unit (CDU) which has two bays of 5 beds each and three chair spaces. There is a room near the reception for the assessment and triage of non-ambulance patients.

We visited the A&E over a weekday during our announced inspection. We observed care and treatment and looked at patients' records. We spoke with many members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We also spoke with patients and their relatives who were using the service at the time of our inspection. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

Summary of findings

Governance systems within the accident and emergency department were insufficiently robust. Whilst the local management team were aware of the issues which posed a risk to the operational effectiveness of the department, there was insufficient evidence to demonstrate how those risks were being managed. Whilst the department engaged in national audits we found that performance had not always been sustained when compared with historical audit results. In some cases we found that performance had significantly worsened suggesting that patient experience and patient outcomes was potentially compromised.

The protocol for monitoring patients at risk was not used effectively; the application of the "Patient at Risk" tool was sporadic and inconsistent.

There was no protocol for managing patients' own medicines in the CDU, which increases the risk of misuse of medicines.

Security staff were trained in control and restraint under their Security Industry Authority (SIA) licences only and had not completed patient specific training courses to improve their awareness when they supervised patients presenting with challenging behaviours, including patients with mental ill health and dementia needs.

Patient flow was poor and waiting times were worse than the national average due to capacity.

Male and female patients were accommodated in the CDU overnight and shared bathroom facilities, which compromised the privacy and dignity of patients and did not meet the standard for mixed sex accommodation. The department was failing to meet their target for closing complaints within an agreed response date.

There was a multidisciplinary collaborative approach to care and treatment that involved a range of health and social care professionals. There was adequate access to both medical and clinical leads to support a seven day a week service. Nursing staff had good access to education to develop their skills and competencies however the number of medical staff trained in level 3 safeguarding children was poor.

The A&E provided a caring and compassionate service. Staff treated patients with respect and kept patients, their relatives and carers well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

Are Emergency & urgent services safe?	Requires improvement ●

The frequency with which nursing staff reported incidents had reduced due to them receiving little or no feedback from incidents they had previously reported. Whilst we found evidence that where incidents were reported, investigations were undertaken and lessons learnt produced, staff reported that there was no evident changes in practice as a result of incidents being reported; junior medical staff did not use the incident reporting system regularly.

Whilst there were sufficient seating arrangements within the department, there were concerns that the current layout placed young people and disorientated patients at risk as a result of automatic entrance doors being in close proximity to the department's ambulance bay.

The protocol for monitoring patients at risk was not used effectively which meant patients may not have been escalated in a timely manner if their condition deteriorated. We found that the Patient at Risk (PAR) tool, used in the department for the escalation of deteriorating patients, was not recorded or consistently reassessed for every patient presenting in the department. The 'cas cards' were out of date as the scorecard on these used for assessing PAR was no longer used in the department. The trust's policies had not been updated to reflect this. There was a concern raised by nursing staff that the Patient at Risk escalation tool was "not taken seriously" by all medical staff.

The department did not have sufficient numbers of medical staff trained at the appropriate levels for safeguarding children.

There was no protocol for managing patients' own medicines in the CDU, resulting in out of date medication being stored.

Security staff were trained in control and restraint under their Security Industry Authority (SIA) licences only (SIA is the organisation responsible for regulating the private security industry in the UK). They had not completed patient specific training to manage patients presenting with challenging behaviours, including patients with mental ill health and dementia needs. This meant that the management of risks did not take a holistic view and risks associated with anticipated events were not fully recognised, assessed or managed.

Incidents

- There were no Never Events in the emergency department between April 2013 and September 2014. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The trust reported 17 serious incidents (SI) to the Strategic Executive Information System (STEIS) relating to the A&E trust wide between April 2013 and March 2014.
- The most common type of reported incident in the A&E trust wide was delayed diagnosis. The next most common incident was slips, trips and falls. We saw evidence of root cause analysis of incidents which included identifying lessons learned, recommendations and actions taken.
- We asked staff directly if they reported incidents. Nursing staff told us that the frequency with which they reported incidents had reduced due to them receiving little or no feedback and that there was no evident changes in practice as a result of incidents being reported.

- Junior medical staff told us they did not use the incident reporting system regularly. This was reflected in the trust wide figures for incident reporting.
- We looked at the minutes of A&E clinical governance meetings dated June, July and September 2014 (August minutes were not provided), which recorded that learning from incidents was discussed by senior medical staff. Nursing representation was only noted for one of the three governance meetings (June 2014). Only three members of staff plus one minute taker was noted to have attended the September 2014 governance meeting. There was limited evidence to demonstrate that where incidents had occurred and investigations had taken place, lessons learnt and changes in practice were disseminated amongst the various health professional groups.
- Medical and nursing staff spoken with knew about a recent radiology never event (May 2014) which resulted in the wrong side insertion of a chest drain.

Cleanliness, infection control and hygiene

- During our visit, we found the department to be visibly clean and tidy. We saw support staff cleaning the department throughout the day and doing this in a methodical and unobtrusive way.
- The A&E had good hand-washing facilities, with hand basins in each bay in the major and minor treatment areas, and we observed staff using them. However, information provided by the trust showed 75% compliance with hand hygiene audits in the A&E for the year to date compared to the trust's plan for 100% compliance.
- Rooms were available for isolating patients who presented with a possible cross infection risk.
- We observed that staff used personal protective clothing (PPE), including gloves and aprons, appropriately and observed the trust's 'bare below the elbows' policy.
- Information provided by the trust showed that 75% of nursing staff and 70% of medical staff at Tunbridge Wells Hospital A&E had completed mandatory training in infection prevention and control. This fell short of the trust's target of 85%.

Environment and equipment

- There was sufficient seating in the waiting room and reception staff had a direct line of site of the area.
- There was a separate waiting room for children but on the day of our inspection we saw children waiting in the main waiting area. We observed an incident where a child ran out of the doors while waiting with parents to be booked in at reception. As arriving ambulances pass on the road directly outside the automatic exit doors, this is a potential safety concern for children in the main waiting area. There was a children's treatment room in the 'see and treat'/minors area, but there was no specific bay allocated for children in majors.
- The department had a suitable room to safely accommodate a patient presenting with mental ill health.
- A room was available for private and quiet discussions with relatives and an adjoining room was available where relatives could spend time with their loved one in the event of their death.
- An electronic 'swipe' card was required to access the department, which maintained a secure environment. There was a facility to 'lock down' the department in the event of an untoward incident.
- There was a good range of resuscitation and medical equipment. This was visibly clean, regularly checked and ready for use.
- Each bed space within the resuscitation area were designed and configured in exactly the same way. This allowed staff working within that area to be familiar with the bed space, which ultimately led to improved working during trauma and resuscitation events.
- There was a specific area for the resuscitation of children. This contained a wide range of equipment so that children of all ages could be immediately resuscitated.
- The clinical decision unit (CDU) had six cubicles and three chairs for ambulatory patients. There was one bathroom which was used by male and female patients. Although the cubicles had walls between them and privacy curtain at the end of each cubicle, the cubicles were very close together. We were told the aim was for a 'maximum of a 23 hours' stay for patients, although this was not always achieved and patients slept overnight in the CDU. This potentially compromised the privacy and dignity of patients accommodated in this area.

Medicines

- The staff we spoke with were aware of medicine management policies for reference purposes.
- We saw that locks were installed on all store rooms and cupboards containing medicines and intravenous fluids. Keys were held by nursing staff.
- Medicine administration records were complete in the patient records we looked at.
- We found that controlled drug stock levels and fridge temperatures were regularly checked by staff working in the department.
- We found the controlled drug cupboard in the CDU was used for storing patients' own medicine, including patients who had been discharged from the CDU. We found morphine sulphate solution and tramadol dated May, July and September 2014. There was no protocol for storing, recording or disposing of these medicines. The nurse in charge of the CDU was not aware that there were named patient medications stored in the controlled drug cabinet.

Records

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'cas card') was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- Specific pathway documentation (for example, medical patients, and surgical patients) was implemented for patients in the CDU or where admission to the hospital was anticipated. The documents were clear and easy to follow. There was space to record appropriate assessment, including assessment of risks, investigations, observations, advice and treatment and a discharge plan.
- We looked at the care records of ten patients and found they were completed.
- Information provided by the trust showed a variable uptake of training in information governance. For example, 58.3% of nursing staff, 16.7% of administrative staff and 55.9% of medical staff in the A&E had completed the training.
- The trust's own audit showed good compliance was attained for ensuring that observation of vital signs for 20 patients were recorded during September 2014.

Safeguarding

- Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. There was access to patients' previous attendance history and to the child risk register.
- A safeguarding nurse, based full time in the A&E, reviewed the notes of all 0-18yr olds presenting in the department.
- We saw a 'safeguarding check' in the department's emergency card. By way of checking and audit, an alert was sent to staff if the safeguarding check had not been completed.
- We saw a resource folder available which included contact details for social services 'out of hours' and safeguarding checks.
- Information provided by the trust showed that 76% of medical staff and 87% nursing staff at Tunbridge Wells Hospital's A&E were trained in safeguarding vulnerable adults. The trust's own target was 85%.
- Information provided by the trust showed that 57.6% of medical staff and 49% nursing staff at Tunbridge Wells Hospital's A&E were trained at level two and 33.3% of medical staff and 39.6% nursing staff were trained at level three in safeguarding children. The trust's own target was 85%.

Mandatory training

- Compliance with mandatory training by staff in the A&E at Tunbridge Wells was good; over 80% of all grades of staff completed health, safety and risk training, fire safety awareness and clinical moving and handling training.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
- Patients arriving in an ambulance were brought into dedicated ambulance triage bays and assessed by a nurse who was given a handover by the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated. With the consent of two patients arriving by ambulance, we observed their triage experience and found it was effective and patients were not left waiting.
- NHS England winter pressures daily situation reports (SITREP) data for the trust between 4 November 2013 and 30 March 2014 showed there were 52 occurrences when ambulances waited more than 30 minutes to hand over. This was better than other trusts nationally.
- Patients who walked into the department, or who were brought by friends or family were directed to a receptionist. Once initial details had been recorded, the patient was asked to sit in the waiting room. These non-ambulance patients were assessed by a triage nurse in time order unless the receptionist thought that a patient needed to be seen urgently. If, during the initial assessment stage, any patient was identified as needing urgent and more intensive intervention, they were transferred though to the resuscitation area, or to another more appropriate area.
- In 2013/14 Tunbridge Wells Hospital achieved a ‘time to initial assessment less than 15 minutes’ for 96.1% of patients. This was better than the government target of 95%. Figures provided by the trust showed this performance has been sustained, achieving the target for 96.6% patients between April and September 2014.
- We were told that a rapid assessment and treatment (RAT) had been implemented in the department. In practice, this was undertaken by the consultant nurse when they were on duty and was not embedded as a practice among the rest of the staff. We asked three trained nurses of various grades to describe the RAT system; two of them told us they did not know what it meant and one nurse told us it was ‘mostly’ the consultant nurse that undertook it.
- We observed that a ‘Patient at Risk’ (PAR) tool was used in the department for the escalation of deteriorating patients. We found that PAR was not recorded or consistently reassessed for every patient presenting in the department. Staff told us they made individual judgements on when it was necessary to implement the tool.
- We were told by several staff that the ‘cas cards’ were out of date as the scorecard used for assessing PAR, which was printed on the ‘cas card’ was no longer used in the department. The trust’s policies had not been updated to reflect this.
- One nurse spoken with expressed concerns that the escalation process using PAR was ‘not taken seriously’ by medical staff.

Nursing staffing

- Nurse staffing levels were based on historical establishments, which had been reviewed over time to take account of changing demand. A specific staffing tool was not used. Nurse staffing had increased following a CQC inspection in 2012.
- The trust employed 183.8 WTE qualified nurses in the A&E year to date against a target of 196.2. The nurse vacancy rate in the A&E trust wide was 2.3%
- During each day shift, the department was supported by 12 registered nurses and three clinical support workers. At night, this reduced to 11 registered nurses and three clinical support workers. There was also a ‘twilight shift’ with one registered nurse between 11.30hrs and midnight. These staff covered the main A&E (resuscitation, majors and minors), triage and the CDU.
- The skill mix for each shift included band 7 sister/charge nurse grades, who were in charge of the shift, with band 6 and band 5 nurses and healthcare assistants (HCA). Staff were allocated to specific areas of the department for their shift, but could be moved around if one area became busier than another.
- Two Emergency Nurse Practitioners (ENP) were on duty in the department each day until midnight and were usually allocated to the minors and ‘see and treat’ area.
- The A&E matron was on maternity leave and the post was being covered by matron from the women and children’s directorate. Nursing staff told us the matron spent a lot of time in the

department and was always approachable.

- We spoke to several nursing staff at length and they all said that they enjoyed working in the department and were well supported.
- Nursing staff were supported by consultant nurse, who also worked clinically. This role coordinated nurse education within the department.
- Handovers between staff were effective. Delegation was clear, and communication skills were good.
- We saw that the department had low reliance on bank and agency staff to ensure that the unit was safely staffed. Bank and agency received a local induction prior to starting their shift.
- The year to date sickness absence rate amongst the A&E staff was 3.7%, which was slightly higher than the trust's planned rate of 3.3%.
- The year to date turnover rate for A&E staff was 11.3%, which was higher than the trust's planned rate of 10.5%.

Medical staffing

- Insufficient numbers of A&E consultants were in post trust wide.
- There were 9.6 WTE consultant posts trust wide plus one long term locum and one middle grade 'acting up'. There was one maternity leave and one vacant post. The clinical director told us 14.6 posts were required to operate safely.
- Consultant cover was provided daily from 08.00hrs to 22.00hrs on weekdays and for six hours on Saturday and Sunday with an on-call rota for outside of these hours. Middle and junior grade doctors were on duty 24 hours a day in the department.
- We looked at the consultant rota for six weeks prior to our inspection which confirmed the consultant hours worked.
- Concern with the availability of competent and reliable middle grade locum doctors was included as a moderate risk on the trust's risk register. This was mitigated by the use of established agencies, local governance mechanisms and the use of regular locum doctors.
- There were no specific children's doctors working in the department due to the relatively small numbers of children who attended. However, we were told that specialist children's doctors were rapidly available if required.
- Junior doctors spoke positively about working in the department and said they were very well supported. They told us that In-house teaching was well organised and comprehensive.
- We observed board rounds taking place so as to ensure that the consultant in charge was aware of each patient in the main A&E department.

Major incident awareness and training

- The hospital had a major incident plan (MIP), which had last been reviewed in September 2011 (with updates to sections in October 2012 and September 2014)
- The trust provided the planned programme for exercise simulating major incidents. We also looked at some of the reports collated following simulation exercises. A chemical, biological, radiological and nuclear (CBRN) scenario based training exercise was taking place as scheduled on the day of our inspection. Records provided by the trust showed 40% staff had completed CBRN training.
- Staff in the A&E were well-briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly, they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (HazMat).
- Information provided by the trust showed there were 92 staff across the trust, including 27 staff from the A&E at Tunbridge Wells, who held a current CBRN permit and formed the decontamination team. Additionally, contact details of staff from Darent Valley Hospital who held a permit were also available.

Security

- The trust used privately contracted security staff from a third party. We spoke with security staff about their role in the A&E. They described the supervision of patients presenting with challenging behaviours, such as those intoxicated by substance misuse and patients with mental ill health

including dementia needs. Staff said they also assisted with patients who absconded from wards or the A&E. Security staff told us it was sometimes necessary to restrain patients.
- Security staff had limited training for the patient groups they worked with in the A&E.
- The trust told us 100% of security staff had completed conflict resolution training and 70% had completed restraint training. Security staff told us they received training in control and restraint under their Security Industry Authority (SIA) licences. (SIA is the organisation responsible for regulating the private security industry in the UK). Security staff expressed concern that the training required for licences they held for 'manned guarding', 'door supervision' or 'security guard' were appropriate for dealing with the general public, but not for patients presenting with challenging behaviours because of ill health.
- Security staff had not received any awareness training specific to conditions the patients they worked with might present, such as mental ill health or dementia.
- Security staff told us the trust had recently provided Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Information from the trust confirmed that 30% of security staff had completed the training. The trust confirmed that 60% of security staff had completed safeguarding training.

Are Emergency & urgent services effective?

Requires improvement

Improvements are required to minimise the risk of patients not receiving effective care or treatment.

The department participated in audits, but the results were not used effectively to improve patient outcomes.

The department was not meeting trust targets for staff appraisal, which meant the professional development of staff was not effectively supported.

There was a lack of consistency in how people's mental capacity was assessed and recorded. Where people lacked the capacity to make decisions for themselves, such as those patients who had arrived into the department unconscious or under the influence of a substance, we observed staff following the principles of the Mental Capacity Act. However, patients' capacity and any best interest decisions were not consistently recorded in the patient records we looked at.

Evidence-based care and treatment

- The department used a combination of the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided and a range of clinical care pathways had been developed in accordance with this guidance.
- Clinical guidelines were accessible on the hospital's intranet for staff.
- Posters of current clinical guidelines and pathways were displayed in the resuscitation bays.

Pain relief

- The A&E participated in two College of Emergency Medicine audits, which included the management of moderate or severe pain. These were the management of patients presenting in moderate or severe pain caused by renal colic and the management of fractured neck of femur.
- 93% of patients who presented to the Tunbridge Wells A&E complaining of pain as a result of renal colic, had a pain scored recorded. This placed the A&E in the middle quartile (quartiles are the values that divide a list of numbers into quarters) when compared nationally. The CEM standard was 100%.
- 14% of patients who presented in severe pain with renal colic were provided with analgesia within 20 minutes of arrival. This placed the A&E in the lower quartile when compared nationally. The CEM standards recommend that 50% of patients presenting in severe pain with symptoms of renal colic, should receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes upon arrival to the A&E. The department was placed in the upper quartile for patients receiving analgesia within 30 minutes (57%) and 60 minutes (100%).

- 14% of patients who presented to the Tunbridge Wells A&E in severe pain with fractured neck of femur were provided with analgesia within 20 minutes of arrival. This placed the A&E in the lower quartile when compared nationally. The CEM standards recommend that 50% of patients presenting in severe pain with fractured neck of femur, should receive analgesia within 20 minutes, 75% within 30 minutes, and 98% within 60 minutes upon arrival to the A&E. The department was placed between the upper and lower quartiles for patients receiving analgesia within 30 minutes (26%) and 60 minutes (46%). The percentage of audited patients that were provided with analgesia wholly in accordance with guidelines was worse in the 2012 audit compared to the 2009 audit. The CEM recommended that the trust should review its processes and consider possible causes for deteriorating performance. We requested evidence of action taken in response to the outcome of the audit, but none was provided.
- Pain scoring tools, relevant to the child's age, were used for children. The trust provided us with the outcome of their own triage audit undertaken in September 2014 for children presenting with pain associated conditions. The audit demonstrated 30% had a pain score recorded and 60% were offered or given analgesia. An action plan was not available in response to the audit. When we discussed this with the clinical director, we were told it was a recording issue rather than an oversight of giving appropriate pain relief. We reviewed ten sets of paediatric notes during our inspection and found 70% of notes did not have a pain score recorded. There was no reassessment of pain score in any of the records we reviewed.

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection.
- Nutritional risk assessments were undertaken, as required. Where food or drink had been offered, this had been recorded in the patient's emergency department care record.
- We observed that intravenous fluids were prescribed and recorded, as appropriate.

Patient outcomes

- The department participated in national College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other A&E departments. Audits included consultant sign off, vital signs in majors, renal colic, and fractured neck of femur, severe sepsis and septic shock. However, there was limited evidence that the trust had developed or implemented action plans in response to the outcome of the audits.
- We noted that in 2013/14 the attendances resulting in admission were higher than the national average (27% compared to England average of 22%). At the time of our inspection, it was not clear why the service was higher than the national average, and further work is required around this.
- The unplanned re-attendance rate to the emergency department within seven days was consistently above the England average.
- The number of ambulance handovers delayed over 30 minutes during the winter period of November 2013 to March 2014, compared to all trusts in England, was better than the expected standard.
- Results from the 2013 College of Emergency Medicine clinical audit relating to 'consultant sign-off' were compared with the same audit in 2011 to determine whether the A&E had made any improvements. The CEM consultant sign-off audit measures a number of outcomes, including: whether a patient has been seen by an A&E consultant or senior trainee in emergency medicine prior to being discharged from the A&E when they have presented with non-traumatic chest pain (17 years of age or older), children under one year of age presenting with a high temperature and patients who present back to the A&E within 72 hours of previously being discharged by an A&E. We found the department's performance significantly worsened between 2011 and 2013.
- During 2011 the number of patients seen by a consultant was 14% compared to a national average of 12%. This had worsened in 2013 to nil% of patients being seen by a consultant compared to a national average was 14%.
- During 2011 the number of patients who were discussed with an A&E consultant prior to discharge was 24% compared to a national average of 12%. In 2013, this had worsened to 4% of patients being discussed with a consultant compared to the national average of 13%. The number of patients discussed with a senior trainee emergency medicine doctor was 79% in 2013 compared to the national average of 36%.
- The number of A&E notes reviewed by an A&E consultant following discharge was 100% in 2011

compared to a national average of 7%. This worsened significantly in 2013, with nil% of ED notes being reviewed compared to the national average of 7%.
- We asked the trust for evidence of action taken in response to the CEM audits. We were shown the trust's own audits for vital signs and pain score in children. There was no other evidence or action plans seen in response.

Competent staff

- The year to date appraisal completeness for nursing staff in the ED was 59.5% against the trust's target of 90% completeness.
- We spoke with junior doctors, who told us that they received regular supervision from the emergency department consultants, as well as weekly teaching.
- The trust had two WTE paediatric nurses in post and these rotated internally.
- Information provided by the trust showed 14 nursing staff in the Tunbridge Wells A&E had a current European Paediatric Life Support (EPLS) certificate and 10 more nursing staff held a Paediatric Immediate Life Support (PILS) certificate.
- Nursing staff spoke very positively of the educational programme within the A&E which supported then to develop their skills and competencies; for example, information provided by the trust showed 24% staff had completed an A&E course and 24% had completed Foundations of Emergency care training.
- We saw evidence that staff were supported in maintaining their competence and training and education included a minor injuries course, intravenous fluids and cannulas, venepuncture, plastering, triage, mentorship and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) regulations.

Multidisciplinary working

- There was effective multidisciplinary working within the emergency department. This included effective working relations with speciality doctors and nurses, social workers and GPs.
- During the day, the mental health crisis team worked within the department to assess and treat patients with acute mental ill health conditions.
- There appeared to be a good working relationship between the A&E team and members of other specialities such as surgery and medicine.
- We observed close working relationships between the nursing and medical staff within the A&E.
- There was a good working relationship with the child safeguarding team and with the community paediatric team.

Seven-day services

- The department had access to radiology support 24 hours each day, with full access to CT and MRI scanning.
- We checked the rotas, and spoke to the medical team and senior nurses, who could show that there was a seven day working approach, and that appropriate medical cover was in place, including out of hours and weekends.

Access to information

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record (referred to by departmental staff as a 'cas card') was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- Staff could access records including test results on the trust's computerised system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that verbal consent was obtained for any procedures undertaken by staff and a range of written consent forms were available including, for example people with parental responsibility to consent on behalf of children who were not Gillick competent.

- Records provided by the trust showed that 85.2% of nursing staff and 50.9% medical staff had completed training in the Mental Capacity Act (MCA) 2005.
- There were no Deprivation of Liberty Safeguards applications made through the A&E in 2013/14 or the year to date.
- The staff we spoke with had sound knowledge about consent and mental capacity.
- Where people lacked the capacity to make decisions for themselves, such as those patients who had arrived into the department unconscious or under the influence of a substance, we observed staff following the principles of the Mental Capacity Act. However, patients' capacity and any best interest decisions were not consistently recorded in the patient records we looked at.
- We saw appropriate mental health referral practices.

Are Emergency & urgent services caring?

Good ●

The A&E provided a caring and compassionate service. We observed staff treating patients with respect dignity, respect and kindness. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. We saw that staff respected patients' choices and preferences and were supportive of their cultures, faith and background. Feedback from people who use the service in the Friends and Family Test was positive about the way staff treat people.

Compassionate care

- Throughout our inspection of the A&E, we saw that staff treated patients with compassion, dignity and respect.
- Two questions in the Adult Inpatient Survey, CQC, 2013, related to people's experience in the A&E department ('While you were in the department, how much information about your condition did you receive?, and 'Were you given enough privacy when you were being examined or treated in the department?'). The trust scored about the same as other trusts in response to both of these questions.
- The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. We found that staff encouraged patients to complete the survey and the response to the survey was better than the national average. Tunbridge Wells A&E consistently scored better than the national average. Data from July 2014 demonstrated that the A&E scored 60 with a response rate of 22.6%. This was better than the national average score of 53 and average national response rate of 20.2%.

Understanding and involvement of patients and those close to them

- During our visit to the A&E department patients and relatives told us that they had been consulted about their treatment and felt involved in their care.
- Comments from patients we spoke with included, "I've been treated really well. I've been kept informed and they've made sure I have everything I need." "I've had regular cups of tea and they keep popping in to make sure I'm okay." "I have absolutely no concerns about how I've been treated. My dignity has been upheld."
- Several people attending our listening events shared positive experiences about using the A&E.

Emotional support

- We observed staff giving emotional support to patients and their families.

Are Emergency & urgent services responsive?

Requires improvement ●

Patient flow was poor and waiting times were higher than the national average due to capacity constraints. This meant patients were not transferred to appropriate specialist clinical areas but were accommodated in the A&E for longer than necessary.

Male and female patients were accommodated in the CDU overnight and shared bathroom facilities. This compromised the privacy and dignity of patients and did not meet the standard for mixed sex accommodation.

The department was failing to meet their target for closing complaints within an agreed response date.

Limited out-of-hours access to the mental health liaison team meant the needs of patients presenting with ill health were not met in a timely way. If patients were experiencing a mental health crisis, their behaviour in the department could be very disruptive.

Service planning and delivery to meet the needs of local people

- The Clinical Decision Unit had six bays and three chairs for ambulatory patients. There was one bathroom which was used by male and female patients. Although the bays had walls between them and had a privacy curtain at the end of each bay, the bays were very close together. We were told the aim was for a 'maximum of a 23 hours' stay for patients, although this was not always achieved and patients slept overnight in the CDU. Patients had to pass other patients of the opposite sex in order to use the one, mixed sex bathroom. Patients also had a direct line of sight to patients in the opposite bay who may have been of the opposite sex. The trust reported no mixed sex breaches in 2013/14 and in the year to date.
- We were told that access to mental health services were good during the day. Staff from the mental health liaison team had an office base in the department and were easily available to assess and treat people with mental ill health. However, at nights and weekends, staff from the mental health liaison team were not on site and patients with mental ill health needs could wait a number of hours to be seen by specialist staff. If patients were experiencing a mental health crisis, their behaviour in the department could be very disruptive.

Meeting people's individual needs

- Children's needs were met by the provision of age-appropriate toys and activities, a separate waiting area and different pain-scoring tools.
- A member of nursing staff was identified as the department's dementia lead and offered training, support and advice to other staff in the department.
- Staff had access to translation services by way of a telephone interpreter system.
- Patient information and advice leaflets were available in English but were not available in any other language or format.
- The department had a room which provided a quiet and private area for waiting friends and relatives. There was an adjoining room which enabled friends or relatives to spend time with a loved one following a death in the department.

Access and flow

- The national target is for 95% of patients in A&E to wait less than four hours to be admitted, transferred or discharged. The A&E at Tunbridge Wells consistently failed to meet this target. In 2013/14 the target was achieved for 93.6% patients. The department's performance has worsened in the year to date, meeting the target for 92.4% patients.
- The percentage of patients who leave the department before being seen is recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they were having to wait for treatment. At Tunbridge Wells A&E performance was around 3%, which was about the same as the national average (month by month for the year ending 2014).
- The A&E department at Tunbridge Wells consistently failed to meet the national 'time to treatment in less than 60minutes' target achieving it for 46.5% patients in 2013/14 against a national target of

50%. The department's performance has worsened in the year to date, meeting the target for 43.6% patients.

- We found that the total time in A&E (average per patient) for the trust was consistently significantly higher than the national average (month by month for the year ending May 2014).
- Staff told us that patient flow was poor at times, due to the hospitals high bed occupancy causing a backlog in the department. Speciality patients regularly stayed in the A&E. Staff expressed concern about the difficulty of getting appropriate beds and mattresses for patients that were kept in the A&E to avoid long periods on trolleys. Staff told us that although there were no patients that spent more than 12 hours from decision to admit to admission, the patient may have waited up to 12 hours for the actual decision to admit.
- The number of ambulance handovers delayed over 30 minutes during the winter period of November 2013 to March 2014 was better than expected when compared to all trusts in England.
- We attended the midday bed capacity meeting. A video link between Tunbridge Wells hospital and Maidstone hospital facilitated a trust wide meeting. Several wards including the MAU were full and some wards were in escalation.
- There was no evidence of an improvement plan aimed at reducing the amount of time patients have to wait to be admitted or discharged.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient Advice and Liaison Service, who would formally log their complaint and would attempt to resolve their issue within a set period. Patient Advice and Liaison Service information was available within the main A&E.
- Staff spoken with were familiar with the complaints process and told us they directed dissatisfied patients to the PALS service when appropriate.
- Formal complaints were investigated by the matron and/or a consultant and responses were sent to the complainant. Information provided by the trust showed the department was not meeting the target for closing complaints within an agreed response date (25 days or negotiated).
- We saw that learning points from complaints were discussed at A&E governance meetings and at nursing staff meetings.

Are Emergency & urgent services well-led? — Inadequate ●

Although operational day to day management of the A&E was good there was a lack of strategic oversight. There was no vision or strategy for the department though the local leadership team reported that they were aware that overall departmental performance and workforce were issues which impacted negatively on the effectiveness of the directorate.

The risks within the department were recorded locally but only those assessed as "red" risks were included in the trust wide risk register; the senior management had limited oversight of risks held at a local, directorate level

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The department had not developed nor implemented an action plan to respond to identified deterioration of performance in the department or for improvement to address challenges that faced the department including capacity and patient flow.

Vision and strategy for this service

- The clinical director confirmed there was no written vision or strategy for the A&E. We were told that although there was no formal strategy, performance and workforce were identified as the issues which impacted negatively on the overall effectiveness of the directorate.
- Staff were not were not aware of any specific vision or strategy, but were able to tell us that a separate children's A&E was hoped for.
- Staff spoke with a sense of pride about their local team and department. They said they felt valued by leaders in the department. Clinical and nursing leaders were visible and approachable.

Governance, risk management and quality measurement

- Whilst there was evidence that the local management team engaged in operating some form of clinical governance system, we judged that the current system was ineffectual and not sufficiently robust to ensure that risks were managed and resolved, where possible. We saw evidence that whilst trust wide risks were discussed at departmental meetings there was no evidence of any other local risks being discussed.
- We saw a risk and governance report dated 6 October 2014. The department had three identified risks on the trust wide register. These related to the paediatric pathway, medicines management and the use of locum doctors in A&E. We were told the department maintained risk assessments locally, which fed into the trust wide risk register. Only 'red' risks were fed into the trust wide risk register. The clinical director and matron were aware of the three risks on the trust wide register, but there appeared to be limited oversight of items held locally.
- Monthly clinical governance meetings were held within the directorate and all medical staff were encouraged to attend, including junior doctors. We looked at the minutes of the meetings for the three months before the inspection and noted that complaints, incidents and audits were discussed. However, from a review of the department's governance minutes, attendance of nursing staff was inconsistent. Nursing staff had reported that the frequency with which they reported incidents had reduced due to a lack of feedback from incidents that had previously reported. Staff told us that they did not believe that lessons learnt occurred as a result of reporting incidents. We found little evidence to determine how lessons learnt were disseminated amongst staff following investigations of incidents.
- Whilst frontline staff were aware that issues such as performance against national targets had worsened, there was limited evidence to demonstrate how the department was attempting to resolve the issues. Furthermore, whilst staff acknowledged that capacity and flow across the trust was problematic, frontline staff were not aware of any remedial actions being taken in an attempt to address those issues in the long term.
- In addition to the lack of action plans to resolve issues such as capacity, flow and performance against national targets, it was unclear how the department was utilising outcomes from national audit programmes to ensure patient experience and outcomes was being improved. We noted that the performance of the department in a number of CEM audits had worsened when compared to previous audits. This further supports our concerns that the departments current governance arrangements are inadequate.

Leadership and culture within the service

- Staff told us there was an open and honest culture and excellent teamwork.
- The morale of all grades of staff in the department was good. They told us that there was an open and honest culture and excellent teamwork.
- The trust wide directorate of acute and emergency medicine was led by a triumvirate, including a clinical director (an A&E consultant), a nursing lead (matron) and a general manager. The general manager had been on sick leave for several months and an interim general manager took up post in the week of our inspection. The A&E matron was on maternity leave and the post was being covered by a matron deployed temporarily from another directorate. The recent changes meant there was some instability in the leadership of the directorate.
- The department's 'middle management' organisation was robust and worked well which meant day to day operational management of the department was good. Nursing staff were divided into four teams with a band seven nurse having line management responsibilities for their team. Additionally, individual departmental responsibilities and lead roles were deployed among nursing staff. This system appeared to work very well as staff took their responsibilities seriously. Staff spoken with told us they felt well supported and thought the A&E was organised and well run.

Public and staff engagement

- We observed staff actively encouraging patients to complete the friends and family test. This resulted in a response rate of 41.2% in the year to date trust wide which exceeded the trust's target

for 25% response.
- There was no evidence displayed in the department of changes made as a result of patient feedback (for example 'You said, we did').

Innovation, improvement and sustainability

- All of the staff we spoke with said change and innovation was encouraged. Nursing staff were particularly enthusiastic about the nurse consultant and the provision of the programme of education provided which they believed supported quality initiatives.

Medical care (including older people's care)

Safe	Requires improvement	●
Effective	Requires improvement	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Good	●
Overall	Requires improvement	●

Information about the service

At Tunbridge Wells Hospital medical care services were managed predominately by the Directorate of Speciality and Elderly Medicine. Specialities included Gastroenterology, Respiratory medicines, Cardiology, Endocrinology, Elderly Care and Stroke. Acute medicine was managed by the Directorate of Acute and Emergency Medicine and the service was provided on the Medical Assessment Unit. Stroke rehabilitation services were based at Tonbridge Cottage Hospital the site of which was owned and managed by Kent Community Health NHS Trust. The Medical care services had a bed compliment of 153 beds, (of which 130 were inpatient beds) and provided approximately 16,400 spells of care per annum at Tunbridge Wells Hospital.

To help us understand and judge the quality of care in medical care services at Tunbridge Wells Hospital we used a variety of methods to gather evidence. We spoke with seven doctors including consultants, approximately 25 registered nurses including ward managers, eight Allied Health Professions and eight Care Support Workers. We spoke with six support staff including housekeeping staff. We also spoke with about 20 patients and about 12 patient relatives. We interviewed the directorate management teams for Speciality and Elderly Medicine and for the Directorate of Cancer and Haematology. We observed care and the environment and looked at records, including patient care records. We looked at a wide range of documents, including audit results, action plans, policies, and management information reports.

During our announced inspection we visited Wards 12, 20, 21 and 22. We visited the Acute Stroke Unit and the Coronary Care Unit. During our unannounced inspection we visited the Stroke Rehabilitation Unit based at Tonbridge Cottage Hospital and the Medical Assessment Unit at Tunbridge Wells Hospital.

Summary of findings

Staff provided kind, compassionate care that preserved patients' dignity. Patients were supported emotionally and received enough information to be involved in their care and treatment. Staff felt supported by their leaders and managers to provide high quality care and there was a culture that was focussed on meeting the needs of individual patients and their families. Service leaders at all levels had systems in place so they knew how well they were doing and were aware of the service needs.

However policies in relation to the checking of blood glucose monitors were not being followed and the temperature of storage of medicines was not robust. Patient records were not always stored securely.

Current clinical guidance was not always easily accessible for staff. Staff sometimes used inappropriate sources of guidance that led to ineffective care. National audits showed patients with stroke or diabetes were receiving below average quality care. Medical care services were not responsive to people's needs as there was insufficient capacity in the service to meet demand. Arrangements for the provision of translation services required improvement.

Are medical care services safe?

Requires improvement ●

Overall, we judged that medical care services required improvement to be safe.

We found that there were effective methods for reporting safety incidents and that any incidents were investigated for lessons learned and staff understood their responsibilities in this regard. The results and learning from investigations were fed back to staff. Slips, trips and falls constituted the greatest concern for all staff and we saw that systems and arrangements were in place to reduce this risk. The majority of patients experienced harm-free care as measured by the national Safety Thermometer scheme.

Patients were cared for and treated in an appropriate, well-maintained environment that met their needs. Equipment was well maintained. The environment was clean and staff used recognised methods to prevent the spread of infection.

We found there were adequate numbers of nurses, doctors, therapists and other staff to meet patients' needs. Staffing levels were kept under review and action was taken to adjust them in the light of emerging concerns or changing circumstances. Staff were up to date with mandatory training that was designed to ensure they could carry out their role safely. There were adequate arrangements to safeguard children and people in vulnerable circumstances.

There were systems that enabled staff to recognise and appropriately treat patients whose condition was deteriorating.

However, there were a number of practices that placed patients at risk. The Trust policies for checking point-of care glucose monitoring were not being followed on MAU, there was no monitoring of room temperatures where medicines were stored and patients' confidential clinical records were not always kept securely in ward areas.

The Stroke Rehabilitation Unit had not reported incidents relating to the transfer of patients, whose condition had deteriorated. This meant there was no monitoring of their safety regarding the appropriateness of transfer to the unit, or the management of deteriorating patients.

Medicines were not always available on all wards timely when requested from pharmacy which resulted in patients missing doses.

Incidents

- There were no reported never events within medical care services. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Medical care services reported 44 serious incidents requiring investigation in the past year; with 10 since April 2014. Slips trips and falls accounted for 24 (54%) of these incidents. Since April 2014 medical care services had reported a total of 288 falls resulting in injury.
- All staff we spoke with were aware that falls accounted for the majority of reported safety incidents. We saw there were arrangements for intervening when the number of falls on a ward exceeded thresholds. On Ward 20 we saw how the trust and ward team had responded to an increase in the incidence of falls by using equipment such as movement sensor technology to alert staff that patients at risk were moving unaided. They also had completed root cause analysis on four falls that had resulted in harm and found that two were unavoidable incidences, one was inconclusive and one was avoidable. We were told these analyses were presented and discussed at a trust panel examining serious incidents requiring investigation. This showed that investigation and actions were taken when the monitoring of incidents indicated an emerging problem.
- Trust policy stated that incidents should be reported through a commercial software system that enabled incident reports to be submitted from wards and departments. All staff we spoke with across medical care services at Tunbridge Wells Hospital were aware of the requirement to report any incidents, knew how to use the system and could demonstrate its use to us.
- At the Stroke Rehabilitation Unit, we found that incidents relating to the transfer of patients, whose condition had deteriorated, had not been reported. This meant the directorate and unit management teams could not use this information to inform their monitoring of safety, for instance the appropriateness of transfer to the unit, or the management of deteriorating patients.
- Once the ward managers had investigated incidents they communicated any learning from the incidents through ward meetings. We saw examples of feedback and staff told us they valued the

feedback given. We also saw examples of when incidents, such as never events that had occurred in other services had been discussed to ensure learning was disseminated across the organisation. We saw copies of prompt cards on the Medical Assessment Unit (MAU) produced by the trust which informed staff of a never-event and the organisational learning that followed.

- The Directorate of Speciality and Elderly Medicine held Mortality Review Panel Meetings. The records of patients who had died were reviewed by a named consultant and if pre-determined criteria were met they were then discussed at the review meeting. We did not see minutes of these reviews, but noted that cases were discussed at Directorate Board meetings, and that these discussions generated learning and action points.

Safety thermometer

- The medical care services at Tunbridge Wells Hospital participated in the national safety thermometer scheme. Data was collected on a single day each month to indicate performance in key safety areas.
- We spoke with the management team of the Directorate of Speciality and Elderly medicine. They felt that ward managers may be subject to data overload and that the safety thermometer data was of a lesser quality due to the methodology used than other data already made available to ward manager. Therefore, it was not routinely circulated to ward managers. However, it was reviewed by the matron and management team. We saw that key elements of the data were incorporated into the directorate performance dashboard.
- Safety thermometer data for medical care services demonstrated that since April 2014 95.7% of patients experienced harm free care in the Directorate of Speciality and Elderly Medicine which exceeded the target of 92%.
- Since April 2014 the number of patients receiving a venous thrombo-embolism risk assessment exceeded the target of 95%.
- The trend over time shows that the rates of pressure ulcers and catheter related urinary tract infections in medical care services had fallen.

Cleanliness, infection control and hygiene

- Overall, we judged that medical care services were compliant with the “Code of Practice on the Prevention and Control of Infections and Published Guidance” issued by the Department of Health. We observed that the environment was visibly clean and hygienic and well-maintained. Patients told us they were satisfied with the standards of cleanliness.
- We were told that audits of cleaning were carried out and we saw the results of these displayed in ward areas. We noted that the audit results did not indicate any concerns. We looked at composite cleaning audit data collated in August 2014 and found that the average six week rolling audit score for medical care services at Tunbridge Wells Hospital was a score of about 98%.
- We looked at the results of Patient Led Assessments of the Care Environment (PLACE) Tunbridge Wells Hospital achieved a cleanliness score 99.45% and the detailed reports for medical care services did not identify any concerns regarding cleaning standards.
- Training for all staff in Infection Prevention and Control (IPC) formed part of the mandatory training programme. Compliance rates for IPC training were 88.5%.
- Hand hygiene was audited monthly. In medical care services the compliance rates for the period April 2013 to August 2014 averaged 95%. In the same period the average compliance for staff being bare below the elbows was 99%. We observed staff de-contaminating their hands in line with The World health Organisations “Five Moments of Hand Hygiene” guidance. There was adequate hand washing facilities and hand sanitizer available in clinical areas. However, on the MAU we found that some sanitizer dispensers were empty, although they were filled during the course of our visit.
- We saw that there were ample supplies of personal protective equipment and we observed staff using it when necessary.
- We saw that disposable curtains were used and we saw that the dates they needed replacing were marked on them. Those we looked at were all within date.
- The cleanliness of commodes was audited. During the period April 2013 to August 2014 the average score for the commode cleanliness in medical care services was 90%. We found commodes and sanitary ware to be clean and hygienic.
- We saw that shared patient equipment was labelled with a distinctive green label indicating that it

had been decontaminated and was ready for use. Staff we spoke with understood this labelling system.

- We observed that clinical and domestic waste was segregated in appropriately coloured bags and that waste in ward areas was correctly stored. An audit of the management of 'sharps' waste in February 2014 achieved a compliance rate of 98%. We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- In medical care services there has been one case of MRSA bloodstream infection since April 2014. The target set was zero cases.
- On the stroke rehabilitation unit we saw there were systems to ensure all patients were screened for MRSA on transfer and then every seven days. This unit had no side rooms. We saw a patient identified as colonised with MRSA being nursed in a bay with other patients. However, we noted that steps were taken to ensure this patient was situated appropriately in the bay and that personal protective equipment (PPE) was available in the bed space. We observed staff and the patient's relatives using this PPE. This showed that the treatment of MRSA colonised patients was planned to minimise the risk of spread to other patients.
- In medical care services a total of nine case of C. Diff diarrhoeal illness had been reported trust-wide since April 2014. We saw that patients were risk assessed by nurses in relation to the risk of acquiring C. Diff and that this assessment resulted in actions being taken to protect patients from this risk; for example increased cleaning regimes.
- Staff we spoke with on Ward 20 described how C.diff incidence was monitored and managed. They told us that they had completed a Root cause Analysis (RCA) on one case and found it to be unavoidable and this was ratified by a trust-wide panel engaged in monitoring Clostridium difficile incidence investigations. We were also told that in April 2014 the ward had experienced a cluster of three Clostridium difficile cases but pheno-typing of the strains had shown they were unconnected. This demonstrated that any incidence of Clostridium difficile was thoroughly investigated for control and lessons learned.

Environment and equipment

- General Health and Safety and Fire safety training formed part of the mandatory training programme. 90.3% of staff had attended Health and Safety Training and 87.9% had attended fire safety. This exceeded the target of 85%.
- We looked at the results of Patient Led Assessments of the Care Environment (PLACE) Tunbridge Wells Hospital scored 98.87% and the detailed reports for medical care services did not identify any concerns regarding condition appearance or maintenance.
- Staff told us that Electrical Medical Equipment (EME) was well maintained centrally by the EME department. They praised the library system in use and said that it was very unusual for them not to be unable to access equipment when it was needed. We saw that all EME had a registration labelled affixed which meant that the department were aware of its existence and that it was maintained in accordance with manufacturer's recommendations.
- On The Medical Assessment Unit (MAU) we looked at point of care blood glucose monitoring equipment. We were told the trust policy was that this should be calibrated daily in accordance with the manufacturer's instructions. We examined the test log books for both machines and noted that these tests had been inconsistently carried out, often with gaps of two or three days. We saw one machine had not been tested for nearly a month. The senior nurse on duty could not give us an explanation of why this had occurred. There was no formal link to pathology for quality assurance. The hospital Pathology Quality Manager told us it would be good practice to have a policy and for the pathology team to be involved in procurement and training. This meant there was a risk that results produced by this machine could be inaccurate and clinical decisions based on them could put patients at risk of inappropriate care. We also noted that used lancets were stored in the box adjacent to ones ready for use which gave the potential for cross contamination.
- We saw all portable electronic equipment had portable appliance testing labels attached indicating that it had been safety tested in the previous year.
- We saw that there was a system of applying coloured labels to patient lifting equipment such as hoists, to show that it had been serviced in line with the manufacturer's recommendations. We saw that this equipment had all been serviced as required by these recommendations.
- We found that each clinical area had resuscitation equipment readily available. There were systems to record that it was checked daily to ensure it was complete and ready for use and we

saw from these records that staff had complied with these systems.

Medicines

- We observed that medicines were administered by appropriately trained staff and that their competency had been appropriately checked.
- There was a ward based pharmacy service. Patients' prescriptions were checked by a pharmacist to ensure their medicines treatment were safe, effective and met current guidance. We saw annotations on prescriptions charts by pharmacists demonstrating such review. Clinical staff could access a pharmacist for advice, and patients and their families could also access medicines advice.
- Staff on ward 12 told us that the re-stocking by a pharmacy technician had been reduced to once weekly. They told us that they sometimes ran short of stocks and that it was often late afternoon before drugs ordered in the morning arrived. They showed us an example of a patient who had missed their morning medicines because supplies had taken too long to arrive. On the Stroke Rehabilitation Unit the ward staff told us that the system for obtaining medicines from the hospital pharmacy was time consuming and there were missed doses because of this; however, they commented that they felt things had improved recently.
- We observed nurses administering medicines and found that overall, The Nursing and Midwifery Council (NMC) Standards for medicines management were being adhered to.
- We looked at drug administration records and found they were fully completed. Prescriptions met legal requirements and were clear and legible. There were no unaccounted gaps in administration identified.
- We saw that management of controlled drugs met legal requirements. We checked order records, and CD registers and found these to be in order. We spot-checked some medicines and found that stock balances were correct. We saw there were arrangements for ward staff to check stock balances weekly and saw records to support this.
- We found that medicines were stored securely in locked cupboards and trolleys.
- We found that the medicine 'fridge temperatures were checked to ensure that medicines requiring such storage were stored in optimum conditions. However, we noted that the ambient temperatures of rooms where medicines were stored were not monitored. Ward staff we spoke with were not aware that room temperature checks were required to ensure medicines remained in optimal condition.

Records

- 83% of staff in medical care services had received Information Governance training.
- Medical care services had integrated patient records shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in a patient's care could see their full record.
- We looked at patient records and found they were comprehensive, contemporaneous and reflected the care and treatment patients received. Patients' records were readily accessible to those who needed them.
- We saw that medical records were not always stored securely and that unauthorised access was possible. Records were often stored in notes trolleys in ward areas to which the public had access. Although these trolleys had the facility to be locked, they were not and staff confirmed that this was usual.
- We saw that patients were risk assessed in key safety areas using national validated tools. For example we saw that the risk of falls was assessed and that the risk of pressure damage was assessed using the Waterlow score. We noted that when risks were identified relevant care plans which included control measures were generated. We checked a sample of these control measures and found them to be in place. We saw that risk assessments were reviewed and repeated within appropriate and recommended timescales.

Safeguarding

- Safeguarding Children and Adults training formed part of the mandatory training programme. 91.7% of staff had completed some training in safeguarding adults and 90.5% in safeguarding children.

- Staff we spoke with were all aware of their responsibility to report potential abuse and knew how they would go about this. Staff knew the name of the Trust safeguarding matron and said that they would not hesitate to contact them for advice and guidance. The support of this role was valued by clinical staff.
- Staff could give us examples of the management of safeguarding concerns which demonstrated that processes had been followed and that they were engaged in the process.

Mandatory training

- In the Directorate of Speciality and Elderly Medicine compliance with mandatory training was 83.4%. This narrowly missed the Trust target of 85%.
- Staff were aware of the mandatory training they were required to undertake.
- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed, when it was due.

Assessing and responding to patient risk

- We found that patients physiological parameters such as pulse and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely Ill-Patients in Hospital.'
- We saw that an early warning scoring system (PAR) was consistently used whenever observations were taken. Staff could talk authoritatively about the scoring system and were confident in its use.
- We watched observations being taken and noted that the technique used would ensure an accurate result.
- We looked at examples were the PAR score had indicated a risk of deterioration and saw that appropriate actions in line with the Trust protocol had been instigated.
- When reporting concerns about a deteriorating patients staff used a standardised format (SBAR). We saw that copies of relevant SBAR documents were in ward areas and staff could explain how they used them with examples of when they had done so.
- Staff could access specialist advice in relation to acutely unwell or deteriorating patients 08.00 – 20.00 hours from a critical care outreach team. We observed this team seeing new patients and reviewing patients for whom concerns had been escalated. Staff also told us that the outreach team were proactive and approached ward staff routinely to help them identify and manage patients at risk of deterioration. However, the service did not operate overnight. The Site Practitioner team carried out this function but the skill levels of this staff group in relationship to critical care was not formally assessed or recognised.
- We attended the site practitioner day to night handover meeting. We noted that the outreach team identified patients on the ward areas at risk of deterioration and their management plans were clarified to ensure they were appropriately monitored. We saw that where necessary, their care had been escalated overnight.

Nursing staffing

- In the Directorate of Speciality and Elderly Medicine the nursing vacancy rate for registered staff was 1.7% with approximately 20 whole time equivalent registered nurse vacancies and an excess of 11.6 WTE unregistered nurse vacancies. The directorate management team told us that recruitment was one of their major concerns and outline their plans for further overseas recruitment initiatives to us. However, the directorate management team used temporary nursing staff from the trust's bank and agencies to ensure there were sufficient staff on duty and to fill any shortfalls caused by this vacancy factor
- At Tunbridge Wells Hospital the use of temporary nursing staff from both the trust bank and external agencies represented 6.48 % of the nursing workforce in the period February 2013 to August 2014. Staff told us that requests for temporary staff were usually filled.
- The numbers of staff planned and actually on duty were displayed at ward entrances in line with guidance contained in the Department of Health Document 'Hard Choices'. We saw that the actual numbers did not fall below the agreed templates. Staff we spoke with told us that it was very unusual for staffing levels not to be maintained, and if it did occur it was due to last minute difficulties such as late notice staff sickness.
- We noted that the number of staff on duty exceeded the 1:7 registered nurses: patient ratio

recommended by NICE. Often there was a ratio of 1:4 registered nurses supported by care support workers who represented less than 40% of nursing staff on duty.

- Staff told us they could access additional staff when patients required one to one care. We saw an example of this on ward 21.
- During our inspection we observed that there were sufficient nurses to care for patients. We noted that call bells were answered promptly and that hourly intentional rounding that ensured patients' safety and comfort was recorded, although we noted these records were not consistently kept on MAU. Patients appeared well cared for and staff did not appear to rush interactions and care interventions.
- Ward managers told us that nursing staffing establishments were reviewed six monthly and that the directorate management team and the board were supportive and were focussed on ensuring there was sufficient staff to meet patients' needs.
- We saw that there were arrangements for nursing staff to handover the care of patients between shifts. This was supported by printed handover sheets. We looked at these sheets and found they contained relevant information on specific patient needs and risks to support the delivery of safe care.
- We saw that there were also arrangements for there to be a daily handover to the whole multi-disciplinary team in the form of a ward board round and we saw these in progress. Therapy staff told us that they considered these a useful format for ensuring they had access to all the current, relevant information they required to provide care.

Medical staffing

- Overall, we found that there were adequate numbers of doctors at appropriate grades to meet the needs of patients. We were told that each medical team cared for approximately 15-20 patients at any one time.
- Within the directorate of Speciality and Elderly medicine the vacancy rate for medical staff was 6.6%.
- The use of locum medical staff in medical care services at Tunbridge Wells Hospital represented 4% of staff during the period February 2013 to August 2014.
- Medical skill mix showed consultants represented 29% of the workforce in medical care services against England average of 33%. Registrars represented 45% against an England average of 39%. This meant there were fewer consultants but more registrars in medical care services than the England average.
- We found that newly admitted patients received a timely consultant review. There were morning and evening post-take ward rounds taking place. However, there was not consultant cover for the full 12 hours per day at the weekend as recommended by the Society for Acute Medicine. Junior doctors told us that sometimes patients were moved in wards in the afternoons and therefore, might not be reviewed by a consultant until the next day.
- There was a consultant on-call system operating. Junior medical staff told us they could access advice from a consultant at any time and that when required consultants attended patients.
- We found that not all patients were reviewed by a consultant each day, except where it was determined this would not affect their care pathway. However, we found that patients were reviewed by their medical team daily during the week and this was recorded in their notes. This meant that although patients were reviewed by a doctor, this was not necessarily by a consultant and this had the potential to delay progress through their treatment pathway.
- Junior doctors told us that their consultants were happy to be called out of hours regarding patients' management.
- We found that the hospital was introducing measures to improve handover between medical teams. The trust had recently invested in an electronic system that enabled staff to have accessible records on new patients. We were told there were formal handovers between day and night medical staff in the assessment unit and that this worked well. We attended one of these evening handover meetings and found that all the medical doctors from the day and night teams were present and that a comprehensive handover of new patients and those on wards who were deemed at risk of deterioration was undertaken. This included specific management plans for these patients. The medical staff also maintained a 'sick list' of patients whose condition was giving cause for concern. For weekend teams a spreadsheet was maintained containing names of patients who required review, or needed attention such as investigations.

Major incident awareness and training

- We found that staff were prepared for a major incident or an event that impacted on business continuity. All staff we spoke with in medical care services were aware the Trust had major incident and business continuity plans. They all had a broad idea of their responsibilities in these situations and were clear about where they would find guidance if needed.

Are medical care services effective?

Requires improvement

Overall we judged that medical care services required improvement in order to be effective.

We found that there were arrangements to ensure people received adequate pain relief, and that they received adequate amounts to eat and drink.

Patients could access the expertise of the full range of healthcare professionals and there were arrangements to ensure the multi-disciplinary team worked well together and had access to the information they required to care for patients effectively. There was some access to the multi-disciplinary team out of hours. Where diagnostic services were not available out of hours locally there were agreements with other providers to ensure patients could access them if needed.

However we found that clinical guidance was difficult for staff to access and in some cases staff were using inappropriate sources of information. Overall practice was compliant with current clinical guidance but patients who had suffered a stroke were not receiving care that met national standards as shown by the Sentinel Stroke National Audit Programme outcomes. Diabetic in-patient patients were receiving care that was below the national average in some areas.

Medical staff's competency in key skills was not assessed to ensure they could carry out procedures safely.

Evidence-based care and treatment

- The directorate management team explained how new guidance from the Department of Health, NICE and learned societies was reviewed and implemented. New guidance issued was disseminated to directorates where it was reviewed by appropriate staff. A report was required that demonstrated where compliance was achieved and identified any necessary actions needed where it was not. These reports were discussed at speciality governance meetings and the directorate were required to report progress to the Trust Standards Committee. This meant there were arrangements in medical care services to ensure that practice remained congruent with current guidance.
- On the whole we found staff were aware of NICE guidance that was relevant to their work for example, Preventing falls In Older People (CG161), IV Therapy in Adults in Hospital (CG174) or Chronic Heart Failure (QS9). Staff talked confidently about the guidance and how they worked to ensure their practice was compliant.
- We reviewed policy documents, for example those concerned with the management of sepsis and found that the evidence base on which they were based was clearly stated. We noted that all local guidance that we reviewed carried a review date that was in the future. This meant the policy documents were evidence-based and current.
- On ward 21 we saw that staff could talk about guidelines from the British Thoracic Association. For example, following a successful trial, the introduction of the Optiflow system required to deliver humidified high flow oxygen via nasal cannulae met guidance from this learned society.
- We found the trust web-based system for accessing clinical guidelines needed improvement. To access a guideline the user had to search on key words which required them to be very specific for the search to produce results. There was no index or contents for each specialty. We asked the management team about clinical guidelines. We were shown examples of local guidelines used in endocrinology and we saw these had recently been reviewed. We saw that the respiratory speciality had developed a chest drain checklist and the speciality lead told us, "Whilst the British Thoracic Society and European Respiratory Society produce such comprehensive guidelines, there is little point re-writing them unless there is significant local variation, which we do not exhibit." We were told all other medical specialties used national guidelines although these were not easy for ward based medical staff to locate. For example, we asked to see guidelines on Acute Coronary

Syndrome, GI bleed and Asthma. Junior doctors could not find these and there was no evidence that these existed.
- On the stroke unit a doctor told us they would use Wikipedia as a source of clinical guidance, and a nurse told us they would use Google to locate documents. This meant there was a risk that inappropriate guidance could be accessed and used which could place patients at risk.
- However, we asked nurses on the stroke rehabilitation ward to locate local guidance on the management of sepsis and they were able to locate these easily.
- We were unable to find any guidelines on several common medical emergency conditions. This meant that although guidance was available its use was difficult in practice due to it not being easily accessible. This presented a risk that staff may therefore, not consult written guidance and provide care based on the most current guidance.

Pain relief

- We saw that assessments of patients' pain were included in all routine sets of observations. We noted that as part of intentional rounding processes staff ensured that patients were comfortable.
- We found that staff had access to specialised pain assessment tools for people living with dementia and those with a learning disability. Staff were able to explain how they would use these. This meant that there were systems to ensure people with poor cognition could be objectively assessed to enable appropriate pain relief to be given.

Nutrition and hydration

- We looked at patient records which showed that patients were assessed for the risk of malnutrition using a recognised, validated tool (MUST). We saw that screening was repeated as necessary.
- When nutritional screening demonstrated a risk we saw that appropriate actions, such as the maintenance of food charts, the provision of dietary supplements or referral to the dietician were made.
- However, in November 2013 an audit of nutritional screening demonstrated that only 62% of patients treated at Tunbridge Wells Hospital had a nutritional risk assessment carried out within 48 hours of admission. 69% of patients were reassessed after seven days in accordance with national guidelines. This shows that at the time of the audit not all patients were appropriately screened for the risk of malnutrition.
- We looked at the results of Patient Led Assessments of the Care Environment (PLACE) for Tunbridge Wells Hospital. A score of 81.2% was achieved for food. We looked at the detailed reports for medical care services and did not identify any concerns regarding food.
- Patients were positive about the quality of food provided. One said, "The food is very good indeed, the portions are about the right size. A further patient described the food as, "Excellent."
- We observed that patients were served a choice of foods and that therapeutic diets were managed well. Patients were assessed by a dietician when screening suggested a risk of malnutrition, or if there were medical problems that compromised patients' nutrition.
- Dietary supplements were given to people when prescribed.
- Audit data from the stroke unit showed that there were arrangements to ensure that patients who had suffered a stroke were assessed to ensure they had a competent swallow and were not denied food or fluid unnecessarily. However, the target of 75% of eligible patients receiving a swallow screen within four hours was not achieved with a performance rate of 63% since April 2014.
- We saw that food charts were generally well completed to enable dieticians and nurses to monitor the nutritional intake of people at risk of malnutrition. Fluid balance charts were used when these were required. However, in MAU we found that these were inconsistently completed.
- We noted that patients were helped to eat and drink. We saw that people were left with a drink within reach.
- Food that met people's special cultural and religious needs was available.
- There were facilities that enabled families and visitors to purchase food and beverages.

Patient outcomes

- Mortality rates for medical care services were in line with national expectations. In the Directorate of Speciality and Elderly Medicine the crude mortality rate since April 2014 was 3.5% against a target of 5.5%.

- The standardised risk of readmission in medical care services overall at Tunbridge Wells Hospital was slightly worse that the national average at 97 for elective admissions and was better for non-elective admissions at 107. This meant that patients in medical care services were no more likely than average to require unplanned readmission, suggesting their care and discharge arrangements were appropriate.
- We saw that the Trust had a comprehensive action plan to improve its stroke services. We found that the progress of this plan was being monitored. The management team and staff working in stroke were aware of this plan and were able to discuss its contents and implementation with us.
- At Tunbridge Wells Hospital one key metric had been achieved with 87.8% of patients being assessed by a trained nurse within 24 hours. Scanning times were below target with the percentage of patients scanned within 1 hours standing at 36.1% against a target of 43%. 7.3% eligible patients received thrombolysis treatment against a target of 15%. This demonstrates that although the SSNAP score has improved, patient outcomes in relation to stroke required improvement.
- In the National Diabetes In-patient Audit (NaDIA) September 2013 hospital performed worse than the England average in 13 of the 22 standards. These included items relating to foot risk assessments, staff knowledge and awareness of a patient's diabetes and meal suitability and timing.
- In a national audit of care of patients with non-ST elevation infarction, as part of the Myocardial Ischaemia National Audit Project (MINAP) Tunbridge Wells Hospital matched England's average whereby patients were seen by a cardiologist (93%), matched the average for the number of patients admitted to a cardiac ward (53%). The hospital performed slightly below the average for patients that were referred for (or had) angiography (71.7% against an England average of 73%).
- We looked at audit data in relation to the complex pacing of cardiac patients. The data indicated good practice and demonstrated a safe and effective service.
- We found that national and local audits resulted in an action plan. We were shown examples of some action plans, for example that generated by the NaDIA and saw that actions to improve compliance with guidance had been identified and their implementation monitored.

Competent staff

- In the Directorate of Speciality and Elderly Medicine 47.8% of staff had participated in an appraisal since April 2014. These percentages relate to the financial year to date and indicate the directorate was on course to complete appraisals for staff by the year end. It is worth noting that in the last staff survey the majority of staff said they had an appraisal in the previous year.
- In medical care services 91.7% of new staff had attended the corporate induction programme. However, only 34% of new starters have had a local induction checklist completed.
- We found that when medical staff had started work in the directorates of Speciality and Elderly medicine there were no arrangements to assess their competency in key skills. The directorate management team had not considered this when we raised this with them.
- We found there was a system for orientating and inducting temporary staff to ward areas in medical care services. We were shown a standard check-list that was used and noted that it had been completed for temporary staff who were working on the day of our inspection. We also saw archived copies of these forms that had been completed prior to our inspection. However, on the Stroke Rehabilitation Unit, no orientation or induction record could be produced for the agency nurse who was working although this nurse assured us this had happened on a previous occasion when they had worked in the last month. We saw that in addition to the standard temporary staff induction, this unit checklist had produced a supplementary checklist covering specific topics pertinent to stroke rehabilitation. This meant there were arrangements to ensure temporary staff could work safely.
- On Ward 20 the ward manager had identified that the patient profile contained a higher than average number of people living with dementia. Although dementia training was available it did not form part of the trust mandatory training programme but the ward managed had agreed the completion of this training as part of all staff's objectives in their last appraisal. At the time of our inspection 60% of ward staff had completed this. This demonstrated that care was taken to ensure that staff were competent to care for needs of patients specific to their clinical areas.
- Junior doctors told us there were good opportunities for learning on consultant ward rounds.

Multidisciplinary working

- Within medical care services we identified that there was a strong commitment to multi-disciplinary working. Each ward area had a multi-disciplinary team meeting on at least a weekly basis to plan the needs of patients with complex needs. We saw documentary evidence of a multi-disciplinary approach to discharge planning.
- On the stroke rehabilitation unit we saw that patients had timetables detailing when each therapist would be treating them that week. This ensured that patients, their families and nursing staff were aware what and when planned therapy sessions there would be.
- Wards teams had access to the full range of allied health professionals and team members described good, collaborative working practices, especially on the Stroke Rehabilitation Unit.
- Ward teams told us they had access to mental health services from a mental health trust. Psychiatric assessments were carried out as a result of referrals.
- In medical care services physiotherapy responded to 76% of referrals and 85% of those were responded to within 48 hours. Occupational Therapy responded to 97% of referrals with 73% seen in 48 hours, speech and language therapy to 78% with 88% seen within 48 hours and dietician to 94% with a 48 hour response rate of 77%.
- On Ward 12 we found that team working was well developed and this extended to support staff. A senior staff member told us, "We value everybody including the domestics and catering staff. One of the domestics comes to the ward meetings; if we are on a period of increased incidence, they are involved".

Seven-day services

- The management team described their approach to seven day services as "A constant work in progress."
- New medical admissions were seen every day on one of the twice daily post take ward rounds.
- Patients were not routinely seen and reviewed by a consultant at weekends in all specialities. For example, there was a cardiology consultant ward round every day, but no routine elderly care ward rounds at weekends.
- There was access to therapy and social care services seven days a week. However, the service at weekends was limited and focussed on assessments that enabled patients to be discharged.
- Endoscopy services were available seven days a week, but not on a 24 hour basis. There was a service four hours per Saturday and Sunday. If urgent endoscopy was required outside service areas there were arrangements with another NHS trust to provide this service.
- There was no interventional radiology service out of hours; however, we were told there were arrangements with other NHS Trusts for patients to be transferred should emergency interventional radiology be required.
- Ward doctors and staff told us that they could access most diagnostics seven days a week. MRI scanning was cited as a service where availability was more limited. This was seen as an issue as other imaging modalities could be utilised. We were told that there were no difficulties obtaining results of diagnostic investigations performed out of hours.

Access to information

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for patients. We were told that patients' old notes were retrieved from the hospital archives when required without delay.
- Ward staff explained the arrangements for ensuring that they received a handover for patients arriving on the ward from areas such as the Accident and Emergency Department that would enable their needs to be met and risks mitigated. However, staff on Ward 12 staff told us they did not receive a full report until the patient reached the ward. Staff reported that this meant that they couldn't plan care before the patient reached the ward, for example the siting of patients at risk of falls in a bed adjacent to the nursing station for better observation.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Training in the MCA and DoLS formed part of the mandatory training programme. 73.1% of staff in medical care services had completed this. 50.3% had completed training with regard to consent to care and treatment.

- Staff we spoke with were able to talk about their responsibilities under the mental Capacity Act. They could name the safeguarding matron who led on matters relating to the MCA and gave examples of how they use their expertise.
- We saw evidence that where required, formal best interests meeting were held to establish capacity and determine best interests in line with the Department of Health Code of Practice for the implementation of the MCA.
- Staff understood the concept of deprivation of liberties and could give examples of where the safeguards had been applied or considered.

Are medical care services caring?

Good ●

Overall we judged medical care services to be caring. People were treated with dignity and respect Care was delivered compassionately and that their privacy was preserved. Feedback from patients and their relatives told us they felt psychologically supported by hospital staff. They also told us that they felt involved in their care and were given adequate information about their care and treatment. Staff spent time talking to people, or those close to them.

Compassionate care

- Overall patients expressed a high level of satisfaction with the care and treatment provided when we spoke with them during our inspection. One patient said, “Care has been very good, very caring, they are nice people.” A relative told us “They are so kind and empathetic with what you are going through. We come in the evenings and stay late and they never make you feel you are in the way.
- During our inspection we observed that patients were treated with kindness and respect. Their privacy and dignity were maintained. Care interventions were carried out behind closed doors or curtains and staff asked before they entered. A physiotherapist told us, that the single rooms for patient privacy is good and they were spacious which is good for transfers and hoisting patients.
- Overall the feedback from patients we spoke with was positive and they told us they felt well cared for. A patient commented, “The care is good, the staff are all very caring. I had a shower this morning and I did not feel embarrassed.”
- At Tunbridge Wells Hospital, the results for the Friends and Family test average 74/100 in the period April 2013 – July 2014; better than the England average is 71.
- We looked at the results of Patient Led Assessments of the Care Environment (PLACE). Tunbridge Wells Hospital achieved a score of 77.4% for Privacy, Dignity and Well-being. The detailed reports for medical care services did not identify any concerns in this area.
- The trust patient satisfaction survey asks, “Where you given enough privacy when discussing your condition or treatment?” In the Directorate of Speciality and Elderly Medicine 97.5% of patients responded that they did.
- Medical care services reported there had been no breaches of guidance on mixed-sex accommodation since April 2014.

Understanding and involvement of patients and those close to them

- The Trust patient satisfaction survey asks, “Were you involved as much as you wanted to be in decisions about your care and treatment? In the Directorate of Speciality and Elderly medicine 87.5% of patients responded that they did.
- The Trust patient satisfaction survey asks, “Did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital” In the Directorate of Speciality and Elderly medicine 95.5% of patients responded that they did.
- In the National Diabetes In-patient Audit (NaDIA) 70.2% of patients reported that they felt able to take control of their diabetes care, which exceeds the England average of 54.7%.
- As part of the Trust patient satisfaction survey 72% of patients responded positively to the question “Did a member of staff tell you about medication side effects to watch for when you went home?” The performance target was 90%. However, staff told us that often patients completed the survey

before their discharge medications were available and that discussion about side-effects and medicines management were held in the discharge lounge once medicines were ready.

- Patients told us they were kept informed about their care and treatment. One said, “They answer all my needs, they answer my questions and show no impatience.”
- We found patient’s relatives were encouraged to support their loved ones. A patient relative said, "I have been here 10 hours a day and the staff have been very accommodating.” Another commented, “I am satisfied with the care. He’s kept clean and the food is nice. I am here up to five hours a day and they do tell me about his condition.”

Emotional support

- Patients told us they felt emotionally supported by the hospital staff. One said, “They can give you their feelings and say we are in this together and this helps.”
- The trust patient satisfaction survey asks, “Did your find someone on the hospital staff to talk about your worries and fears?” In the Directorate of Speciality and Elderly medicine 93% of patients responded that they did.
- Staff could refer patients to a mental health liaison service. We looked in a patient’s notes and saw that a referral had been made when they expressed suicidal thoughts as a result of their condition. We noted that the response was almost immediate and that an appropriate mental health assessment was performed.
- We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care and that these staff offered appropriate support to patients and their families in relation to their psychological needs.
- There was a hospital chaplaincy service and staff were aware of how to contact spiritual advisors from major world faiths in order to meet the spiritual needs of patients and their families. We saw records of daily visits by the chaplaincy service to the Stroke Rehabilitation Unit.

Are medical care services responsive?

Requires improvement

Overall we judged that the responsiveness of medical care services required improvement.

Staff met patients’ individual needs. They demonstrated awareness of people’s needs and could access specialist advice and equipment. We saw there was a focus on a dementia friendly care ethos and environment.

Medical services responded timely to comments and complaints and these were viewed as a valuable source of feedback and used to evaluate and improve care and treatment.

Although medical care services were meeting national targets in relation to access to care and treatment there was insufficient capacity in the service to ensure that patients received the right care in the right clinical area first time.

This meant that patients were cared for in non-speciality beds, were moved around the trust a number of times during their admission and that medical elective admissions were cancelled as a result of lack of capacity.

Patients were often taken to Maidstone General Hospital because there was insufficient space at Tunbridge Wells Hospital. During the unannounced inspection GP medical admissions were being diverted to Maidstone from Tunbridge Wells. Feedback from the public at listening events was that being required to travel to Maidstone due to capacity issues was not responsive to their needs. We were told by staff that divert arrangements were in place 50% of the time.

We found that there were insufficient arrangements to ensure that patients for whom English was not their first language were offered professional interpreting services when required.

Service planning and delivery to meet the needs of local people

- At the listening event, members of the public commented that they were often taken to Maidstone General Hospital because there was insufficient space at Tunbridge Wells Hospital. At our unannounced inspection we noted that there was a divert of GP medical admissions to Maidstone from Tunbridge Wells. The public felt that being required to travel to Maidstone due to capacity issues was not responsive to their needs. A junior doctor commented that this divert arrangement was in place, "About half the time."

- We saw that the Trust was promoting supported discharge arrangements for stroke patients so they could continue their rehabilitation at home. A staff member on the Acute Stroke Unit said, "We have effective working with MAT and close links with the Satellite Unit at Tonbridge Cottage Hospital, and, "As a team we involve the community team more which focusses on early discharge." Since April 2014 46.2% of stroke patients have been supported by and Early Supported Discharge Team."

Access and flow

- At Tunbridge Wells the average number of medical patients in non-speciality beds was 171 per month. During the period April – July 2014, three patients were moved more than four times for non-clinical reasons. This indicates that patients potentially did not always receive the right care in the right place the first time.
- We found that when demand for beds exceeded the available number, areas such as the cardiac catheter areas were used to provide additional capacity. Staff told us that this had resulted in patients having cardiac procedures cancelled as these beds were not available, or could not be adequately decontaminated quickly enough for their procedures to proceed safely. At Tunbridge Wells Hospital patients were cancelled in each of the five months April – October 2014. In May 2014, 12 patients were cancelled. This indicated that a lack of bed capacity was having a negative effect on bed availability for elective cardiac procedures.
- The overall bed occupancy rates exceeded the national benchmark of 85%. In the Directorate of Cancer and Haematology bed occupancy was 96.3% and 95.5% in the Directorate of Speciality and Elderly Medicine. Staff we spoke with reported feeling that there was constant pressure caused by bed shortages. This meant there was little flexibility to facilitate good bed management practices which culminated in the impacts described above.
- The overall length of stay was in line with England averages at Tunbridge Wells Hospital in medical care services in relation to non-elective admissions. However, we noted that for non-elective admissions the average length of stay was better, especially in the speciality of Geriatric Medicine.
- 57% of patients with a stroke were admitted to a specialist stroke unit within 4 hours against a target of 75%. Clinical staff cited lack of capacity as the main reason this was not achieved.
- All specialities with medical care services were meeting national standards for referral to treatment times.
- No patients were reported as waiting longer than six weeks for diagnostic tests in medical care services.
- In the Directorate of Speciality and Elderly Medicine delayed transfers of care represented 6.2% exceeding the target of 3.5%. Staff and managers told us that most delays were attributable to awaiting care home places, or other community based services.
- Staff described that recent organisational changes to community care managers employed by Kent County Council had exacerbated delays. However, they could describe how they had engaged with the council to improve matters and how things were changing as a result of those discussions.
- Medical handover arrangements ensured that medical patients in non-medical beds were reviewed in a timely way.

Meeting people's individual needs

- 88.4% of staff in medical care services had attended Equality and Diversity Training.
- We saw that patients with sensory impairments were identified through the use of a discrete magnetic sign to ensure staff could manage their communication.
- People living with dementia were identified by a discrete 'forget-me-not' sign so all staff would be aware of their special needs. We saw that 'This is me' documents produced by the Alzheimer's Society were used to ensure staff had access to a patient's biographical data so that it could inform their care plan.
- On Ward 20 we saw how the ward staff had obtained and used funding from the Dementia Challenge Fund to create a 'Dementia Café'. We saw this was a pleasant area situated away from the bustle of the ward where people with dementia their friends and families and could be together

in an environment that had been created especially to meet their needs.

- The ward managers we spoke with were unaware of any evaluation of their ward areas for dementia friendliness. However, ward staff we spoke with were able to discuss the principles as described in publications by the University of Sterling; for instance the use of coloured panels behind toilet seats to provide recommended colour contrast and we saw appropriate pictorial toilet signage in MAU. However, other elements such as the provision of way-finding landmarks, attention to polished floors and the disguising of staff areas had not been addressed. We noted the Trust action plan following the National Audit of Dementia care in General Hospitals contained no reference to environment.
- We saw that bathrooms and toilets were suitable for those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoist to enable staff to care for patients.
- Hospital mattresses provided protection from infection and pressure damage. Where the risk of pressure damage was particularly high, staff could access specialist dynamic mattresses to ensure patients' needs were met and they were protected.
- Ward staff explained to us how they could access specialist equipment for the treatment of bariatric patients.
- Interpreting services could be accessed via the hospital switchboard. However, members of staff that spoke another language were used rather than professional interpreters. They thought that these staff had undergone some system of checks to ensure they were competent to do so but could tell us any details. This meant the patients whose first language was not English were not provided with independent translation services whose quality could be assured.
- We did not see any patient literature displayed in languages other than English.

Learning from complaints and concerns

- In the directorate of Speciality and Elderly Medicine 85% of complaints were closed within the agreed date by the directorate.
- We observed that literature advising patients how to raise a concern or complaints was displayed in ward areas.
- We saw minutes of meetings, and displays in ward areas showing that complaints, their outcomes and lessons learned were discussed at ward level. The management team reviewed complaints, and their themes and trends as part of their governance meetings.

Are medical care services well-led?

Good

Staff were aware of the Trust and ward based vision and values and demonstrated these in their work. Ward areas had developed their own visions which were congruent with those of the organisation.

There were adequate governance arrangements in the directorates that provided medical care services and performance was monitored and managed. All staff and management teams were aware of the main concerns, challenges and areas for improvement in their directorates and were aware of development planned across the organisation.

Minutes of Directorate Board meetings demonstrated a robust governance framework. Directorate dashboards were maintained and these provided a range of key management and quality metrics that could be benchmarked against agreed performance targets.

Staff were supported to deliver high quality care. They were positive about their work and spoke well of the organisation and were fully engaged with its work and development.

Directorate managers and board members were recognised by ward based staff and told us that middle and senior managers visited ward areas.

We saw examples of innovative practice in the care of patients living with dementia on Ward 20.

Quality and safety issues were prioritised in the directorates.

There were no arrangements to ensure that efficiency gains made as part of the national Productive Ward initiative were sustained.

There were cost improvement plans but the impact of these had not been sufficiently assessed by the Directorate of Speciality and Elderly Medicine to give assurance that the cost improvement could be sustained while maintaining the same level of quality and safety. The management team confirmed that providing a safe service that met people's needs was a priority when there was conflict the cost improvement plan. However the cost improvement plan submitted to use by the directorate contained financial information only and lacked any impact assessment, or measures that might or would need to be taken to mitigate the cost improvement plan's influence of safety and quality.

Arrangements for monitoring a service level agreement with another Trust for support services at the Stroke Rehabilitation Unit were insufficiently robust.

Vision and strategy for this service

- The trust vison and values were prominently displayed in medical care services, and staff we spoke with were aware of these.
- We found that ward areas had developed their own visions which were congruent with those of the organisation. Staff spoke passionately about these visions and told us how they tried to make them part of their work.
- We noted that staff were engaged with the broader issues of the Trust and were aware of developments planned across the organisation. For instance they could discuss a never event that occurred in another directorate in relation how the lessons learned had resonance across services,

Governance, risk management and quality measurement

- We found that there were satisfactory governance systems in the directorates. We found that management teams were aware of the key challenges in their directorates. Similarly, staff on the wards knew their directorate's areas for improvement, for instance in falls management or improving stroke care.
- There was system of speciality governance meetings which fed into directorate meetings. These included a monthly half-day governance meeting where items discussed included complaints, serious incidents, audit results, new guidance and performance and Directorate Board meetings. We looked at minutes of these meetings and established they represented a robust governance framework.
- The directorates produced a quality and safety report which was reported through trust structures such as the Health and Safety Committee and Standards Committee to enable board level challenge and assurance.
- We saw directorate's dashboards were maintained and that these provided a range of key management and quality metrics that could be benchmarked against agreed performance targets.
- Performance information was displayed in ward areas in the form of 'How we are Doing' displays accessible to staff, patients and their families. Some ward managers displayed additional performance data. Staff we spoke with were aware of this data and took an interest in their team's performance.
- We saw that some events such as falls or C. Diff infection were assigned incidence thresholds. When these were reached the ward entered a period of focussed activities and enhanced monitoring of key metrics related to the issue. In this way medical care services intervened early when safety themes were emerging.
- At the Stroke Rehabilitation Unit we found support services were provided by another trust who owned the premises that hosted the ward. The ward manager could tell us how she informally monitored the Service Level Agreement (SLA), and gave examples of where they had identified shortfalls in service. However the directorate did not undertake any regular, formal monitoring of the agreement and its quality. We also learnt that the SLA had not been signed for this financial year. We saw an action plan that outlined progress on actions taken to address some of the failings identified locally. This meant that services supplied by a partner organisation were insufficiently monitored.

Leadership of service

- Staff we spoke with said they felt supported by the directorate management team and the board to deliver high quality care.

- Directorate managers and board members were recognised by ward based staff and told us that middle and senior managers visited ward areas.
- A physiotherapist told us, “I feel really supported. They are a good team of managers, I can talk to them about anything, and they are very accessible even though they have two sites.”
- A patient told us, “I think they are well-led. One of them was here and I said it was nice to be with someone who knows what they are doing.”
- However, we found one instance where a group of managers did not feel supported by their immediate line-manager.

Culture within the service

- We observed that staff spoke positively about their work colleagues and the organisation. Each person appreciated the contribution they made to the care of patients.
- We found that staff showed a keen interest in their work, and that of others and demonstrated a commitment to improving services.
- Staff sickness rates within the Directorate of Speciality and Elderly medicines were 4.1% exceeding the trust target of 3.3%.
- Staff turnover in the Directorate of Speciality and Elderly Medicine was 8.5% better than the trust target of 10.5%. These figures suggest a stable workforce.

Public and staff engagement

- Ward areas in medical care services operated a variety of models to ensure staff were kept informed of developments in their service. However, all the staff we spoke felt that whichever system was used, it was effective and met their needs.
- Junior staff told us they felt supported by their line managers. They phrase ’listened to’ was frequently used to describe how staff felt.

Innovation, improvement and sustainability

- We discussed the Directorate’s cost improvements plans. It became apparent these programmes may not be sustainable. However, this was because the management teams elected not to compromise aspects of safety and quality
- In the Directorate of Speciality and Elderly Medicine, the management team discussed how the cost improvement plan related to nursing staffing, but that providing a safe service that met people’s needs was a priority and when there was conflict the cost improvement plan became secondary. This had been confirmed with ward managers in our discussions relating to staffing. We examined the cost improvement plan submitted to use by the directorate. We noted that it contained financial information only and lacked any impact assessment, or measures that might or would need to be taken to mitigate the cost improvement plan’s influence of safety and quality.
- We saw evidence that ward teams had used the Department of health ‘Productive Wards’ programmes to promote efficient working practice in clinical areas. Whilst elements of the approach were evident, ward staff told us that the techniques and processes used as part of the programme had not been re-visited for at least two years. This meant that medical care services could not be sure that efficiency and quality gains resulting from the productive ward programme were sustained.
- We judged that that the development of the Dementia Café on Ward 20 to be innovative practice.

Surgery	Safe	Requires improvement	●

Effective	Requires improvement	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Requires improvement	●
Overall	Requires improvement	●

Information about the service

Tunbridge Wells Hospital provides a range of surgical services including emergency surgery, general surgery, ear nose and throat surgery and trauma and orthopaedics services. The hospital has 416 beds, all in single en-suite rooms. The surgical beds are distributed over four wards and a short stay surgical assessment unit.

The Surgical Assessment Unit (SAU) provided for patients admitted via their GPs and also took surgical admissions from the accident and emergency department. A daily consultant led clinic aimed to reduce hospital admission for many patients presenting with uncertain diagnosis. Co-located with the SAU is a Day Surgery Unit.

The Trust sits around the midway point for surgical activity when compared to other trusts across England with 40,565 surgical episodes reported in 2013/2014. At the Tunbridge Wells site, 46% of surgical episodes were day case surgery, 15% elective surgery and 39% emergency surgery.

We visited all ward areas where surgical patients were being cared for and the short stay surgical assessment unit to observe care and speak with staff and patients. We spent time observing clinical practice in the operating theatres, tracked patient care from admission to discharge and reviewed the medical records of 26 patients. We observed ward rounds and the handover of patient care from one area of the hospital to another.

We spoke with staff of all grades both individually and in groups. We also met with senior staff and managers responsible for surgical services across the trust. In total we spoke with over 60 members of staff involved in the provision of surgical services although as some of these were in focus group setting and some worked across both Trust sites, it was is possible to specify which site they worked on.

Surgical services at the Trust had been a concern following our last inspection of Maidstone Hospital in February 2014 but we did not inspect Tunbridge Wells Hospital at this time. Some of the issues where we found concerns related to the trust wide provision of surgical services, in particular how the Trust monitored the quality of the services provision. We issued a compliance action about this and asked the provider to submit an action plan detailing how they were going to respond to our concerns.

Summary of findings

Patients found the staff to be caring but improvements are required to ensure the service is safe, effective, and responsive. Improvements are required in the well led domain.

Whilst most people admitted to Tunbridge Wells Hospital were happy with the quality of care they received and patient outcomes were, generally, in line with national averages, there remained significant shortfalls in the way services were provided.

The Surgical Assessment Unit provided real benefits to patients and increased the effectiveness of surgical services at the Trust.

The operating theatre department was well managed and demonstrated improving efficiency and effectiveness. Patients received safe peri-operative care and all appropriate measures were taken to ensure optimal outcomes for during and immediately after their operation.

Where there were patients that were complimentary about the care they received there were others who reported negative experiences with the level of care they received.

The Trust had good resuscitation provision and staff understanding of the safeguarding policies was good. However, the level of falls seen and the impact of these on patient wellbeing were unacceptable. Falls prevention work was ongoing but had not been embedded in the surgical patient pathways.

Record keeping was poor; individual patient's records were disorganised and incomplete. Risk assessment and care planning for patients was not always adequate.

The Trust had reduced the number of hospital acquired infections and the latest recorded level showed performance below the national benchmark but there was still work to be done improving compliance with hand hygiene policies as this was well below the target of 100%.

Team working within the surgical directorate meant patients were not admitted under a named consultant and were frequently passed between teams. This resulted in a lack of continuity of care, indecisiveness over the plan of care and mixed messages to the patients.

High bed occupancy levels led to ineffectiveness in the service provision. Operations were frequently cancelled, patients experienced unexpected delays and were cared for in unsuitable environments.

Surgical patients were cared for on non-specialist wards and received sub-optimal care; this was of particular concern for patients with spinal problems. It also resulted in frequent transfers between sites for non-clinical reasons. There were concerns about 'out of hours transfers' and The Trust was unaware how frequently patients were being transferred between sites for non-clinical reasons.

There was a lack of access to a translation service with staff relying on relatives, sign language and staff who spoke another language.

Leadership was very variable. Some staff felt supported whilst others felt disempowered and "Cut adrift". Where we saw good leadership it was at a local ward or department level and reliant on the personalities and managerial skills of the individual. There was no sense that the staff working directly with patients understood what was happening at board level; the reverse was also true with little sense that the executive team and board really understood what was happening operationally across the Trust.

There was little evidence of effective trust wide learning from incidents and complaints.

Are surgery services safe? — Requires improvement

There was very limited learning from incidents. What learning there was appeared to be very localised and reliant on the quality of local managers. There was very limited dissemination and no drive of improvements through incident and complaint analysis and action planning. The action plans we saw in response to quite serious complaints and incidents were insufficiently robust to be effective.

Falls prevention work at the hospital was at an early stage with a clear strategy which had yet to embed in practice. More people were falling and sustaining injuries than was expected compared to other trusts nationally.

Infection rates across the Trust were falling consistently over time. The hospital was visibly clean with clear evidence that housekeeping arrangements and monitoring being good. However the Trust hand hygiene policy was not being adhered to by all staff. Trust wide audits showed poor levels of compliance and we observed some poor practice.

The surgical site infection rate following total hip replacement was worse than the national benchmark. The trust was completing a root cause analysis on each case which was shared with the surgeon concerned.

Record keeping was very poor with loose documents spilling out of files, no systematic order to any filing that had taken place and entries that did not comply with the guidance from professional bodies.

Resuscitation services were well managed and ensured that equipment was available and ready for use across the Trust. Staff participated in practice scenario's to ensure their skills were maintained. Adequate numbers of staff had completed advanced life support training, although the uptake of the mandatory Basic Life Support training was low.

Staff had a good awareness of the trust safeguarding policy and were able to give us examples of where they had raised concerns.

Incidents

- There were several incidents relating to retained maternity and gynaecology swabs and packs. We were shown that the World Health Organisation Surgical Safety checklist had been amended in light of these incidents to prevent recurrence. The action plan provided by the Trust confirmed that this was completed in June 2014. However, we also saw a recent incident report which related to a nerve block given to treat the wrong leg; this should be classified as a never event, based on the information that we saw. The reporting process is retrospective and we would not have expected this to have shown on the national reporting database at the time of the inspection. We would have expected the Trust to have robust systems in place to disseminate any learning from this incident across the Trust in a timely and responsive manner. We spoke with a senior nurse with responsibility for oversight of surgical services and were told that they were unaware of the incident.
- We looked at the records relating to the investigation and learning from an incident where a patient sustained a fractured hip after falling. They had also sustained a pressure wound following the fall. Given the trust was aware that there was a high incidence of falls in their hospitals, we would have expected a comprehensive analysis of the reasons for the incident occurring and a robust action plan to address any concerns raised. We would also have expected to see dissemination of learning across the Trust. The action plan provided to us was inadequate; it had no target date for completion of the suggested actions and insufficient detail to enable improvements in service delivery to be made. There was no evidence of learning from this incident. We shared the action plan with the Director of Nursing who agreed it was an inadequate response.
- The level of falls at Tunbridge Wells was highest in Trauma and Orthopaedics but the level in this speciality was significantly higher than would be expected with 175 recorded incidents against a plan of 84 for the current year.
- From talking with staff and looking at the dissemination of learning from incidents, it was clear that any learning and action following incidents was usually a local response. Staff had a good awareness of how and when to report incidents but there was a limited response and it appeared that some reports were filtered and dealt with by the directorate leaders.
- We saw a poster and spoke with staff who told us that some anaesthetists used an incident reporting system using a commercial survey provider that was not part of the Trust's reporting systems. We looked at this site and saw it was related more to the working hours and circumstances surrounding the incident than any details about the patients. It did raise concerns that there were two parallel systems in use and that information which should be used to improve the service was not being shared fully with all Trust personnel.
- We saw and heard evidence of better learning from incidents within the theatre teams. Any action required following reported incidents and key messages were disseminated across both sites and all theatre staff. This was due to strong local leadership and there was still limited learning outside of the theatres.

Safety thermometer

- The level of pressure damage experienced by patients at the Trust had fallen from a high in September/October 2013 to none reported in April 2014. The levels were seen to have risen subsequent to this period but the overall trend is a reduction from the preceding year.
- A similar pattern could be seen with high levels of falls reported in July 2013 and a subsequent reduction in incidence over several months. The level appeared to have increased in June and July

2014. The level of falls across the trust was above the national average for all acute trusts in England and the overall annual level for 2013/2014 was significantly higher than in 2012/2013 (46 reported incidents against 36 the previous year). Some staff spoken with perceived this as being due to having all single rooms at the Tunbridge Wells site but we noted the highest incidence reported by any ward was on a traditional open bayed ward at the Maidstone site.

- The Quality and Safety Committee Meeting Minutes dated July 2014 showed that there had been an increase in complaints about basic nursing care and reported concern about avoidable pressure ulcers and the level of falls sustained across the Trust. The minutes showed that the nursing key performance Indicators were met 50% of time against a target of 90%. This level of underperformance by nursing staff meant that patients were placed at risk of harm through inappropriate care planning and delivery.
- The safety thermometer showed the percentage of harm free care for the current year as an average of 96.9% with a range of 90.3% in April rising to 97.3% in June.
- The crude mortality figures for Trauma and Orthopaedics showed rates above the planned level for patients presenting with a fractured neck of femur. However supporting evidence provided showed that the Trust was providing treatment for an older cohort with significant co-morbidities. Patients aged over 90 years of age made up 29% of these admissions compared to 21.5% nationally. Similarly, 9.9% of patients with a fractured neck of femur were admitted from a nursing home compared to 7.4% nationally. These variations were sufficient to mitigate concerns about the crude mortality figure.
- The safety thermometer was visible across the hospital and prominently displayed on wards.

Cleanliness, infection control and hygiene

- The hospital appeared visibly clean. Public areas and individual rooms were clean. All staff seen were following the ‘Bare below the elbows’ policy.
- There were adequate supplies of hand gel and hand wash available in all areas of the hospital. People we spoke with reported that staff washed their hands prior to providing care. We did observe two junior doctors failing to wash their hands before or after examining a patient. The examination included removal of a surgical dressing and was observable because it was being conducted with the patient’s room door open. The doctor was resting the medical notes on the bed to write them.
- We also noticed another patient was sitting on an incontinence pad with their upper thighs exposed where the sheet covering them had slipped. A nurse saw us looking at the patient and adjusted the sheet to provide more cover; she did not wash her hands or use gel when she left the room.
- Hand washing audit reports demonstrated poor compliance with the Trust hand hygiene guidance.
- In the operating theatre we observed good infection prevention and control (IPC) practice. The theatre manager was the link person for IPC and had sight of housekeeping and cleaning audits carried out in the theatres. There was, however, no input from the IPC team in relation to environmental audits.
- In the operating theatre local audits were completed and showed good compliance with the hand hygiene policy.
- The Trust reported that their targeted action to improve the incidence of Clostridium difficile had been effective with a lower number of Clostridium difficile infections diagnosed than in the previous year. The reported level of 35 cases was below the maximum trajectory for the year of 42.
- Methicillin-resistant Staphylococcus aureus (MRSA) screening remained below the planned level with 96% of patients admitted for elective surgery being screened against a target of 100%. The screening rate for non-elective surgery had improved to 97% against a target of 100%.
- The surgical site infection (SSI) rate for Trauma and Orthopaedics was above the Clinical Commissioning Group (CCG) target with a rate of 126.15 per 10,000 compared to a target of 88.2. Overall, the incidence of surgical site infection for trauma and orthopaedic patients had fallen from the previous year’s level. This may have been, in part, because the surgical teams could not meet the recommendations for pre-warming of patients prior to their operation due to a lack of available beds.
- The data provided by the Trust relating to Surgical Site Infections following total hip replacement (THR) showed that the rate of SSI post THR was significantly above the national benchmark. In the period October 2013 to December 2013 the trust rate was 2.2% compared to a national benchmark figure of 0.5%. This rate had fallen and levelled out for the first two quarters of this year but

remained above the national rate. We were shown evidence that the Directorate had set up a task group chaired by the Trauma and Orthopaedics Clinical Director with representation from anaesthetic, microbiology, theatre staff and ward staff. An action plan had been created to attempt to reduce the level of SSI further. A Root Cause Investigation was completed on each SSI presenting and the findings shared with the individual consultant and Clinical Director. Wider dissemination of the findings might prove more effective.

- The rate of SSIs following knee replacement surgery increased from none in 2013 Quarter 1 to 1.5% at Tunbridge Wells Hospital (compared to a national benchmark of 0.5%) in 2013 Quarter 3. Indicative data for 2014 Quarter 1 showed the level appeared to have fallen to below the national benchmark. No explanation for the increased rate was given.
- A third party contractor managed the hospital maintenance and was able to demonstrate that effective systems for checking the water systems, plant and equipment were in place.

Environment and equipment

- Adult resuscitation services across the hospital were well managed. The resuscitation officer was clear about the provision and had a firm grasp of the service they led. Equipment was checked in accordance with the Trust protocols and any shortfalls that were identified were rectified in a timely manner. Staff knew where resuscitation equipment was kept and were aware of their responsibilities in relation to resuscitation attempts.
- We did not review the use of Do Not Attempt Cardiopulmonary Resuscitation forms in relation to surgical patients as this is reported under the End of Life care section of this report.
- The provider of the Private Finance Initiative that enabled the hospital to be built provided ongoing facilities and equipment management support as part of the contractual arrangements. Following reconfiguration of surgery at the Trust, a large amount of theatre equipment had been found that was not listed on the inventory. Some of this equipment had still not been Portable Appliance Testing (Pat) certified which meant it could not be deemed safe for use. A significant backlog had resulted in this equipment gradually being tested and listed but after nine months some was still outstanding.

Medicines

- The fridges in the operating theatres were checked daily and occasionally recorded as being warmer than eight degrees centigrade. There were no comments on the checklist that showed the problem had been reported or rectified.
- The controlled drugs registers on the wards and in the theatres were checked at each shift change.
- During a previous inspection concerns had been raised about drug cupboards being left unlocked and drugs being drawn up in advance of use. The Operating Department Clinical Governance Meeting Minutes dated October 2014 showed that full discussion and consideration had been given to the practice of leaving the theatre drug cupboard unlocked whilst a list was in progress. A risk assessment had been undertaken and it was felt that patient safety might be compromised if anaesthetists did not have immediate access to emergency drugs.

Records

- We reviewed 26 sets of notes from across the Trust. Some related to patients that had already been discharged and some belonging to current patients. We found that records were not well maintained. In general they were disorganised with muddled documents, many not fixed into the files. In one set of medical notes we could not find the operation notes although it was clear the patient had been to theatre.
- The format of the notes was disorganised with multidisciplinary surgical care pathways used for recording all care and intervention by staff. These records were incomplete and failed to give a comprehensive account of the care people received. There was also duplication of information in some cases. Trying to track the care a patient had received was very difficult.
- Not all records were completed in accordance with the standards set by the Royal Colleges. In general, junior doctors made the best records with their entries being legible, dated, signed and having a clarity that was missing from the entries made by many other staff. Specialist staff entries such as clinical nurse specialist input were also formatted and recorded correctly. Many other

entries we saw were not signed or dated, not written in black ink, illegible with numerous abbreviations and acronyms and no clear analysis or plan.

- Several nursing records that we looked at were inaccurate and incomplete. One person had no record of any pre-operative preparation or their returning to the ward from the operating theatre. We asked a ward manager about where we might find this record but they were not able to locate it.
- Poor record keeping was highlighted as a concern on the Trust risk Register.

Safeguarding

- Staff spoken to on the SAU had a sound understanding of their role and responsibilities in relation to safeguarding vulnerable adults. Staff we spoke with on the surgical wards were also able to demonstrate their knowledge and how they adhered to safeguarding policies in practice.
- In the operating theatres staff were made aware of their responsibilities in respect of safeguarding adults and children at a team meeting. Safeguarding champions, who had completed level three training, were identified.
- All staff were given a safeguarding information leaflet with the name of the safeguarding champions on it.

Mandatory training

- We asked for details of the mandatory training completed by staff but were told that the ward did not keep records. The ward manager was unclear who had completed any training. We were later supplied with ward level training records by the trust. These showed that the majority of staff had completed most mandatory training in areas such as infection prevention, information governance and control and patient handling. The completion rates for other areas of mandatory training were not as good with low levels of uptake of training in basic life support and venous thromboembolism. Few staff had completed the mandatory training on consent and capacity.
- Sepsis training was mandatory and since 2010, was required to be undertaken every 2 years; the level of training completion on surgical wards was low.
- The Trust risk Register had an entry opened in August 2014 that showed an internal audit had highlighted a failure to meet statutory and mandatory training targets.

Assessing and responding to patient risk

- A clinical audit report of non-gynaecological patients admitted to the gynaecology ward said that, "The review of post-operative vital signs and monitoring demonstrated a presumption by staff of a Trust policy on the topic that does not exist, along with varied perspectives and practices surrounding the care of patients as they return to the ward. Such inconsistent practice could lead to the deterioration of a patient following surgery that could be avoided with appropriate monitoring".
- The Surgical Directorate Report to the Quality and Safety Committee dated March 2014 raised concerns about the care of 'spinal outliers', people recovering from spinal injuries and surgery who were being cared for on wards where staff lacked the specialist knowledge to provide optimal care for them.
- On the short stay unit the pre-operative process required staff to memorise the patient's details. There was no paper record or patient slip and staff simply called for the patient by name. This gave room for error and delays and meant there was no handover about the particular needs, risks and preferences of the patients.
- In the operating theatres we saw that patients had completed risk assessments including for Venous Thromboembolism (blood clots in the deep veins of the limbs) Events (VTE). Patients were fitted with anti-embolism stockings and boots that provided intermittent pressure to the calves with a consequent improvement in venous return and reduced risk of clot formation.
- Warming blankets were being used in the operating theatre to maintain patient's body temperature and reduce the risk of post-operative infection. However, the Surgical Directorate Report to the Quality and Safety Committee dated March 2014 showed that both elective and non-elective patients who had a fractured neck of femur were not reaching the ward within an hour of admission and the Trust policy for fast track care for these patients was not being met due to a lack of bed capacity. This meant there was no opportunity to pre-warm these patients who were generally elderly and frail and more likely to have a reduced body temperature. This increased the risk of

post-operative infections.
- Staff in theatres used the WHO Surgical Safety checklist with adapted versions for maternity cases, ENT surgery and cataract surgery. Spot checks were carried out by the theatre manager to ensure compliance with the safety checking process. Use across the Trust had been variable and an action plan was created to address this dated September 2014. There was a target date of November 2014 for completion of Trust wide dissemination of learning.
- Delays in leaving the recovery area due to a lack of available beds meant the Trust enhanced recovery programme could not be followed.

Nursing staffing

- The operating theatres used a baseline tool developed by the Association of perioperative Practitioners (APP) and provided staff in accordance with this guidance. From the rotas we could see that there was a minimum of four staff available in theatre. There were four vacancies but these were filled on a temporary basis by the use of regular bank and agency staff. At the time of our visit, all eight theatres were in use; they appeared to be adequately staffed in accordance with the staffing plan.
- On the SAU the nursing staff was fully established, with no vacancies. This allowed three registered nurses and one clinical support worker during the day with two registered nurses and a clinical support worker at night. The unit was fully staffed seven days a week over the full year.
- The Day Surgery Unit had similar levels of staffing with three registered nurses and a clinical support worker on duty when the unit was open from 7.00am to 9.00pm Monday to Friday.
- One ward had four full time nursing staff vacancies which were covered using agency staff. The data we were provided with showed correlation between high levels of agency nurse use and increased incidents. We were assured that agency staff had been provided with induction training and support but did not see records of this.

Surgical staffing

- The Trauma and Orthopaedic directorate held consultant led handover meetings with junior and middle grade staff at 8.00am and 8.00pm every day of the year. All referrals, including those discharged home from the accident and emergency department, were discussed.
- In general surgery a 3 team rotating model was used with the acute team worked Monday to Friday and provided the on call cover from Friday to Monday. They saw all admissions. The two other teams were ward based. There were 12 consultants supporting the on call rota. Additionally, there were six registrars covering emergency surgery, wards, on call, night duty and the two teams.
- Several consultant surgeons talked to us about patients being handed from one team to another with a resultant lack of continuity of care. The job plans for surgeons in some specialities were team plans created since a review of Upper GI surgery by the Royal College of Surgeons (RCS) at Maidstone Hospital reported in December 2013. The report criticised the effectiveness of team working and lack of continuity of care. In a response to 'Future Forum phase two' the Royal College made clear that the expectation was that each patient should be admitted under the care of a named consultant. The response from the RCS made it clear that the expectation was that patients were seen before, operated on and reviewed post-operatively by their named consultant. This was not happening at Tunbridge Wells where team working was used.
- The ENT team had an on call consultant at all times.

Are surgery services effective?

Requires improvement

Trust performance when compared against other trusts in England was, generally around the mid-point. Most patients had positive outcomes and experiences but there remained significant scope for further improvement and development.

Poor Flow and a lack of beds across the hospital impacted on the Trauma and Orthopaedic team's ability to comply with the Trust Fast Track Policy for patients with a fractured neck of femur. The lack of protected elective beds meant that the surgeons could not admit patients to beds prior to their operation and could not pre-warm patients as part of the enhanced recovery programme.

Patients were admitted to the reception/waiting area before 7.00am for surgery later that day. This resulted in excessive fasting times, which increased the risk of complications postoperatively. The situation was addressed by intravenous fluids being given for even relatively short procedures.

Individual consultant performance monitoring and challenge was not well developed; team outcomes were reported but the governance processes did not provide robust assurance about the quality of individual practitioners work. Individual attendance at multidisciplinary meetings was monitored but there was no evidence that inconsistencies in attendances were discussed with individuals. It was seem as team representation at the meeting.

Staff reported good support for their learning and many told us about higher level courses they had completed that increased their knowledge and skills. Advanced practitioners were working in the SAU which improved flow, as did the nurse led discharge.

The theatre staff practice was good and there was clear evidence of plans for further improvements to improve patient care. The waiting and changing facilities did not meet the needs of pre-operative patients.

Evidence-based care and treatment

- At the time of the inspection the policies relating to care in the operating theatre were being revised in line with current professional body guidance. Protocols such as the anaesthetic machine checks were in line with the Association of Anaesthetists guidance. The swab count protocol for the Trust had recently been revised in line with the APP guidance.
- NICE clinical guidelines in respect of VTE assessment and prophylaxis (CG92), IPC (CG139) and pressure damage prevention (CG29) were being followed in the theatre department.
- Local audits were being undertaken and the results were shared amongst colleagues within the directorate. There was not much evidence of wider sharing and action plans that we saw were insufficiently robust to effect significant change.

Pain relief

- On the SAU and DSU pain scores were routinely recorded.
- People on the wards we visited said that their pain was well managed and that they were offered analgesia frequently. We saw some evidence in the nursing notes that pain levels had been assessed and analgesia offered but this was not routinely recorded. Pain assessment tools were incorporated into the surgical pathways but these were not always completed by ward staff.
- We did see significant input from the chronic and acute pain teams. It was clear from recordings in patient's notes that medical and nursing staff sought their advice routinely. We were also told that the pain team provided support to theatre staff and that there were link nurses who attended pain team meetings. There were two full time clinical nurse specialists providing pain advice across both sites.
- Staff working in the theatres and on some surgical wards had completed training in the management of epidural analgesia and patient controlled analgesia pumps. All patients with epidural analgesia in place were cared for on one ward where the staff were familiar with the medical devices and able to provide safe care to these patients.

Nutrition and hydration

- Not all patients had been assessed to determine their level of risk of malnutrition; some assessments were partially completed and a Body Mass index (BMI) had been calculated but this had not been used to inform the risk assessment. This was consistent with concerns raised by the Parliamentary and Health Service Ombudsman in September 2013 when they wrote to the trust commenting on poorly completed nutritional risk screening and management of hydration.
- Patients were admitted to a reception area between two surgical wards at 7.00am. They were advised to have a drink on waking but then had nothing further pre-operatively. The last patients went to theatre up to 4.30pm. This meant that some patients were without fluids for over ten hours. The RCN Perioperative fasting guidelines for adult and children report it is safe for adults to drink water up to two hours pre operatively. Nursing staff told us they contacted the anaesthetist, "If they

were worried" or if someone was particularly frail but that as the list was subject to changes and the order could be moved around they couldn't risk people drinking.
- In theatre we observed a patient was given replacement intravenous fluids during a short (40 minute) procedure.
- We saw that, post-operatively, people were encouraged to drink plenty on the wards. Water was provided and within reach; hot drinks were provided throughout the day.
- Patient's views on the food were very mixed. Some felt it was, "Quite reasonable for mass catering" and others that it was, "Ghastly". Most felt it was reasonable and that there were sufficient options available.

Patient outcomes

- Due to lack of availability of beds, the Trust had many patients accommodated on wards other than the speciality they were admitted to. Whilst these were mainly medical outliers on surgical wards, there were also surgical outliers on medical wards. This impacted upon the quality of care these patients received. A Clinical Audit Report which looked at the care of non-gynaecological patients admitted to the gynaecology ward. Stated, "There was a considerable lack of evidence to demonstrate the nursing care they (the patient's) were receiving. Many did not have nursing assessments carried out, nor individualised risk assessments, nor appropriately completed care plans". It concluded that, "Outliers on the ward are not managed as effectively as gynaecology patients and are therefore at risk of developing unnecessary issues and complications throughout their admission".
- The Royal College of Physicians (RCP) National Hip Fracture Database contacted the Trust in September 2014. They said that during an analysis carried out over three calendar years it was noted that Tunbridge Wells Hospital case mix adjusted 30 day mortality rate for 2013 was 10.4%, which was more than two standard deviations higher than the national average of 8.02%. The RCP did not consider that the deterioration in mortality figures warranted the Trust being identified in their report but felt that the situation needed further scrutiny. A working party was being set up to review the deaths that occurred in this cohort of patients and to reconsider the patient pathway. Indicative data provided by the Trust suggested the Trust averaged 12 month mortality rate had fallen to be in line with the national average in June 2014. The Trust average time to operation for patients presenting with a fractured neck of femur was consistently below the national average.
- The percentage of patients meeting the Best Practice Tariff (BTP) criteria was variable over the year preceding the inspection. The percentage of patients whose care met BPT ranged from 50% in August 2014 and 60% in March 2014 to 80% in April 2014. The time to operation also showed inconsistency over time with an indicative range of approximately 52% to 85%. The Trust suggested that the causality of the BTP attainment falling in March was due to the absence of one of the ortho-geriatricians. A later fall in performance in August 2014 was attributed to an unexplained rise in trauma work at that time. The trauma and orthopaedic directorate is hampered by a lack of bed space and poor patient flow that impact directly on patient outcomes by causing delays and a failure to follow the fast track pathway for patients with a fractured neck of femur.
- The hospital performance indicators showed low levels of patients having pre-operative assessment by an ortho-geriatrician. This was said to be included in the remit of the working party being set up to review the 30 day mortality rate.
- Whilst Patient Reported Outcome Measures (PROMs) scores were above the national average, the reported scores following knee replacement were below the national average. The Adjusted Health gain score using the Oxford Knee Score fell between the 95% and 99.8% of trusts control limit level. This meant the score for the Trust was amongst the lowest performing Trusts nationally. An audit of patients who had a worse than expected improvement following knee replacement was due to start shortly after the inspection visit. This was said to be considering any predisposing factors amongst the cohort but did not appear to include any failings in care and treatment provision. There was no suggestion that the review might consider what the one surgeon named as performing better than their peers was doing differently.
- All total hip, total knee, total shoulder, total ankle and total elbow replacements (and revision surgery) were recorded on the National Joint Registry.
- The length of stay for elective total hip replacements was 2 days and the average length of stay for a total knee replacement was 3 days. These figures compared well to the national benchmarks and were possible because of pre-operative preparation which included attendance at the hip and knee

schools managed by the physiotherapists and occupational therapists. Where patients experienced longer stays it was usually because of pre-existing co-morbidities.

- The assessment of compliance with national recommendations in the National Emergency Laparotomy presented at the Quality and Safety Committee in July 2014 showed said that whilst the Trust met many of the recommendations there was still work to be done to improve the service such that it became fully compliant. It said, “Our emergency teams are in the process of developing protocols for the management of acutely ill elderly surgical patients”. We spoke with both nursing and medical staff but they were unaware of the protocols. We asked the Trust to provide copies of the protocols but these were not provided. The assessment showed other areas where the Trust fell short of fully meeting the recommendations.
- The Standardises Relative Risk Readmission data provided by HES 2013/2014 showed that overall the readmission rates for patients having surgery at Tunbridge Wells Hospital was slightly below the expected level. There was some variation between specialities with ENT having notable more readmissions than both general surgery and trauma and orthopaedics. We were not shown any evidence that this inconsistency was being addressed.
- Performance in the national Bowel cancer Audit showed the trust was generally performing in line with expectations. The notable exceptions were in ensuring patients having major surgery had full data completion where the Trust scored only 46% compared to the benchmark of 79% and CT scans being reported where the Trust scored 63.5% compared to the benchmark of 89.1%. Improvements on the previous year’s results were demonstrated by increased MDT involvement (Trust score of 99% compared to a benchmark of 97.8%) and the involvement of a clinical nurse specialist (Trust score 99.4% compared to benchmark of 87.7%).

Competent staff

- Nurses working on the SAU had all completed training in patient assessment. The department lead and nurse practitioner had completed advanced training.
- Nurse led discharge was well established in the DSU.
- Staff education was valued by the Trust and staff reported that they were encouraged to gain additional qualifications that supported their work.
- Most staff reported having annual appraisals. The data provided by the Trust supported this although as it was collated from April through to March each year, it looked as if the levels for this year were lower than they actually were.
- Comparative data held on individual surgeons was difficult to evaluate as the majority of surgeons worked in teams as opposed to holding individual accountability for their patients. The Trust website had a link to the NHS Choices website but no specific details of individual performance were yet available. We were provided with the data the Trust used for monitoring the performance of Upper GI surgeons but this was not broken done to individual surgeons’ performance despite serious concerns having been raised previously about their performance. Culturally, the Trust did not appear to confront poor performance amongst consultants directly but found a way to work around problems. We were told by the clinical lead that they asked consultants who were “affable” and “amenable” to do the difficult aspects of the teams work rather than confront the behaviour of other consultants.

Multidisciplinary working

- We observed good multidisciplinary working from the SAU and DSU. Staff on these units worked with theatre staff and a range of surgical teams to ensure good outcomes for patients. We also observed good relationship with local GPs.
- We also saw evidence of collaborative working with specialist tertiary centres. On an observed ward round a patient had fallen and sustained multiple injuries including a head and neck injury. The orthopaedic surgeon took time to explain clearly to the patient about the need for specialist staff from another hospital to review their scans and provide advice on their clinical management. The consultant followed this up in discussion with junior and middle grade medical staff to ensure they were clear what was being asked of the tertiary unit.
- We saw that physiotherapy and occupational therapy staff were based in a satellite unit just off the main trauma and orthopaedic ward. This enabled staff from these departments to provide ongoing support to the patients and ward staff.
- Attendance at multidisciplinary team meetings by surgeons was generally good. We were provided

with a record of attendance at all tumour group MDMs across the Trust. For a nine week period between 1 April 2014 and 1 June 2014 the record showed that all head and neck surgeons attended the MDT meetings regularly. The attendance by lower gastrointestinal (GI) surgeons was more variable; some weeks there was no representation of the surgical team at the lower GI MDT meeting. Similarly, the attendance of urology consultants was also very variable with four surgeons attending some weeks and no representation at other times. The records demonstrated that one urologist attended MDT meetings twice as frequently as their colleagues.

Seven-day services

- Emergency surgery was provided at all times, dependent on need. Two consultant emergency surgeons supported this work.
- Trauma and orthopaedic surgery also took place over seven days. Radiology was booked when weekend lists were running. Two full time trauma co-ordinators were employed to manage patients waiting at home for admission for planned trauma surgery. They also managed the ortho-geriatric pathway.
- The on-call trauma and orthopaedic consultant was present in the hospital from 8.00am to 8.30pm every day.
- At night there was one senior house officer, one registrar and one foundation year1 (FY1) doctor on site. There was an additional registrar to cover emergency surgery and an additional FY1 working a twilight shift. A consultant surgeon was available, on call, at all times.
- Pharmacy provided a daily service, including on Saturdays. Outside of the usual working hours there was an on call pharmacist, if necessary.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to online training in the Mental Capacity Act 2005, the MCA Deprivation of Liberty Safeguards and had been given hand outs to support their understanding of this legislation. At the time of the inspection 65% of theatre staff had completed the training but this figure was calculated from April to March, so the level was not unreasonable.
- The Trust Risk Register showed an entry opened in spring 2014 following an audit of compliance with the Mental Capacity Act 2005, carried out across both sites. The results of the audit showed that practitioners were not implementing the MCA policy into their practice. Tools for assessment were not being used. Medical records reviewed during our inspection visit showed that capacity assessments were not being routinely carried out and record keeping in relation to best interest decisions and the involvement of family members was generally poor.
- For trauma and orthopaedic surgery the patient consent rate was 98% in both 2012 and 2013, which compared favourably with the national patient consent rate of 91.5% (2013).
- Guidance and a flow chart were in place to support staff where patients declined treatment with blood components. It provided a simple decision making algorithm that considered whether the patient had written and signed an advanced directive to refuse treatment.
- Consent forms seen were generally well completed. Patients assured us they had been given full explanations about the risks and benefits of surgery. They said they had the opportunity to ask questions.
- Consent was checked several times on the day of surgery as part of the WHO Surgical Safety Checklist process. Audits of the WHO checklist showed improving levels of use across the Trust.

Are surgery services caring?

Good

Patients reported receiving very kind and attentive care. One patient described a clinical support worker staying beyond their shift to provide support and reassurance to another patient who was very frightened and who had been admitted for emergency surgery**.** All the patients and relatives that we spoke with assured us that the staff, particularly the nursing staff were always gentle and provided sufficient assistance.

Staff we spoke with told us they would be very happy for their relatives to be cared for at the hospital. One nurse said, “I love working here, we all do and that affects the way we look after patients. A happy nurse means happy patients”.

Nurses assisting patients in the immediate pre-operative period were less caring because the process and facilities meant they had to rush patients through, just as they were at their most anxious.

The Family and Friends test for the hospital overall scored above the national average but there were areas of inconsistency with some surgical wards scoring very poorly at times.

Compassionate care

- Staff we observed were, generally, kind and attentive to patients. We saw a senior nurse offering assistance to visitors in a public area of the hospital and offering to show them where to go. We heard from patients that nurses were, “Kindness itself”. Relatives who were visiting one patient told us they were really pleased with the care their elderly parent had received. They said, “It is hard to believe this is and NHS hospital after all you read in the papers. It is first class healthcare and we should treasure it”.
- Call bells were heard to be answered reasonably promptly and patients reported this was usually the case.
- We spoke with one patient who told us they had been admitted as an emergency after a fall to the SAU. They told us they were very happy with the quality of care they received and loved having a single room as they had privacy, their own toilet and shower and it was fairly quiet at night. They told us they had spent time watching staff in the accident and emergency department and on the SAU dealing with very elderly frail and confused patients. They said, “You might think when the inspectors aren’t here things are different. Of course, they put up posters and make sure there are no coffee cups lying around, you’d expect that, but the kindness and care hasn’t changed. Everyone, and I mean everyone, is gentle and patient with those who are more vulnerable.”
- Whilst observing how patients were prepared for theatre we saw that despite a long wait in the reception area, they were rushed by staff at the last minute because the arrangements for them to change were inadequate. We saw one very nervous patient being rushed through the reception process and becoming increasingly nervous because of this. The theatre practitioner failed to listen to the patient and kept saying they would give them a blanket if they were cold. No attempt was made to address the patient’s anxieties. At the beginning of the procedure the patient’s blood pressure had increased and the anaesthetist had to give the patient a drug to help them relax.
- The Families and Friends test scored particularly well on the SAU with a 98% positive response. On the surgical wards the responses were inconsistent. We did not see any evidence that the inconsistencies were addressed and were repeatedly assured that the hospital scored well on the Family and Friends Test – which it did overall.

Understanding and involvement of patients and those close to them

- Junior doctors that we spoke with were unaware of their statutory duty of candour. The introduction of the Duty of Candour was recognised as an issue by the Trust on their Risk Register and a plan was in place to heighten awareness.
- People we spoke with felt that they had received very good explanations of the treatment and care plans from the surgical teams. When we asked them to tell us what the plans were they were less clear. We saw on a ward round that the consultant orthopaedic surgeon gave time for questions and answered them in a way that was understood by the patients.
- We spoke with two relatives who told us they had been impressed with the level of communication provided by the staff. They said they had missed the ward round due to work commitments but that the doctor had returned later to ensure they understood what the plan was for their mother’s care.
- Another patient we spoke with was uncertain whether they were awaiting an operation or were going home. They were not confused; the plan had not been made clear as there was an issue around retaining the bed.
- There were leaflets all wards that we visited that provided additional information to support what staff had told patients.

Emotional support

- Clinical nurse specialists worked closely with the wider multidisciplinary teams to ensure optimal support for patients and their families.

Are surgery services responsive?	Requires improvement ●

Capacity to cope with the number of patients being admitted led to significant shortfalls in the responsiveness of the service. Patients operations were cancelled after they had arrived at the hospital for their surgery; delays were frequent and there were excessive waits in the accident and emergency department when patients should have been moved to a ward. There were also post-operative delays in finding space on the wards for patients; they had been taken to theatre before a bed was available for them, delays in moving or discharging other patients resulted in a backlog in the recovery area. There were times when patients were cared for in recovery overnight. Bed occupancy was at a level that exceeded the Royal College of Surgeons recommendation. The bed escalation policy had become a ‘business as usual’ situation.

Whilst some of the capacity problems may have been due to patients awaiting care home or community hospital beds, there were also significant impact from patients remaining in hospital to protect the bed and an over cautious attitude to discharging well, relatively young patients. Patients were told they could, “Go home when they are happy”. We saw several patients’ records which said they were fit to go home following a consultant ward round but who were still there several days later.

The Surgical Assessment Unit was one of only three similar units in the country. It demonstrated safe and effective practice and was well supported by two emergency surgery consultants. There were clear operational policies and a strong understanding of how the unit improved patient outcomes.

The operating theatre team had begun to look at the causality of operating list and patient delays and develop ways of improving the timeliness of surgical list commencement and efficiency of the theatres. A golden patient system had been introduced to ensure the first patient was prepared and ready for their surgery on time. A spreadsheet of the reasons for any delay in the start time with surgeon and anaesthetist arrival times recorded had resulted in surgeons with a tendency to tardiness arriving more promptly more often.

Translation services were inadequate and failed to meet the needs of people who had limited ability to understand or speak English. Staff told us they used relatives and sign language to communicate; this was insufficient to ensure that patients understood what was being discussed and were in a position to give informed consent.

Falls prevention work had been strengthened and the Trust was making progress with falls reduction strategy but this was still very much a work in progress. The level of falls remained higher than expected but was reducing. There was a need for the falls prevention processes to be embedded in everyday care practice, with staff routinely assessing falls risk and taking mitigating action to reduce the incidence.

We saw very limited and localised learning from complaints. There were delays in responding to complainants and a tendency towards a dismissive response. Since the Parliamentary and Health Service Ombudsman had made recommendations about complaint management at the Trust, improvements were being made.

Service planning and delivery to meet the needs of local people

Access and flow

- Bed occupancy was said by the Trust to be over 90%. Data we hold suggests that for quarter three 2013/2014 the level was 95.6% and for quarter one 2014/2015 it was 93.9%. NHS England statistics show the national bed occupancy for general and acute hospital beds averaged 89.5% for Q4 and 88.1% for Q1. The Trust was running at above the national average occupancy levels and this had a significant impact on patient flow and outcomes. Several consultant surgeons told us the trust had, in practice, occupancy levels above 100% which resulted in patient’s operations being cancelled after they had arrived at the hospital. One consultant described the situation as, “patients having to bunny hop between beds and sites”.

- We were also told by a number of doctors and nurses that patients were operated on when no bed was available for them post operatively. We heard that patients were kept excessive times in the recovery area when there was no space on the wards. This was an inappropriate place to care for patients after the immediate post-operative period as there was not ready access to toilets, catering facilities and single sex accommodation. It also meant that there were either too many patients being cared for in a limited space or that other operations were delayed until there was more room in recovery.
- We were also told that there were no dedicated beds for people being admitted for elective surgery. Beds intended for elective orthopaedic patients were taken by medical and surgical outliers which resulted in patients operations being cancelled. We were told by numerous people that this happened, “Quite often”.
- In the SAU nurses undertook telephone triage of GP calls. There were advanced practitioners employed who helped ensure patients received appropriate assessment and treatment in a timely manner.
- The trauma theatre team had developed an initiative called the, ‘Golden Patient’. A specific patient from the operating list was identified at a meeting on the evening prior to surgery. This was usually a relatively well patient having uncomplicated surgery. The patient was prepared and ready for an 8.30am start in the operating theatre which reduced delays and allowed staff to prepare for other cases once the first patient was on the operating table. This facilitated the smooth running of the list.
- The process of collecting and assisting patients from the Short Stay Surgery unit to prepare for theatre was ineffective and resulted in long waits followed by rushing the patients through changing and immediate pre-operative preparation. It also resulted in delays to the theatre lists when patients were not ready on time for the start of their operation.
- One person, writing on the NHS Choices website said, “My mum went in for a replacement hip operation, the letter said arrive at 7.30am. Coming from outside the area, we arrived at 6.50am. All her observations were done very professional by 9.30am. Then came the wait... everyone else went in, finally at 3pm one of the surgical team arrived, my sister and I let out a cheer hurrah!!!” The facilities for waiting patients and their families were uncomfortable, with rows of hard chairs fixed together with no space between them. The waiting area was also the reception area to the wards on that floor. There was a television but to have the volume set such that the people using the room could hear it would have been very intrusive on other people who preferred not to watch television.
- Staff told us that the reason for many beds being unavailable and the excessive lengths of stay for patients was mainly because the local authority was slow to arrange the necessary care packages in a timely manner. Whilst this may be true of many patients, there were also clear examples of inappropriate admissions for procedures that could have been treated by most GPs, delays in discharging well, younger, patients and patients being told to stay in their bed and not to go home between two operations as they would, ‘lose’ their space. This bed holding culture contributed towards high occupancy rates and a lack of beds when they were most needed. It is not acceptable to hold patients in recovery when people who are well are occupying the bed they need for fear another bed may not be made available at a later date.
- The lack of capacity caused backlogs in other areas of the hospital and had a negative impact on patient care. We were told that there was a, “Very big problem” with patients often being nursed on trollies in the accident and emergency department instead of being moved to wards. We saw two patients who had been accepted for admission by the trauma and orthopaedic team. The decisions to admit then had been made at 2.45pm and 3.50pm respectively but both were still on trolleys in the accident and emergency department at 7.00pm, having been there for approximately eight hours.
- The reason no bed was available was apparently because a ward patient was awaiting transport but this had been delayed. Ward staff were reluctant to move the patient to the discharge lounge as they as they had been nursed for eight hours in the theatre recovery following elective surgery the previous day.
- During the period April 2014 to September 2014 the Day Surgery Unit was used to accommodate patients overnight on 82 occasions. This worked out at approximately 45% of the time and was a business as usual situation rather than an escalation response.
- Data provided by NHS England that relates to cancelled operations was confusing. It showed that

the Trust had reported 0 operations cancelled where the patient had not been treated within 28 days for the period April 2011 to June 2014. Alongside this information is data presented as a percentage rather than absolute figures that showed that between 3 and 6% of patients had their operations cancelled and were not treated within 28 days over the same period.

Meeting people's individual needs

- We were told that the Trust had a strong focus on falls prevention. Patients assessed as being at increased risk of falling were provided with wristbands to alert staff. We were also told the ward staff used pressure mats to warn them when a person prone to falling tried to move unassisted. We were also told about very low beds to reduce the risk and height from which a person might fall. We asked to see these in use on an orthopaedic ward but were told there were no patients with them. We did see the wristbands and noticed the non-slip socks that had been provided to patients at risk of falling.
- The Trust Risk register had an entry opened in August 2014 that showed there was a lack of easy read information across key areas of the Trust. Written information was not provided in a way that was accessible for people with learning difficulties.
- Availability of translation services was limited. Staff we spoke with were uncertain about the arrangements and told us that they relied on relatives and other members of staff who spoke languages other than English. One senior nurse told us. "We usually manage to get by with simple instructions and sign language. We don't have many people needing interpreting so it's not really a problem". This meant that the few patients who did have a limited understanding of English might not fully understood any discussions about their care and treatment. It would also have been difficult for them to give properly informed consent.
- A complaint received by the Trust in September 2014 showed that a patient felt vulnerable and isolated because of a language barrier.
- The only complaint made by people we spoke with was about the lack of wireless internet access. They said they felt, "cut off from the outside world".
- The waiting and changing areas for people admitted for elective surgery did not meet people's needs. People were asked to attend at 7am and were then required to wait in a communal reception area outside the wards. The area was stark and uncomfortable.
- People we spoke with liked the single rooms and felt it made their hospital stay more comfortable. They had control over the room temperature as there were windows that opened, they were not disturbed by other patient's behaviour and they were able to have visitors without fear of disturbing others. People also felt that they were afforded greater privacy and could have discussions with staff without being overheard.

Learning from complaints and concerns

- During the period August 2013 to July 2014 the Parliamentary and Health Service Ombudsman (PHSO) received 75 enquiries about the Trust. The PHSO accepted 12 complaints for investigation and made formal recommendations to the Trust because of concerns identified in the handling of complaints.
- Concerns included delays in responding to concerns and poorly managed local resolution meetings. At the time of the inspection it was noted that delays in responding to complaints continued.
- We looked at the reports of investigations carried out into three complaints about surgical services at the Trust. One complainant made repeated contact asking for a response from the Trust but kept getting a standard and inadequate reply about the investigation being ongoing and a response being sent as soon as possible. The delays were compounded by lost emails. There is also an email from another Trust that made it clear a similar concern about prescribing opiates by staff at Maidstone and Tunbridge Wells NHS Trust had resulted in a patient dying, resulting in a coroners hearing. The email said "It is perhaps unfortunate that it is only now that the MTW guidelines are being reviewed". The investigation into the complaint was insufficiently honest and robust and left many unanswered questions – which the complainant then asked, received no further clarification and went to the PHSO. Not only was there inability to communicate openly and honestly with the relative but there was a degree of dismissiveness of the original concerns. We saw the action plan

from this complaint. There were three vague actions without start or completion dates and no evidence to support progression or completion. We gave the Director of Nursing the opportunity to provide us with a more comprehensive response but none was available; they were unsurprised at the lack of rigour in the process. There was no organisational learning.

Are surgery services well-led?

Requires improvement ●

The Trust presented a clear vision but this was not understood by all staff. Many staff told us that the posters and other supporting documents to make the vision more visible were only introduced very recently.

When asked, staff were unable to tell us what PRIDE (the Trust vision statement) meant. We were shown postcards produced to spread the message across the hospitals. Staff told us they had not seen them prior to the day of the inspection.

Learning from complaints and incidents was very limited. The system resulted in local management of incidents and learning kept within the immediate team where it had happened. There was a lack of ownership by the executive team for service delivery and quality

Some consultants were very happy with the configuration of the service, the support they received from the Trust and their work environment. Others were deeply unhappy, and felt they were not listened to and that their concerns about the safety of patients were dismissed.

Underperformance was managed through workarounds that failed to address the root cause of problems.

A strong team of band 7 nurses were said to be supportive and approachable. They were clearly visible on the wards and departments and knew their staff well. We saw some very good examples of local leadership in the SAU and in theatres.

External relationships appeared good; we received positive comments about the open culture and commitment to improvement from a number of stakeholders.

Vision and strategy for this service

- Staff were wearing badges and we saw posters relating to the trust new vision. PRIDE – Patient First, Respect, Innovation, Delivery, and Excellence – was the message being passed out from the executive team across the Trust. Many staff were unaware of the message; others had only heard of it very recently. More work was needed to ensure the trust vision was fully embedded.
- The Trust was developing their five year strategy with a public consultation accessible via their website.
- Many staff had accepted the reconfiguration of surgical services across the Trust but a significant number, particularly doctors had not.

Governance, risk management and quality measurement

- In the operating theatres there were bi-monthly Theatre Governance Meetings. Minutes were provided for the October meeting which demonstrated that the Operating Department gave due consideration to the monitoring of practice and risks. Action plans were created where shortfalls were identified. The surgical directorate held monthly meetings but we were not given any evidence of outputs from these meetings.
- We were provided with the results of spot check audits of WHO Surgical Safety Checklist use across all theatres at the hospital. The audits were carried out by band 7 nurses who recorded use of the checklist rather than undertaking a qualitative review of how the checklist was being completed. In October 2013 the level of compliance was variable across the eight theatres with three scoring a low 92%. The audit showed improvement over time with the most recent results for August 2014 showing the lowest level of use had improved to 98% and three theatres scored 100%. This demonstrated a commitment by the band 7 nurses to improving patient safety through sound governance.
- The Upper GI surgery service at Maidstone Hospital which was criticised in the RCS report of December 2013 was stopped at the Trust. All surgery for upper GI malignancy was transferred to London. We asked for assurance that this group of surgeons were performing safely when

undertaking surgery for benign conditions. We were provided with a spreadsheet with the Trust that showed the 30 day mortality, length of stay and readmission rates for benign upper GI surgery. It gave very little information although we noted the 30 day mortality rate for hernia repair had doubled between 2012/13 and 2013/2024. The numbers involved were very small with a cohort of 417 and 398 patients respectively, meaning the actual number of deaths was very low. There was no analysis of this information and no information to determine whether the deaths were related to surgery or to other causes.

- Following criticism of the very limited time given to Quality and Safety Committee in our report of Maidstone hospital inspection in February 2014, a 'Deep Dive' review was held after each meeting which focussed on a particular aspect of the Trust work where there were concerns. The first 'Deep Dive' looked back at the RCS report into Upper GI Surgery. Whilst the increased focus on areas of concern was welcomed the minutes of the meeting showed that the time was spent going over old ground rather than looking at ways the service could be improved and the learning that should have come from the report.

Leadership of service

- We saw several examples of strong local leadership from individual managers. The SAU was particularly well led at Tunbridge Wells Hospital. The operating theatre manager also provided good leadership. They were aware of the improvements they felt could be made to theatre practice and had a clear plan that they were working through.
- Some surgeons that we spoke with voiced concerns about the effectiveness of their clinical leadership. They described a situation where the Medical Director issued instructions rather than engaging with them.
- The Clinical lead for surgery had only been in post two months which was insufficient time to assess their impact. The current post holder was full time and had additional administrative support so had capacity to bring about service improvements.
- We visited one ward and spent 25 minutes trying to find the person in charge of the ward, because the ward manager had gone to a focus group. It remained unclear who had been in charge of the ward during that time.

Culture within the service

- When we met groups of staff they were positive about their work and the trust. They told us the Trust had changed and was now more receptive to staff opinion. However we heard a different story when we met with staff individually and in smaller groups. A significant number of staff of all grades from a band 6 nurse to consultant surgeons told us they felt they voices were not heard. One person said, "They are listening, or at least pretending to listen, but they are not hearing".
- The trust executive representatives told us that they were an open and transparent organisation that engaged well with the staff. This is not what we found in practice. We found that two years ago a group of consultant surgeons had written to the Chief Executive Officer (CEO) raising concerns about the safety of surgical services provided across two sites and asking for a fuller options appraisal. In a meeting between the Trust and the group of surgeons, promises were made to involve them in changes and to consider wider options for reconfiguration as they had asked. Subsequently they were told, "It's not going to happen". The meeting record supported the surgeon's view that they had been promised involvement and a wider consideration of their concerns. Surgeons we spoke with felt their concerns and ideas had been placed in the, "Too difficult" category and simply laid to one side.
- The report following a review of Upper GI surgery at Maidstone hospital in December 2013 pointed out that problem within the speciality had been identified by various staff, "years ahead" of a number of deaths forcing the Trust to respond. Numerous staff had raised concerns about poor outcomes and inappropriate behaviours that had been dismissed at the time. This should have given the Trust a clear message about hearing their staff. There appeared to be a similar dismissal of the consultant surgeon's ongoing concerns. We were told that some of the consultants had raised the concerns with the Medical Director two weeks prior to the inspection but had been brushed aside. Some consultants that we spoke with voiced concerns that the two site working and team job planning hid a lack of consultant input.
- We also heard from a ward manager that they had raised concerns numerous times about patients

being cared for inappropriate environments, being held excessive time in recover and even being cared for in their bed in the reception area of the ward or the corridor. We did not see and could not corroborate this during the visit but heard similar anecdotal accounts when we met with a group of nurses.

Public and staff engagement

- Staff in the operating theatres were very positive about the level of support they received locally.
- Other staff told us that they felt engagement was, “Tokenistic” and that their voices were not being heard. There was a common perception that decisions were made before consultation took place.

Critical care

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

Information about the service

The Intensive Care Unit (ICU) at Tunbridge Wells Hospital, part of Maidstone and Tunbridge NHS Trust offers care to level 2 & level 3 critically ill patients, who require either organ support or closer monitoring in the immediate post-operative period. The unit has a sister Intensive Care Unit (ICU) at Maidstone Hospital, fifteen miles away, and shared, for example the unit Matron and Consultants.

The unit admitted approximately 500 patients a year and cares for patients aged from 18 years upwards.

The unit has 9 beds which were all commissioned and open at the time of the inspection. Most of the patients were admitted following major surgery; however, the ICU also accepted both medical and surgical admissions from A&E. The unit is staffed to provide Level 3 care, that is for patients who are critically ill and require one-to-one nursing support, for example patients requiring mechanical ventilation and level 2 patients, with a ratio of 1 nurse to 2 patients.

There were two level 2 beds in the maternity unit. These were for women who required close monitoring/observation either pre or post-delivery. Specially trained midwives cared for these women. If a woman required level 3 care, they would be transferred to the ICU.

The outreach team provides support for deteriorating patients located on the wards; this is a day time service only.

The ICU has Consultant cover 24 hours a day seven days a week. There was always a junior doctor present in the ICU. However, the consultants who were on call at night and weekends, although were Consultant Anaesthetists were not always Consultants who specialised in intensive care. As a consequence, at weekends and at night, the on-call ICU Consultant is shared between the Trust's two ICUs, Tunbridge Wells and the ICU in Maidstone, fifteen miles away.

As part of our inspection we spoke with 25 staff, 2 patients and 2 relatives. We spoke with a range of staff including nursing staff, junior and senior doctors, a physiotherapist and managers. We observed care and the treatment patients were receiving and viewed all of or part of 10 care records. We sought feedback from staff and patients at our focus groups and listening events.

Summary of findings

Staff were caring but improvements are required to make the service safe, effective, responsive and well led.

There were no apparent admission guidelines in use to show the criteria for admission to the ICU and we observed a lack of direct supervision of Level 3 patients.

Medicines management systems were safe.

The unit was clean but patients that were being isolated because of an infection had their room doors left open.

Governance systems were inadequate, for example at mortality and morbidity meetings, not all deaths were discussed and there was no record of the meetings that had taken place.

Improvements were required to ensure that all incidents were reported through the same Trust wide system and were acted on promptly.

Although the ICU was obtaining mostly good quality outcomes, there was some lack of compliance with national guidelines. For example, at weekends, there was only one ICU Consultant led ward round per day and the consultants were often more than 30 minutes away as they were shared between the Trust's two ICUs. The two hospitals were 15 miles apart.

Staff cared for patients in a compassionate manner with dignity and respect. Both patients and their relatives were very satisfied with the care provided. However, patients who were ready to be discharged to a ward environment were often delayed for up to a week due to lack of ward beds and in many instances were discharged home directly from the ICU. There were inadequate facilities for these patients. The patients were nursed in single rooms but there were no en-suite facilities or separate male/female toilet or bathroom facilities.

Improvements were required to the leadership of the ITU to ensure that the national best practice guidelines were followed.

Are critical care services safe?	Requires improvement ●

Although there were effective arrangements for reporting safety incidents, the systems for following them up and learning were limited.

The Critical Care Unit at Tunbridge Wells Hospital was clean. There were systems in place to ensure the cleanliness of the critical care unit and to reduce the risk of infection for patients.

Risks were assessed and monitored and appropriate action taken in response to changes in risk levels. This included individual patient risks, such as the risk of sepsis or pressure ulcers, as well as other risks, such as staffing levels. However, we directly observed three level three patients left unsupervised during our inspection with staff relying on monitors to sound an alarm should any body system fall out of set parameters. Furthermore, nursing staff observed patients outside the individual rooms and it took some time for them to respond to patients needs as protective equipment was required to be put on. There were plans in place to manage and mitigate foreseeable risks, including major incidents.

Generally nursing staffing levels were in line with the 'Core Standards for Intensive Care Units'. However, medical staff worked one day at a time, rather than the recommended 4-5 in a row, which adversely affected continuity of care. At night and at weekends, not all the consultants on call were intensivists. General anaesthetists were included in the rota. Furthermore, at weekends only one consultant covered both of the trust's intensive care units which were located at Tunbridge Wells and Maidstone. This often led to delays in routine ward rounds and response to urgent requirements.

Incidents

- The unit had reported no 'Never Events' (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers) in the year 2013/2014.
- From the incidents we reviewed, staff were open and honest about incidents they reported. We reviewed the ICU incident reports from April 1 2014 to October 2014. There was a mixed category of incidents reported with no particular identifiable trend. We saw staff reported when they made an error, such as needle stick and splash injuries. This was an infrequent occurrence. We reviewed one incident undertaken by the manager of the sister unit in the ICU in Maidstone. The incident had been thoroughly investigated with all the relevant parties involved. There were action items and lessons learned which had been shared with staff across the two sites. The staff we spoke with were aware of the incident and changes to practice to ensure the incident did not reoccur. However

when we reviewed incidents for the past six months we found that 7 incidents were awaiting investigation, some of which were overdue. 9 were being reviewed; some of these were overdue.

- Mortality and morbidity was reviewed within generic Anaesthetic Department Clinical Governance meetings. No other members of the ICU multidisciplinary team attend these meetings. There were no minutes made of these meetings. Consultants told us that not all deaths were discussed at these meetings, which is contrary to best practice. There was lack of clarity regarding actions and lessons that arose from these meetings. With no record or action plan from the meetings, we were unable to determine who was accountable for any actions or learning, or whether there had been any shared learning within the entire ICU multidisciplinary team and anything that had improved as a result.
- There was a Trust wide electronic incident reporting system. However, the Consultant Anaesthetists and Intensivists had developed their own system which was hosted via an external survey company. This meant that the Trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons so that similar incidents were not repeated.
- The night before our inspection, a patient sustained a pressure injury from a pneumatic compression device. We saw that there was only one available evaluation of the patient's skin condition since application of the device in the operating theatre. However, later in the day, staff found additional documentation which showed more frequent evaluation of the condition of the patient's skin. There was a delay of a number of hours before reporting the pressure injury as the staff on the night shift were unsure whether it was a reportable incident. There was no available guidance for care of a patient with a pneumatic pressure device.

Safety thermometer

- Safety Thermometer data for ICU was showing low risks and no specific concerns. There were no falls with harm.
- The unit had high scores when audited for completion of safety data. In the month ending September 2014, for example, 10 records were audited and the ICU had scored 100% for completion of risk assessments, action plans, fluid balance charts and care plans. The audit had shown a steady improvement in compliance with safety audits.

Cleanliness, infection control and hygiene

- The unit had nine single rooms, with large glass windows and doors, arranged around a central island, containing a large work station at each end and a large office. The unit and equipment was generally visibly very clean, tidy and well organised. Even though the ICU was purpose built, for the number of beds, the ICU had limited space for storage. However, nursing and cleaning staff ensured areas were kept clean and well organised.
- We observed that the doors to the patients rooms, who were being source isolated, were left open. This could potentially put other patients and staff at risk of cross infection.
- The ICU was clean. Cleaning of the unit was carried out by two permanent members of staff. One explained to us the use of different coloured mops and buckets for cleaning different areas to reduce the risk of cross infection. They also explained the process for deep cleaning of the ICU, which took place regularly. Cleaning of the unit was checked. The unit was audited almost weekly for cleanliness as it was deemed to be an area of high risk due to the vulnerability of the patients. The audit scores were high, 98%, which demonstrated that the unit was being cleaned effectively.
- There was an awareness of the Trust policies in relation to infection control. Staff were 'bare below the elbow.' All staff uniforms appeared clean and in good condition. When appropriate to do so, staff wore gloves, aprons, and masks. We did not observe any procedures where eyewear was used, however, it was available. There was good adherence to disposal of personal protective equipment (PPE) when caring for patients in isolation. We observed good hand-washing techniques. Hand-wash sinks were supplied with hot water, soap and paper hand towels. There was hand-sanitising gel at the entrance to the ICU and we observed staff and visitors using this when arriving and leaving the unit. This was also available at patient rooms and other clinical areas, such as the dirty utility room.
- It was notable that the medical notes for the patients were kept separately to the patients at the

central work station. The medical notes were taken into the patient rooms during the ward round, including the rooms of patients being isolated due to infections, before returning the notes to the central nursing station. This practice potentially increases the risk of cross-infection between patients.

- The infection rates for the unit, as reported through the ICNARC, were low and were consistent with most similar critical care units in England.

Environment and equipment

- Security of the unit was good. The ICU was locked and visitors were required to use an intercom, identify themselves upon arrival and would be met by staff. Staff entered the unit by means of a swipe card that was unique to them.
- There was enough equipment for the services provided to patients. There were enough ventilators to service 9 level 3 patients and two transfer ventilators which were used to transport ventilated patients when having investigations in other parts of the hospital. There was an anaesthetic machine, which could also be used to mechanically ventilate a patient in the very short term. Transport ventilators could also be used on a temporary basis until the patient could be transferred to another facility, or a fixed ventilator obtained.
- In the clinical storage room, equipment was colour coded according to its use, for example respiratory equipment was stored and all labelled in green and vascular equipment was labelled red. This was so that equipment could be located quickly. There were boxes, ready for use, with all equipment required for commonly carried out procedures, for example insertion of a central venous line. Although the space was small for such a large amount of equipment, it was very well organised and tidy.
- Resuscitation and other equipment, for example blood gas machines were available and checked. We reviewed the nature of the checklist and regular checks and they were completed twice daily. The healthcare support workers who checked the equipment were aware of what to do if they needed to escalate concerns with regards to equipment.
- Equipment was taken to a central medical library to be cleaned. It was returned to the department with a sticker in situ to indicate it had been cleaned and was safe to be used.
- A difficult intubation trolley, whilst not located within the ICU, was located immediately next to the ICU in the emergency recovery. This appeared appropriately stocked and was instantly available for use within the ICU.
- There were two level 2 beds in the maternity unit, which was in another part of the hospital. These were used for women who required close monitoring/observation either pre or post-delivery. These beds were planned for when the new hospital was built. There was sufficient equipment in the Maternity Unit to ensure these women could be monitored adequately.

Medicines

- Medicines were managed safely. The controlled drugs were stored in a locked unit and the keys held by the nurse in charge at all times. The other medicines were in lockable cupboards behind the nurses' station. Medicines requiring refrigerated storage were appropriately stored. We saw that the temperature of the refrigerator was checked each day. There was an awareness of what action to take if the fridge temperature was outside safe parameters.
- Medicines were accurately recorded and administered. We reviewed a sample of the controlled drugs, and found the registers to be an accurate report of the stocks held. The entries were made as required in that the administration was related to the patient and was signed appropriately, new stocks were checked and signed for and any destruction of medicines was recorded.
- We checked a sample of different medicines in the general cabinets and found them all to be in date. The expiry dates and batch numbers of the medicines matched the boxes they were stored in. The cupboards, though, were overfull and untidy.
- The unit had support from the pharmacy team. The pharmacist did not attend ward rounds. This is contrary to Core Standards for Intensive Care Units (2013)
- Medicines were safely administrated and patient records we reviewed showed medicines given when they needed to be. Any gaps in administration shown on the charts were appropriately explained.

Records

- The patient notes and all associated clinical work, such as medicine administration, were all done on paper records. There was no plan to upgrade these to more secure, efficient electronic records.
- We reviewed six sets of nursing notes. Risk assessments and the care plans were completed. The care plans included the malnutrition universal screening tool (MUST) score, a pressure ulcer risk assessment tool, use of anti-embolism stockings, moving and handling risks, falls prevention, delirium risk and bedrail assessment. Bedside notes and charts were not always up to date. We found two records of care planning and evaluation of care that had been provided to the patients in the morning were being retrospectively written at 4pm;this was not timely documentation.
- We found two sets of notes that had scraps of paper in them with the patient's weight and urinalysis results. These could have easily been mislaid.
- Vital signs were well documented, along with cardiac and respiratory indicators. Neuropathic indicators such as pain and pupil reaction were well documented.
- Prescription drug charts were clear and complete. The trust generic drug chart was used for patients with additional ICU-specific drugs recorded on the patients' bedside observation chart. Medicines were appropriately signed for and if discontinued were signed and dated at the date of discontinuation and crossed through.
- The doctor's notes were kept separately at the central work station. No daily proforma was used and instead a non-structured ward round entry was written by the duty doctors. On reviewing 5 sets of notes, the entries were found to be disorganised with a lack of clarity about the diagnosis, current issues and management plan.
- We observed it was not easy to use the notes to obtain an overall summary of the patient's stay in ICU.

Safeguarding

- Staff had been trained to recognise and respond in order to safeguard a vulnerable patient. Records showed that 94% of staff had been trained in safeguarding vulnerable adults. We spoke with three staff, clinical and administration regarding their role in ensuring patients were safeguarded from abuse. All were clear about their responsibilities to report abuse, as well as how to escalate concerns both internally and externally. All staff we spoke with knew the Trust had safeguarding leads for both adults and children and some were able to name them.

Mandatory training

- We saw from Trust records that the majority of training for staff in mandatory subjects was up to date. Staff said they were responsible for ensuring that they completed their training, much of which was via e-learning; this was checked and reviewed by the Matron or their manager.

Assessing and responding to patient risk

- The hospital trust had implemented use of early warning scores, Patient At Risk Scores (PARS). It was the same system as in the sister hospital at Maidstone. This was a mechanism for calculating certain indicators to determine whether or not a patient was clinically deteriorating, and if so, whether further or new intervention was required. This included simple physiological observations of the patient's respiratory rate, oxygen saturation, temperature, blood pressure, pulse rate, urine output and level of consciousness. A higher score triggered further intervention from a senior nurse or doctor to ensure that any changes in a patient's status were managed immediately.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patient. Alarms were set on monitoring equipment to alert any changes in the patient's condition. This meant deteriorating patients would be identified and action/escalation to an appropriate team could be initiated without delay. However, we saw on three occasions that Level 3 patients were left unobserved for periods of time, with a reliance on audible signals from monitor alarms. The nurses sat outside the rooms and observed the patients rather than being in the rooms with them. For example we saw one patient who was awake, had a tracheostomy, and was being weaned from a ventilator. The patient was also being barrier nursed. This led to a delay in attending to the patient, whilst personal protective equipment was put on by the nurse. We saw one nurse sitting at the nurses' station using a computer when they were

responsible for caring for their own level 3 patient and another level 3 patient, whilst their nurse was taking a break. There was little awareness of the patient's condition, for example they did not know that the patient they were observing was receiving inotropic support (pharmaceutical support to ensure that the heart is functioning adequately and blood pressure maintained.)

- Patients were monitored for different indicators. For example, each patient could be monitored to ascertain the level of carbon dioxide present in respiratory gases. This was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions.
- There was an outreach team that provided support for the management of deteriorating patients on the wards. This service was available seven days a week from 7.30 am to 8.30 pm. The hours of this service had very recently increased from 8.30 am to 6.30 pm, five days per week to 7 days a week. However, the National Confidential Enquiry into Deaths (NCEPOD) recommended in 2011 that outreach teams in hospitals should be available 24 hours a day, seven days a week. Staff we spoke with were complimentary about the service that was offered by the outreach team, particularly as they visited each ward every day to assess and offer advice to the staff on any patient that may be causing concern. The outreach staff reported to us that they had a good relationship with the ICU consultants and were able to approach them for advice, should they need to. In order to facilitate extended hours, the service had been reduced from two nurses on duty for outreach, to one. Some staff were critical that the service had been reduced in this manner, which was felt to have diluted the service. A senior nurse told us this was to mitigate the extra cost of providing a service for longer hours.
- There were two level 2 beds in the Maternity Unit. These were for women who required close monitoring/observation either pre or post-delivery. Specially trained midwives cared for these women. Both units at Tunbridge Wells and Maidstone supported student midwives on placement in order that they had an understanding of providing level 2 care. The maternity unit was included in the outreach service, so that if there were concerns about a woman's condition, it could be escalated. If a woman required level 3 care, they would be transferred to the ICU.

Nursing staffing

- The unit followed the staffing standards from the core standards of the Intensive Care Society and the British Association of Critical Care Nurses guidance for the staffing of critical care units. There was one nurse for each patient needing intensive care (level 3) and one nurse for two patients needing high dependency care (level 2). In addition the nurse in charge was supernumerary. On the day of our inspection there was a nurse for each patient, including the Level 1 patient who was ready to go to the ward. The staffing rota was planned and staff worked on a rotational basis on days and nights. The nurse manager informed us that staff shortfalls were covered mostly by the ICU's own staff or internal bank staff. We were shown a diary where permanent staff stated their availability for extra shifts, should there be a shortage of staff. Occasionally agency staff with ICU experience were used. We saw a graph which demonstrated that use of temporary staff was rare. At the time of our inspection, there were six senior nurse vacancies, because of maternity leave, sick leave and temporary secondment. However, the ward manager told us that most would be returning to duty by the end of the year.
- Agency staff were, when booked, provided by an agency who were known to the Trust and had given evidence and assurances that the staff they supplied were qualified and had current registration with the Nursing and Midwifery Council. In addition new agency staff were given a brief induction to the unit. They were required to sign to confirm they were qualified to care for level 2 or 3 patients, that they were aware of Trust policies and they had current skills to administer medication via intravenous lines. In addition, the nurse in charge told us that in the rare event of a member of staff being unknown to them, they were usually allocated a less dependent patient and were supervised by an experienced nurse in the next room and the nurse in charge.
- There was a good handover between nursing staff when shifts changed. A formal 30 minute handover at the start of each new shift took place at the patient's bed space to the nurse coming on duty. The majority of nurses worked the trust-standard 12.5-hour shifts, unless a different flexible arrangement was agreed.
- There was a ward clerk in post from Monday-Friday, who was able to free the nurse in charge from non-clinical duties and managed booking temporary staff when they were needed. In addition a healthcare support worker worked Monday to Friday and assisted the nursing staff with clinical

duties. They were responsible for checking equipment and had been trained to do so. They were also responsible for a number of other non-clinical tasks. The band 7ward manager was rostered to do a clinical shift every two weeks which gave them sufficient time for other duties such as supervision.

- There was a mix of senior and more junior member of staff. 76% of nursing staff were in possession of a formal critical care qualification; this was better that than required national standard of 50%. The band 8b critical care matron was not rostered for clinical duties as they did not have a critical care background. This was mentioned to us by several staff members of all different grades. Best practice guidance from Intensive Care Society and the British Association of Critical Care Nurses states that the lead nurse for critical care units should have a critical care qualification. The band 8b lead nurse was an experienced matron, but also had responsibility for several other areas, including the operating theatres and decontamination services, across two sites.
- We were shown both recent and historic information regarding dependency scores to demonstrate the number of patients who required level 2 or 3 intensive care support. We saw that there were links between the dependency, staffing levels and the number of patients being admitted. None of the staff we spoke with mentioned that they were short staffed.

Medical staffing

- Care in the ITU was Consultant led and delivered. There were a total of twelve ICU Consultants who worked in rotation and were responsible for providing senior cover across the Trust's two critical care units located at Tunbridge Wells and Maidstone Hospital. In addition there were a number of junior doctors who provided care to the patients under the jurisdiction of the consultant. In daytime hours, the consultant covering ICU did not have other clinical commitments, other than the critical care unit at Tunbridge Wells.
- Monday to Friday there were two ward rounds each day, led by the Consultant with input to the morning ward round from other relevant staff, including junior doctors, nurses and allied healthcare professionals.
- The Intensive Care Society and the British Association of Critical Care Nurses guidance states that the consultant work patterns should deliver continuity of care. However, the consultants only worked one day at a time, covering the ICU Monday to Friday, between 8am and 5pm. It is usual in critical care units that the consultant works 4-5 days in a row to provide continuity of care. We spoke with a consultant and two nurses who agreed this working pattern was not ideal. The junior doctors were not critical of this method of working. However several staff members were able to recount incidents where plans to wean patient from ventilators were altered on a daily basis according to the individual consultant preferences. One consultant we spoke with agreed that this was not an ideal situation and told us, "We have tried to get two days in a row working if we can, but it's a bit ad hoc." There was some support from the consultants to cover the unit on a daily basis, one consultant told us, "It's a fresh pair of eyes. Continuity of the juniors and trainees helps." A patient told us, "I have been here for 7 days. I have seen a different doctor every time. I suppose they all know what they're doing."
- At night and at weekends, not all the consultants were Intensivists (doctors specialising in critical care medicine,) but instead were general anaesthetists. The Trust had consultants on call out of hours; a general anaesthetist and an Intensivist. Each Consultant is on call for one of the Trusts two hospitals, covering not just the ICU, but also theatres, A&E and all other anaesthetic emergencies. This model of care conflicts with The Core Standards of the Intensive Care Society, which recommends that Consultants on-call for ICU must have daytime direct clinical care commitments within the ICU; the general anaesthetists, who cover one of the Trust's two ICUs out of hours, do not have such experience. Additionally, The Core Standards of the Intensive Care Society states that Consultants on-call for ICUs must not be responsible for providing other services, aside from their commitment to the ICU. One consultant told us, "It's not a perfect on call system. I think a different on call model will emerge."
- At weekends, there was only one intensive care consultant responsible for providing senior cover across the Trust's two critical care units located at Tunbridge Wells and Maidstone, whilst also being the anaesthetic consultant for one of the Trust's two hospitals. This meant that only one consultant led ward round was held daily on each unit, rather than the two recommended in The Core Standards of the Intensive Care Society and the British Association of Critical Care Nurses. Furthermore, the standards recommend that the consultant on call should be available within 30

minutes. This was not always the case. Although the distance between the two units was fifteen miles, the journey could take considerably longer than this, depending on traffic.

- Staff told us that depending on which unit the consultant started their ward round on, the other unit may not have a consultant led ward round until later in the day, at times, as late as 4pm. This meant for example, that patients who were ready to be weaned from a ventilator, may have this delayed until the following day as it is not good practice to commence weaning late in the day.
- The Core Standards of the Intensive Care Society and the British Association of Critical Care Nurses recommends that a ratio of 1 consultant to 14 patients should not be exceeded. When both the units at Tunbridge Wells and Maidstone were busy, this ratio was, at times, exceeded.
- The lead Consultant told us there were plans to recruit more intensive care consultants and estimated that 15-20 more would be needed to cover the units at both sites. One new consultant was due to commence employment in February 2015. They thought that the Trust had plans to recruit a further two early next year, but these plans appeared to be imprecise.
- Handovers between consultants were undertaken twice a day. However, these did not always take place at the patient's bedside; they were often done by telephone or email.
- Prior to the trust merging the two sites at Tunbridge Wells and Maidstone two years ago, the consultants worked solely at one site or the other. However, since then there had been cross site working. We received some information prior to our inspection that this had caused some antagonism between two groups of consultants
- Not all the ICU consultants had regular daytime commitments in both ICUs that they cover out of hours. All consultants had a base ICU, where they provide the majority of their daytime cover.

Major incident awareness and training

- There was a hospital-wide major incident plan, which included intensive care and anaesthetic response. The policy referred staff to an action card that would be used in the event of a major incident. There was a large folder, easily accessible with the nurse in charge's action card. We spoke with three members of staff who were clear with regards to what a major incident was and their role is responding to it. We saw that about 70% of staff had signed the policy to say they had read it.

Are critical care services effective?

Requires improvement

Patients were assessed regularly for pain, nutrition, hydration and effective care or treatment. The unit took part in some clinical audit work, in order to determine if patient care was effective when compared nationally. However, recognised guidance for the care and treatment of critically-ill patients was not always followed by the unit.

The unit also contributed to the Intensive Care National Audit and Research Centre (ICNARC) data collection. This enabled the service to be judged on important clinical indicators against other comparable units and the national picture. The service compared well with other units in terms of outcomes, including low mortality rates.

Nursing and medical staff were appraised to judge their competency and professional development. There was limited multidisciplinary work, with support provided to the unit by a range of professionals, which was not as comprehensive as guidelines recommend.

The hospital supported a critical care outreach team, although only during day-time hours, seven days a week. Out of hours the hospital was led by the clinical site manager with input from medical and surgical teams and involvement from the ICU junior doctor. There were suitable arrangements for out-of-hours support from other services, such as physiotherapy, imaging and pharmacy.

Evidence-based care and treatment

- Recognised clinical guidance was not always followed:

- NICE guideline CG83, 2009 – rehabilitation after critical illness. Research shows that up to 70% of patients who have an admission to a critical care unit, have some degree of post-traumatic stress (PTS) following their discharge. There was no post discharge follow up of patients in the unit to recognise and treat PTS.
- NICE guideline CG50, 2007 - acutely unwell patients in hospital: recognition of, and response to, acute illness in adults in hospital. Part of this guideline states that patients should not be transferred from the unit at night. However, data that we saw demonstrated that 40 (14%) patients had been transferred from the ICU to another ward between 10pm and 7am. This was due to pressure on beds, for example, if a patient required admission to the unit either from another ward or A&E, they were given priority.

- The unit participated in organ-donation work and had a specialist nurse and lead consultant for organ donation. The trust was part of the National Organ Donation programme and followed NICE guideline CG135 – organ donation for transplantation. The organ donation rates for the unit were, however, very small.
- There was no robust system for post discharge follow up for patients who had been a patient in the ICU. This was currently being developed and was in its infancy. Follow up after discharge is a recommendation from the Intensive Care Society's Core standards 2013 and NICE CG83 2009.
- There was a lack of clinical guidelines, for example although there was a protocol for weaning from a ventilator, it was not readily available, there was little awareness of its presence and therefore was not used routinely for weaning.
- A gap analysis that was dated 2 October 2014, which was carried out in response to the NCEPOD report, "On the Right Trach" published in 2014 recommends best practice for caring for patients with a tracheostomy showed compliance with some aspects of the recommendations. The areas that were partially or non-complaint had action points and a person responsible to action these. However, there was no date when these actions should be completed and no date for the multidisciplinary team to meet again and consider progress.
- In 2013 the ICU team came second place in a national competition hosted by the Nursing Times for their work on managing patients suffering with delirium whilst in an ICU.

Pain relief

- Pain relief was well managed. Pain scores were documented in patient records, using recognised techniques and measures. Nursing staff said, and we observed, that patients who were awake were regularly checked for pain. Pain was also managed by prophylaxis, which is to anticipate pain and provide relief in advance.
- The trust employed within their pain team, an acute pain clinical nurse specialist (CNS) who worked across both sites at Tunbridge Wells and Maidstone. They reported that there was a good relationship between them and the ICU staff. They were aware of any patients having major surgery and visited them post operatively to ensure their pain relief was effective. They reviewed all patients who had epidurals inserted to control their pain and left a list of these patients for the weekend on call anaesthetist, in order that regular reviews continued.
- The pain team, which included acute and chronic pain team members, undertook a number of audits to ensure their practice improved in line with Royal College of Anaesthetists Guidelines.

Nutrition and hydration

- The unit used the Malnutrition Universal Screening Tool (MUST) to assess the nutritional needs of patients. Nutrition and hydration was managed effectively. Fluid intake and output was measured, recorded and analysed. The method of nutritional intake was recorded and evaluated each day. Energy drinks and food supplements were used for patients who needed them. ICU staff followed a protocol for hydration and nutrition for ventilated patients and enteral tube nutrition was initiated. Dietician support was available Monday to Friday.

Patient outcomes

- Quality indicators for patient outcomes were good. The data provided to the Intensive Care National Audit and Research Centre (ICNARC) showed that, when compared to similar units, rates

for patients readmitted to the unit were low. The readmission rate (within 48 hours of being discharged) was 0.4%. For patients being transferred to other units, the service had a rate similar to that of other comparable units. These transfers were for clinical reasons, such as needing more specialist treatment, for example patients who had an acquired brain injury.
- The unit had low mortality rates compared with similar units.. Most of the admissions were following routine elective surgery with some emergency medical and surgical admissions.

Competent staff

- There was a comprehensive induction for new staff. This included both a trust wide and local induction. One induction programme had been designed for permanent staff and students and another for flexible workers, such as bank and agency staff. The ICU had developed an induction cross-site competency pack for band 5 (the most junior qualified) nurses.
- Staff we spoke with reported they had regular appraisals where they could discuss their work. They discussed their performance and career aspirations with their line manager. All the staff said they found the appraisal process useful.
- Staff were given the opportunity for specialist training. 76% of the nursing staff had a post-registration critical care qualification. The Core Standards for intensive Care recommends that 50% of nursing staff should have this qualification. All ICU staff were trained in adult and child intermediate life support. The band 6 and 7 nurses had all completed their Advanced Life Support (ALS).
- The unit had developed a course for nurses, ‘Foundations of Nursing the Critically Ill.’ This was accredited by the University of Greenwich. Several staff were undertaking this course.

Medical staff

- Some of the junior medical staff were undertaking a rotation programme and as part of this had protected study days.

Multidisciplinary working

- There was a multidisciplinary team (MDT) that supported patients and staff in the unit. For example, there was a dedicated critical care pharmacist who provided advice and support to clinical staff in the unit. However, not all members of the multidisciplinary team attended the doctor’s ward rounds.
- There was no daily MDT meeting at Tunbridge Wells. The ward round was described as an MDT; however, this was held at the patient’s bedside and did not include the whole multi-disciplinary team. National best practice considers it usual for MDTs to include the whole team including relevant consultants, junior doctors, nurses, therapists, microbiologist and pharmacist.
- Speech and Language therapists visited the unit when required. They were not part of the formal MDT.
- The ICU had an outreach team. An outreach team is a recommendation jointly of the Faculty of Intensive Care Medicine and Intensive Care Society core standards. It is a team of senior nurses used within the hospital to provide advice and guidance for staff caring for patients in other wards who may be showing signs of deterioration. They also visit patients who have been discharged from critical care back to a general ward. The team worked during the day 7 days a week. At night the service was provided by the site manager, who although was a band 7 nurse, did not have specific training in recognising a deteriorating patient.
- There were physiotherapists attached to the ICU, who joined the ward rounds to discuss, for example, weaning plans and mobilisation and rehabilitation for patients. Physiotherapists were available at weekends and out of hours on an on call basis.

Seven-day services

- There was consultant cover for patients in the unit 8am to 5pm and an on call service out of hours. However, they were not necessarily a specialist in intensive care medicine; some consultants were general anaesthetists and also had other commitments within the hospital as well as covering both units at Tunbridge Wells and Maidstone.

- Consultants worked on rotation and were responsible for ensuring the unit had adequate clinical cover from junior doctors at all times when a consultant was not on duty in the unit.
- Most facilities were available out of hours, this included physiotherapists, radiographers, radiologists and pharmacy service, all available at night and weekends.

Consent and Mental Capacity Act

- Patients were able to give their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff we spoke with understood and said they acted in accordance with the Mental Capacity Act 2005 if it was decided to temporarily deprive a patient of their liberty. Staff had received training in aspects of the Mental Capacity Act 2005, and provisions for depriving someone of their liberty in their best interests.
- Care and treatment was given to patients who could not give valid informed consent in their best interests. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration and performing tests were made by the clinical teams. If more serious decisions were needed, the staff would hold best interest meetings with those people who could speak for the patient to hear all the views and opinions on future decisions. The assessment form for mental capacity and best interests was thorough. These were completed by the patient's consultant. The ward manager described a recent incident where a patient had no relatives or someone who could represent them. Therefore the hospital arranged to have an Independent Mental Capacity Advocate (IMCA) so that best interest decisions could be made on behalf of the patient.

Are critical care services caring?

Good

Comments from patients, relatives and carers about the care they had received were overwhelmingly positive. Patients were cared for by dedicated, kind and caring staff. We saw and overheard sensitive and considerate interactions between staff and their patients. Patients were treated with privacy and dignity. Patients and relatives were involved in decisions about care and treatment and, where able, gave informed consent. Patients not able to provide informed consent were cared for in their best interests.

Compassionate care

- Staff practiced and understood the principles of delivering compassionate care to patients receiving intensive care. This included supporting patients who were confused or anxious. Staff said they would talk to a patient and tell them their name, smile, be relaxed and try and help patient relax.
- All the patients we met told us their care had been good. Relatives we spoke with said staff had met with them soon after they arrived the first time, and had updates on each subsequent visit. All visitors we met said they had been given time with the nurses and doctors to ask questions and this had been done in a private room if appropriate.
- We observed care being delivered where patients' privacy and dignity was preserved. Nurses and healthcare assistants were talking to patients and their relatives with kindness and compassion. We observed the door being closed and blinds closed when any patient received personal care.
- Staff said they would talk to a patient and tell them their name, the date and time of day. They would then tell them what they were going to do when delivering care and why. They would explain, for example, when medicines were given, when staff changed at handover, or if the patient was being moved to another department for a test. However, we did see that level 3 patients were left unsupervised on three occasions and that nurses sat outside the room rather than in the room with the patient. This meant that subtle changes in the patient condition, which were imperceptible to monitoring systems, such as increased perspiration or restlessness may not have been noticed immediately.
- We saw one doctor examine a patient's abdomen. They did not introduce themselves or explain to the patient what they were about to do.

Understanding and involvement of patients and those close to them

- We spoke with one patient who said they had been asked for their consent for any treatment and their opinions for any decisions to be made. Relatives told us staff had given them the advantages and disadvantages of any proposed treatment options, including the risks and benefits.
- Patient confidentiality was maintained easily within the single rooms.
- Patient nursing and communication notes were stored either outside or in the patient's room, at the bedside. Doctor's notes were stored securely behind the nurse's station.

Emotional support

- The unit had a ward clerk who worked on week days. The unit was designed in such a way that the ward clerk was located just inside the unit door and greeted patients and their relatives. They were warm, friendly and approachable.
- The unit was using 'patient diaries.' These were used for staff to record progress and friends and family to record their visits or significant events. The system for commencing diaries was not well-developed, for example we saw one patient whose dairy had commenced the day before, although they had been in the unit for eleven days. Staff we spoke with were unsure what happened to the dairies once a patient was discharged from the ICU.
- When there was a death on the unit, staff told us there were sessions held to enable debriefing and support. This included non-clinical staff, for example the ward clerk. However, there was no counselling in place for bereaved relatives.
- There was no system in place for pre-operative visits, or information that was routinely given to patients to the ICU to allay any concerns patients may have prior to their stay.

Are critical care services responsive?

Inadequate ●

The ICU was not able to respond at all times to the need to admit or discharge patient's at the most appropriate time. This meant patients were kept in the ICU inappropriately, when they were fit to be discharged. There were inadequate facilities for these patients.

There was one shower and toilet, which would have been suitable for a patient who had a disability. The ICU had a quiet room for relatives to have discussions in private; however, this was minimally furnished. There was a small main waiting area for relatives near the entrance to the unit.

The unit was able to meet the individual needs of patients and provided personalised nursing care. However, medical care was fragmented and inconsistent. There were no resources for meeting the needs of people who may not have English as their first language. Complaints from patients were infrequent, but these were responded to appropriately. However, there was no evidence that they were shared with staff to improve future care and treatment.

Service planning and delivery to meet the needs of local people

- Certain categories of patients who needed specialist services would, therefore, be transferred to appropriate units, the nearest being in South East London. However, the unit did take medical patients directly from the A&E as well as elective surgical patients who required close monitoring post operatively.
- The hospital did not have a separate high dependency unit and therefore, at busy times relied upon care being provided on wards, transferring patients to Maidstone Hospital, caring for patients in the post-operative recovery room or discharging patients to wards at inappropriate times. There was a recovery room adjacent to the ICU and although this had equipment to safely monitor and care for critically ill patients, it was outside the main ICU and was unsuitable for anyone requiring longer term support. It was mostly used for supporting patients whilst a bed was made available for them in the main ICU.
- The ICU did not have any negative pressure rooms. One room did have an adjoining utility room

where PPE could be put on and removed. There was adequate hand washing facilities.

- Although the ICU had a quiet room for relatives to have discussions in private, it was sparse. There were two rooms where relatives could stay overnight.
- Patients who were ready to go to a ward often remained in the ICU for several days until a ward bed was available. Staff told us it was not unusual for patients to remain in the unit for several days waiting for a bed. There was only one shower room and toilet for these patients to use.
- When new patients were admitted, they were not always seen by a consultant in intensive care medicine as recommended by the Core Standards for Intensive Care. If a patient was admitted during the evening or at the weekend, this was often not achieved.

Meeting people's individual needs

- Patient equalities and diversities were considered, although there was no specific resource in one place for staff to access. Staff were able to describe the areas of equality and diversity they had experience of supporting. They were knowledgeable about the strands of equality and diversity and what made each person an individual. Staff would respect different cultures and religious needs by, for example, providing only male or female staff if this was important to the patient. One nurse we spoke with told us, "If I am looking after a patient of the opposite sex, I would ask another nurse to help me wash the patient. I would leave the room if the patient was embarrassed about me being there." Staff we spoke with said all patients would be treated and cared for as individuals and adjustments would be made to ensure the outcomes for patients were as good as they could be.
- There were no translation services available. If patients did not speak English, a family member or a member of staff would provide translation.
- Staff had access to a network of support for patients' spiritual needs, both within the hospital and from the local community. The chaplaincy based at the hospital visited the wards regularly and specific visits could be arranged.

Access and flow

- Bed occupancy was around the national average at just over 80%, with a small increase over the winter of 2013/14, which was not unusual from other units.
- The discharge of patients from the unit was often not done at the optimal time. Studies have shown discharge at night can:

  -Increase the risk of mortality.
  -Disorientate and cause stress to patients.
  -Be detrimental to the handover of the patient.

- Between April and September 2014 8 patients (14% of admissions) had been transferred from the ICU for non-clinical reasons, for example, if another patient was admitted as an emergency and required an ICU bed.
- There were a very high number of patients discharged more than four hours after they were fully ready for discharge (around 82%). We found that patients were often delayed leaving the unit by several days. The week before our inspection staff reported that two patients who had been ready for discharge had stayed on the ICU for a week. In the past when patients' discharge was delayed by more than 24 hours, it was logged as an incident. This then highlighted a continuing problem to senior managers and the board. However, since January 2014, when there were a number of such incidents, the staff were asked by a member of the senior management team not to continue to record them any further. The reason given for this was because unlike the four hour waiting times in A&E and 18 week referral to treatment times for surgery, there were no financial penalties to the Trust by breaching these best practice guidelines. The senior staff told us they continued to escalate this to the Matron via the daily bed meeting but the practice continued. Conversely, staff told us that if a patient required urgent admission from A&E , a bed was always found and the ICU patient who was fit for discharge but had experienced a delay in being discharged from ICU was always moved to a ward; this indicated that beds could be made available when required.
- The facilities on the ICU for patients who were ready for discharge to a ward were lacking. There was one shower room/toilet which was shared between patients of the opposite sex, should there be more than one awaiting discharge. Although the senior staff told us this was escalated to the Matron and discussed at daily bed meetings, it was unclear if this was reported as a breach of

providing single sex accommodation, as we were unable to speak to the Matron.

Learning from complaints and concerns

- The unit received few complaints or concerns. Informal concerns or complaints were dealt with by staff on duty and the Matron either took responsibility to address these, or was informed about how they had been managed. Formal complaints were redirected to the hospital's Patient Advice and Liaison Service who initiated an acknowledgment. The complaint was then passed to the relevant person in the unit to respond fully.
- Outcomes and actions from complaints were disseminated to staff informally. Staff told us they were aware if a complaint had been raised. However, they were not disseminated by any other means or by staff meetings, which were too infrequent for information to be given in a timely manner.

Are critical care services well-led?

Inadequate ●

There was no statement of vision which was specific to critical care services.

Financial and quality governance systems were not wholly integrated; budgetary constraints had led to delays in the development of services such as the nursing outreach programme.

Governance arrangements were unclear which lead to existing arrangements being inefficient and ineffective. This led to delays in the review of critical care procedures and ensuring best practice guidance being implemented.

Although there was some evidence of nursing audit and learning overall there was little written evidence of actions or learning and who would be accountable for change and development.

Clinical Governance meetings did not include nursing staff or other key members of the multidisciplinary team and nursing and medical teams did not work together to ensure continuous improvement.

The critical care team was well motivated and supported at local level and the local nursing leadership were well respected because of their clinical skills and knowledge.

Vision and strategy for this service

- Band 6 and 7 nursing staff team leaders were well supported and well respected by their own teams. All staff we met were committed to high quality, compassionate and safe care and treatment.
- The outreach service increased their hours of cover from 5 days a week, to 7 at the end of September 2014. Plans to increase the outreach service to 24 hours, to comply with NCEPOD guidelines were on hold due to current budgetary constraints.
- There were plans to increase the number of Consultant Intensivists, one commencing in February 2015. However, firm plans to employ more were not explicit with no clear business case or confirmed funding in place to facilitate such an expansion of the consultant workforce.

Governance, risk management and quality measurement

- There was a Trust risk register in use and although there was an entry regarding delayed discharge of patients trust wide, there was no entry specific to ICU and patients being kept in an unsuitable physical and psychological environment. We noted that there was no service level risk register in place.
- There were clinical governance meetings, held monthly. However these were anaesthetic based sessions and were not attended by the senior nursing staff or other vital members of the ICU multidisciplinary team. The minutes of these meetings were not distributed to the entire ICU team. In the main, the nursing and medical teams did not work together to ensure continuous improvement.

- We were shown minutes notes from Clinical Governance Half Day, which, according the invitees were across site meetings, dated 14 May 2014 and 12 June 2014, which briefly outlined sessions held, led by doctors on topics such as Patient Controlled Analgesia (PCA) guidelines, re-audit of sepsis guideline, gynaecology readmissions and re-audit of ICU admissions compared to ICNARC data. However, there was no record of attendees, of discussions held; reviews of action plans were blank. The meeting from 14 May 2014 stated that the action points from the previous meeting were not available. There was little ICU specific data.
- We were shown minutes of Clinical Governance meetings dated 17 September 2014 and 9 October 2014, from the anaesthesia service. The meeting dated 17 September stated there were no minutes available from the previous meeting. There was no date when the previous meeting had been held. However, both meetings described issues arising from general anaesthetics and paediatrics. There was nothing specific to ICU.
- We were shown a document, 'Terms of Reference for Critical Care users Forum' which had been approved on 12 August 2014. Meetings to be held quarterly. However, there were no records of any meetings held.
- There was no evidence to support any improvements made or who was accountable for change and development from either the medical or nursing teams.
- There was a data coordinator in post who collected data and submitted it to ICNARC. Senior staff were aware of the latest Intensive Care National Audit and Research Centre (ICNARC) data results, which were shared at a joint consultant/senior nurse meeting. However, it was reported this was poorly attended by the consultants. We were not shown any minutes

Leadership of service

- The unit was led by a band 8 Matron senior clinical nurse and a consultant clinical lead, both of whom had responsibility for both sites at Tunbridge Wells and Maidstone. Nursing staff at all levels said they thought the band 8 Matron had a very large remit over both Tunbridge Wells Hospital and the Trust's other site in Maidstone. Their responsibilities covered ICU's, the operating departments and decontamination. There was awareness amongst all staff that although the Matron was an experienced clinical manager, they were not experienced in critical care and therefore did not have a full understanding of the issues involved in an ICU.
- The band 7 clinical lead and band 6 charge nurses were all respected by the nursing staff because of their experience and knowledge. However, some Band 7 nurses were appraising nurses of the same grade. It is usual for appraisals to be carried out by someone senior to the appraisee.
- There was some criticism of lack of cohesion between some of the medical staff. Coupled with the frequent change of Consultant lead on a daily basis, staff often felt frustrated that treatment plans devised on one day were not followed through the next because the Consultant for that day had a different view. This was perceived as a barrier to continuity of care, with for example weaning patients from ventilators. One member of staff told us, "You just have to get on with it. Eventually you get used to what each individual Consultant wants. It is frustrating though when plans change, sometimes it seems, for the sake of it."
- Staff told us their values and patients were at the centre of their descriptions. Staff also said how they valued their teams and the work they did.

Culture within the service

- There was a strong culture of teamwork and commitment from the nursing staff in the ICU. All the staff we spoke with said the strength of the unit was a friendly and cohesive team. Patients and relatives also commented on the positive nature of the staff they met.
- There was appropriate action to deal with issues of poor performance among staff. The ward manager said staff would enter a capability pathway if they did not complete their mandatory training, or there were other performance issues. There were human resource procedures to be followed and support available for disciplinary matters that needed to be escalated to senior management.
- The consultants did not appear to work cohesively either amongst themselves or with the nursing management team.

Public and staff engagement

- Due to the nature of critical care there was no general public involvement with how the service was run, but patients and their relatives were asked to comment on their care. There was no analysis of feedback, or any trend analysis to drive practice improvements.
- The relatives and patients we spoke with were all complimentary.
- Most staff we met felt they had a voice and their opinions were valued. There was a degree of flexible working, which the staff appreciated.

Innovation, improvement and sustainability

- There were two clinical practice facilitators, who between them worked as one WTE. The rest of their hours were spent working clinically so that they could maintain their skills. They were committed to ensuring the nursing staff had a thorough induction to the ICU and that their clinical education continued throughout their employment there. They ran a series of individual and group sessions to improve skills and confidence. On the day of our inspection, they were doing some scenario training, whereby they were teaching staff how to deal with different clinical problems by setting up different situations for them to work through.
- Clinical governance was ineffective and therefore reviews of critical care procedures and ensuring best practice was slow. For example we saw a draft protocol for Catastrophic Brain Injury which had been discussed at a meeting in February 2013. However, the draft document had only just been written and had not been approved for use by October 2014.
- There were no current plans to improve or develop the service. The patient notes and all associated clinical work, such as medicine administration, were all done on paper records. There was no plan to upgrade these to more secure, efficient electronic records.
- The team working in critical care had strong, shared values, but there were no longer-term objectives for the team to work towards improving to reach standards, for example Core Service Standards for Critical Care, NICE guidelines and NCEPOD guidelines, some of which have been outstanding since 2009 and are the basis for achieving clinical excellence for all ICUs.

Maternity and gynaecology

Safe	Requires improvement	●
Effective	Requires improvement	●
Caring	Good	●
Responsive	Good	●
Well-led	Requires improvement	●
Overall	Requires improvement	●

Information about the service

The maternity services at Tunbridge Wells Hospital provide women using the service with their own room during their antenatal and postnatal stay as well as for labour and birth. During 2013/2014 the total number of deliveries for the trust was 5,377, 59% were normal (spontaneous) deliveries.

There were 31 postnatal beds, 16 antenatal beds and the gynaecology ward had 11 beds. On the delivery suite there were 17 delivery rooms, which included two rooms with large birth pools. The triage unit assessed mothers in labour; there was also an early pregnancy assessment unit as well as antenatal clinics. There was easy access to both obstetric theatres and the neonatal unit, which were based alongside the delivery suite.

We visited the maternity and gynaecology wards and units and talked with 15 members of staff, including midwives, consultants and nurses about the maternity and gynaecology services available in the hospital. We spoke with six mothers about their experiences through pregnancy, labour and during the postnatal period. During the inspection we looked at care and treatment, we also reviewed care records. We received comments from our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed performance information from, and about, the trust.

Summary of findings

The maternity services at Tunbridge Wells Hospital were well planned and organised, there were systems in place that ensured that safety was a priority; women and their babies were treated in a well-equipped environment.

Women’s care and treatment followed national evidenced-based guidelines; we were told that staff involved women who use the service as partners in their own care and in making decisions, with support where needed. Risks were effectively assessed and managed, there was a process for reporting incidents and any areas of learning were shared with staff in the maternity service.

However, the gynaecology service did not mirror the same robust approach to the recording of incidents on the electronic recording system. The maternity service demonstrated the trusts vision, being proud of the service they offered to women.

Investigations and internal reviews to look at interpersonal relationships within obstetrics and gynaecology consultants needed to be completed and the findings feedback to staff.

The organisation supports safe innovation; the maternity service recently developed a tongue tie service that had been introduced to meet the needs of local mothers.

Are maternity and gynaecology services safe?

Requires improvement

There were systems in place that ensured that safety was a priority; women and their babies were treated in a well-equipped environment. Staffing numbers were reviewed to ensure that service needs could be met. The maternity dashboard showed that the midwife – to – birth ratio was 1:32 (one midwife to 32 mothers), which was lower (worse) than the nationally recommended ratio of 1:28. The head of midwifery said that the service had a ratio of 1:27 using Kings Fund data (2011).

Risks were effectively assessed and managed; there was a process for reporting incidents and any areas of learning were shared with staff in the maternity service. However, in the gynaecology service there was not the same robust approach to risk management. There were fewer reported incidents completed on the electronic reporting system Datix; there was a trigger list to remind people about recognising and reporting incidents.

Incidents

- The Strategic Executive information System (STEIS) records serious incidents and never events. Serious incidents are those that require an investigation. There were 12 Serious Incidents (SI) STEIS reported at Tunbridge Wells Hospital associated with the maternity service between May 2013 to August 2014.
- Never Events ('Never Events' are classified as serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented). There were no Never Events reported for Maternity services in the year preceding our inspection.
- There was an electronic incident reporting system in place to report near misses or adverse events. Maternity incidents were entered onto the system and graded according to the severity of the incident. Staff we spoke with understood the reporting process. There were weekly risks meetings held; a dedicated risk manager/clinical governance lead for maternity and gynaecology followed up and fed-back about incidents. The weekly risks meetings were open to all staff who wished to attend.
- Gynaecology services did not appear to have as robust an approach to risk management as the maternity unit. There were few reported incidents completed on the electronic reporting system Datix; there was a trigger list to remind people about recognising and reporting incidents.
- Four of the maternity SI's had root cause analysis (RCA) undertaken to learn from the incidents and reduce the likelihood of future harm to patients. Each of the four RCA's we reviewed had action plans in place to reduce the likelihood of a reoccurrence; there was also evidence of shared learning for staff and despite the action plans this did not reduce recurrence of similar incidents suggesting that learning form these vents was not effective. We saw that all the women affected by the incidents had been seen, counselled and an apology offered.
- There was concern that incidents that would normally be considered never events had been downgraded to a serious incident. Evidence from The National Patient Safety Agency (NPSA) Never Events list 2013/2014 update states 'Incidents are considered to be never events if; there is existing national guidance or safety recommendations which if followed would have prevented this type of never event from occurring; e.g. swab counting and checking. Four incidents of retained swabs were not categorised as never events. Although action plans had been put in place after each incident it did not prevent recurrence.
- There were no dedicated perinatal mortality meeting (opportunity for shared learning between obstetrics and paediatrics). Instead cases were presented at alternate bi-monthly clinical governance meetings.

Safety thermometer

- On the maternity unit there were 'How we are doing boards'. Information on display about staffing

numbers both anticipated and actual numbers were also seen at the entrances to the wards.
- Feedback from incidents was disseminated to staff on an individual basis or to groups. For instance there was a monthly risk newsletter; information included outlines of incidents trends and any actions taken.
- The maternity risk manager liaised with ward managers, who then discussed with individual staff to give them feedback. There was a weekly risk meeting, this linked into a monthly clinical governance meeting to ensure that that learning from incidents took place and lessons learnt.

Cleanliness, infection control and hygiene

- The maternity unit we seen to have a good level of cleanliness. There was hand disinfection solution available at all entrances and staff were observed adhering to the bare below elbows policy.
- Cleanliness compliance audits were recorded on the Safety Thermometer boards. Results for weekly cleanliness audits completed between the 1st September 2014 to 29th September 2014 for both the delivery suite and postnatal ward averaged from 97.3% to 98.76%.
- All women were screened on admission for both Clostridium difficile (C.diff) and methicillin-resistant Staphylococcus aureus **(**MRSA).
- The trust performed better than others in the 2013 maternity survey in relation to cleanliness.

Environment and equipment

- The environment in the maternity service was secure. All areas were accessed through secure doors using swipe cards and /or keypads. Each patient/mother was afforded single room accommodation.
- The birth environment was regularly audited using the National Childbirth Trust audit toolkit, (a nationally recognised tool for auditing and evaluating the birth environment to support normal birth).
- There was sufficient equipment in each area visited to ensure patient safety was maintained. The equipment was maintained by medical engineering on a daily basis.
- There was easy access to both obstetric theatres and the neonatal unit, which were based alongside the delivery suite.
- There was a centralised Cardiotocography (CTG) monitoring system; staff said that they had access to enough CTG machines.
- On the delivery suite there were two rooms with birthing pools and one free standing pool. Each of the birthing rooms had wall mounted resuscitation equipment which was checked daily. We were informed that there was a business plan in place to upgrade to include blended oxygen (New-born life support – Resuscitation Council 2010) for babies born of less than 32 weeks gestation.
- There was access to a foetal blood analyser which was available on the delivery suite. A pod (vacuum) system was used for transporting specimens to the laboratory.

Medicines

- There were appropriate arrangements in place for the safe storage of medications in clinical areas; these were stored in lockable rooms and controlled drugs were appropriately stored. Midwives were aware of and followed Nursing and Midwifery Council (NMC) guidelines on the administration of controlled drugs.
- Controlled drug checks were completed at the beginning of each shift. Nitrous oxide (Entonox) was delivered by a piped system in all delivery rooms.
- Fridge temperatures were recorded on a daily basis, results were within the normal expected range.

Records

- Four sets of case notes were reviewed for consistency in completion of records and recording of data.
- Within the records, all relevant risk assessments had been completed including pre-operative checklists and WHO safety checklists for three patients. All patients had had a venous thromboembolism (VTE) risk assessment completed. No VTE incidents had occurred.
- One set of records did not contain a fluid balance chart post operatively and the obstetric early

warning chart had not been fully completed.
- Notes were stored appropriately when not in use. There were clear signs advising staff not to leave notes or records unattended at the midwife reception desk.
- All women were given a "red book", also known as the child health record, which provided information on the health of their baby including neonatal examination and new birth hearing screening.
- In June 2014 a clinical audit report on the gynaecological ward was undertaken, one area audited was record keeping. It was noted that an area for development was health records in relation to notes not being secured effectively, in order of filing; on the day of the inspection on the gynaecology ward there were notes that were loose, held together by paperclips and poor filing of the notes.

Safeguarding

- There were systems in place to identify and protect vulnerable people from abuse.
- Staff received safeguarding training in line with the trust's mandatory training policy. All doctors and midwives received level 3 child protection training.
- There was support and advice available from the Trust adult safeguarding lead. Staff were able to articulate when they had to seek advice for women with substance misuse problems.
- Three midwives were able to tell us about safeguarding procedures and the trust's abduction policy which was available on the intranet.
- One set of notes was randomly selected to review the automatic alert process. Multidisciplinary team notes were available in the records. Risk assessments were completed at the booking appointment and repeated again prior to the baby being born.

Mandatory training

- Staff received effective mandatory training; they had access to and support from five skills facilitators who all have different roles in the provision of training.
- Included in the mandatory training programme were moving and handling, fire and basic life support. Other topics also covered were mentorship, cardiotocography (CTG) interpretation/training as well as breast feeding principles and support.
- All midwives undertook level three safeguarding training relevant for those practitioners in a supervisory role. In alternate years staff completed Mental Capacity Act training.
- Members of the multidisciplinary team, medical staff and midwives had undertaken a specialist training programme called PROMPT (Practical Obstetric Multi-professional Training). On a monthly basis interdisciplinary obstetric simulation training was undertaken involving all staff grades; including obstetricians, anaesthetists and two to three midwives. Scenarios are used from incidents constituting obstetric emergencies.

Assessing and responding to patient risk

- Detailed assessments were completed when women booked into the service, included were social and medical assessments.
- The triage process was overseen by midwives with all calls being diverted to the triage service. A history sheet was completed and the women's details were entered onto the system and tracked. Outcomes were dependent on how patients were presenting, either being sent to the delivery suite, antenatal clinic or home.
- Modified Early Obstetric Warning System (MEOWS) charts were used and utilised appropriately. In the four sets of case notes that were reviewed the MEOWS charts were part of the risk assessment process.
- WHO maternity surgical safety checklists were used to monitor surgical safety.
- Policies for transfer to secondary care from the Midwifery Led Unit or home were clear and accessible.
- Policies and guidelines that were checked at random were Multiple Birth and Obstetric Haemorrhage; both were consistent with national guidance from the Royal College of Obstetrics and Gynaecology (RCOG) and were within date.

Midwifery staffing

- The maternity dashboard showed that the midwife – to – birth ratio was 1:32 (one midwife to 32 births), which was lower (worse) than the nationally recommended ratio of 1:28. The head of midwifery said that the service had a ratio of 1:27 using Kings Fund data (2011).
- Support workers played a valuable role within the maternity care team and took on additional roles.
- The maternity service had their own bank midwives; if agency midwives were used there was a local induction policy.
- The Trust had a record of 100% 1:1 care for women in labour. The service was staffed up to establishment, but was allowed to go over establishment during busy periods. The dashboard showed that in July 2014 the funded establishment as whole time equivalent (WTE) was 186, the actual number of WTE midwives in post was 176.
- The midwifery service used the Birth rate Plus Acuity tool to assess activity, staffing levels and the dependency levels of women..
- There was a clear escalation plan and an on-call system for midwives (three midwives per night were available). If extra staff were required the community midwife or a midwife from the Birth Centre at Maidstone would provide further cover as needed. The midwifery service has recently recruited 11(not all WTE) new midwives across the whole trust.

Medical staffing

- There were 15 consultants within the Maternity and Gynaecology service.
- The staffing skill mix for medical staffing, which comprised of 51 WTE doctors, was made up of 52% Specialist Trainee grade doctors and the remainder were 12% at junior doctor's grade and 4% at Foundation Year 1-2.
- Multi-disciplinary handover took place twice daily at 08:30 and 20:30. Attendance for key members of staff was required unless they were occupied with an emergency.
- The process for the handover followed a 'WHO' style, systemic review of delivery suite board, overview of the unit, outliers e.g. Intensive Care Unit (ICU), staffing review, bed availability and priority for review.
- The dashboard showed that the weekly hours of dedicated consultant presence on the delivery suite had increased; from May 2013 to March 2014dedicated consultant hours were 66 hours. From April 2014 to August 2014 consultant hours on the delivery suite have increased to 74.5 hours.
- We observed part of a ward round on the 15 October 2014, with two pregnant women on the antenatal ward. We noted that the ward round was structured; there were discussions between obstetric doctors and the midwife caring for the pregnant women.
- We spoke with three medical staff who were all positive about working for the organisation, they felt well supported and had protected teaching time. They said that following the introduction of the 'Hot Week' for consultant cover, there was improved continuity of care for patient's journey through maternity services.

Major incident awareness and training

- The maternity service reported that there had been no unplanned closures of the unit between May 2013 and August 2014.
- There was a Business plan cycle, currently there is a business case proposing extended the opening hours of the Emergency Gynaecology Assessment Unit (EGAU) to provide a weekend service.

Are maternity and gynaecology services effective?	Requires improvement ●

National evidenced-based best practice, professional standards and expert guidance were routinely used to ensure that mother's needs were assessed and care was delivered that was safe and effective.

Care and treatment was based on nationally recommended guidance, which included National Institute for Health and Clinical Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). Women had access to comprehensive antenatal assessment which reflected their choice based on clinical need.

In the gynaecology unit we requested to look at written guidelines and policies that staff would utilise to provide evidence based care and best practice for the patients. We reviewed 12 guidelines/policies, of these 11 policies had expired with review dates from 2008-2011.

Evidence-based care and treatment

- The maternity service was managed in accordance with the principles in 'Safer childbirth (RCOG 2007), currently dedicated consultant presence on the delivery suite was 74.5 hours. Midwifery co-ordinators were supernumerary as per the guidance.
- Policies routinely made reference to guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) and the National Institute for Health Care Excellence NICE).
- We looked at the number of women booked into the antenatal pathway before 12 (+6) complete weeks. Scheduled bookings of women attending the antenatal clinic (1st visit) from May 2013 to August 2014 averaged from 78% to 85%.
- Women were routinely offered advice during the antenatal period, including topics about smoking cessation and foetal anomaly screening. This reflects care that is consistent with the NICE quality standard 22 for antenatal care.
- Evidence from the maternity dashboard indicated that the number of women who successfully opted for a vaginal birth following caesarean section (VBAC) varied from 47% to 83% over a 16-month period. We did not have information to measure what the key performance indicator (KPI) of VBAC was set at for the service.
- In the gynaecology unit we requested to look at written guidelines and policies that staff would utilise to provide evidence based care and best practice for the patients. We reviewed 12 guidelines/policies, of these 11 policies had expired with review dates from 2008-2011. It had been identified and recorded in the minutes of the Women's directorate meeting that polices in both maternity and gynaecology were out of date. Action to rectify this had been identified.

Pain relief

- Pain relief provision encompasses a range of choices for women in labour; opioids, epidural, use of water and aromatherapy.
- There was a good response rate from anaesthetists to women requesting epidurals. The response rates were audited regularly; the response to request times was consistently 30 minutes or less. Women having an epidural for pain relief were reviewed and followed up on the postnatal ward by the anaesthetist. There was 24 hour anaesthetic cover provided for the unit.

Nutrition and hydration

- The maternity unit had two Breast Buddies volunteers; they said that they were well received by mothers. They described themselves as a "Peer group and non-medical"; they both felt supported by the staff that highlighted women for them to visit and support.
- The breast feeding rates at initiation were 84%; currently the unit had UNICEF Baby Friendly Initiative level one status and planned to raise this to level three.

Patient outcomes

- Data collected before the inspection, showed that the trust had a similar profile of delivery compared to all trusts in England (2013/2014).
- The maternity dashboard for the trust indicated a caesarean section rate of 27.1% to 31.2%; from April 2014 to July 2014. This was measured against a key performance indicator (KPI) of 25% for caesarean sections performed.
- However, there was some discrepancy in the data reported as being higher than actual figures on some elements of the dashboard. One element was related to caesarean rates. There was a discrepancy between data supplied from the information department and that supplied by the

maternity database system.

- The solution to ensure the robustness of the data included a business case being implemented and approved; designated personnel from the information department would oversee data input.
- Data collected prior to the inspection showed that there were no maternal outliers.
- The total number of deliveries for the trust was 5,377; 59% were normal (spontaneous) deliveries. This was statistically similar to other trusts nationally.
- The total number of deliveries categorised as ‘other forceps delivery’ was 5.9%. This was statistically higher than other trusts nationally.
- There is no dedicated Obstetric Anal Sphincter Injury Service (OASIS) clinic for follow up of women with third and fourth degree perineal tears. Women are seen for postnatal follow up between six to eight weeks in a gynaecology clinic.
- A component of the action plans developed following the RCA’s into the retained swabs, was to audit maternity perineal suturing. Five sets of notes were audited weekly to check documentation and adherence to guidance, there have been no further incidents reported or recorded as an SI.

Competent staff

- Midwifery supervision by the Supervisors of Midwifery (SOM): had completed 96.6% of annual reviews. The Nursing and Midwifery Council (NMC) target was 100%. Eight new SOM were in post, this had increased the SOM ratio of supervisors to midwives from 1:20 to 1:12.
- There were clinical facilitators to support preceptorship midwives five-days per week.
- Information given to us by the trust indicated that in August 2014, non-medical appraisal compliance was 77.1%. This was against a target of 90% compliance.
- Medical staff within the women’s services directorate had achieved an appraisal compliance rate of 82%. This was against a target of 85% compliance.
- The trust has two WTE antenatal and new-born screening co-ordinators who provide educational updates for midwives and staff.
- Electronic foetal monitoring CTG training was provided yearly to midwives.

Multidisciplinary working

- A clinical audit of the gynaecology ward was undertaken from the 17th to 25th June 2014. The audit identified areas of good practice but also identified areas that could be improved including procedures to support non-gynaecological patients.
- There was effective working with other health and social care services with examples including liaising with health visitors at 24 weeks gestation.
- Discharges were sent electronically to General Practitioners (GP’s) and community midwifery teams. It was reported that there were some problems with remote access to IT from GP surgeries.
- There is a High Dependency Unit (HDU) team of 20 plus midwives, obstetric and anaesthetics leads, who have strong links with the Intensive Care Unit (ICU). They work with the ICU to promote shared training sessions for midwifery staff.
- There is a neonatal outreach team that visits the postnatal ward daily, they were also available for advice and support. Transitional care was provided for an average of eight cots for babies from 34 weeks gestation upwards. The transitional care facility on the postnatal ward was supported by nursery nurses.
- Community support workers (band 3), with a team of 10 midwives offered support specifically around new-born screening, breast feeding support and parent education. There were joint clinics held for women with co-morbidities, such as diabetes.
- There were close links with regional specialist units, for cardiac and advanced screening.
- There was a designated perinatal consultant psychiatrist, who had patients referred for patients with mental health issues. Substance misuse involving pregnant women were looked after by the Concern and Vulnerability team.

Seven-day services

- The maternity, delivery suite had 74.5 hours of dedicated consultant cover per week. There was a named weekly consultant who covered Monday to Friday, with two consultants on call. The consultant was resident at the weekend between 9am to 3pm.

Access to information

- There had been concerns raised by consultants about the impact on changes from within the Clinical Administration Unit (CBU); this included a reduction in the amount of secretarial support. This had impacted on them being able to access reports, results availability, letters and management of their clinic appointments. We have seen from minutes of the Women's Directorate meeting that measures were being looked at to redress these concerns.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Midwives undertook mental capacity training; this was provided on alternate years via the Trust mandatory training, and was also available as an eLearning module.
- There was evidence of consent being obtained from women. Informal consent was obtained from women for suturing or episiotomies. Full written consent was obtained from women undergoing caesarean section or an instrumental delivery.

Are maternity and gynaecology services caring?

Good

Feedback from people who used the maternity service was positive about how staff treated them. All staff involved women who use the service as partners in their own care and in making decisions, with support where needed. Staff told us that providing a positive experience for women and their families was their priority.

Compassionate care

- We observed a partial ward round on the antenatal ward; we saw that the staff reviewed any relevant information prior to meeting the women to discuss their progress and further treatment options.
- We observed that the women were shown respect, their understanding and concerns about their condition or management were answered. We saw that staff paraphrased to give clarity and understanding to ensure the women understood and agreed with their treatment plans.
- The 2013 CQC Survey of Women's Experiences of Maternity Care reported that the trust performed in line with the England average for the maternity survey. However, it performed worse in the maternity survey in relation to staff introducing themselves.
- The Friends and Family Test (FFT) for maternity services showed better or in line results with average FFT results, although there were low response rates.
- Bounty representatives visited the unit each day. The representatives were subject to the same privacy and dignity policies as trust staff.

Understanding and involvement of patients and those close to them

- Written information was readily available on the unit.
- It was possible for pregnant women and their partners to view a virtual tour of the maternity unit on the trust's website; the normal birth pathway was incorporated as well. It was also possible to ring the delivery suite and have a tour of the facilities and meet the staff.
- On the trust website there was a comprehensive leaflet called 'Choice for Place of Birth at Maidstone and Tunbridge Wells NHS Trust'. The leaflet gave detailed information for parents to choose their preferred birth option.
- Evidence from records that women receive appropriate advice/explanation re: choice of location for birth. Risk assessment was completed at booking and repeated again at 34 weeks. Women had a named midwife or community midwife.
- An example of positive impact of the supervisor role in working with women was a letter from a mother who had engaged with the supervisor and was able to discuss birth options and commented positively on the input and sensitivity shown in helping her to make her birth options.
- Four women and their partners that we spoke with on the day of the inspection were positive about the communication between themselves and the staff, also the way in which they had been treated.

- Two fathers felt that they had been involved in decision making and helping with caring for their partners

Emotional support

- There were two bereavement specialist midwives who supported parents. There was a separate room available close to the main labour ward, to offer parents privacy.
- The specialist midwives acted as a resource especially for midwives in completing documentation referring to stillbirth or neonatal loss pathways.
- The unit worked closely with the local Tunbridge Wells Stillbirth and Neonatal Death Charity (SANDS) group, who offered support to parents.
- The average length of stay for mothers was two days. Early transfer home was available if the condition of the mother and baby permitted.
- There were two memorial services held per year one was conducted by the hospital Chaplin; the other by local SANDS group. Invitations were sent out to all parents who had suffered a foetal or neonatal loss.
- Pastoral support was offered by the Chaplin, who met parents.

Are maternity and gynaecology services responsive?	Good ●

The maternity service delivers care which meets and is responsive to the women who use the service. There is active engagement with relevant stakeholders to provide coordinated pathways of care.

However, in the gynaecology service review of patients on the gynaecology ward by medical staff, timing of ward rounds and discharge plans could impact on patients being discharged in a timely manner. There were concerns raised about the delay in referral from the diagnosis of cancer to the gynae-oncology service, meaning that some patients were close to breaching at referral.

Service planning and delivery to meet the needs of local people

- The maternity service was proactive in supporting women's choices and promoting normal birth. There is a normal birth newsletter.
- The maternity unit had four telemetry sets which had been purchased following feedback from women, the benefit was improved choice for women to have their baby's heart rate monitored whilst mobilising or in the pool.
- Birth Voices – Maternity Service Liaison Committees (MSLC) work closely with the service to meet the needs of women and their families. An example of this was identified as a result of feedback re: concern from women who use the service that birthing pools were not always available, the solution was that a portable birthing pool was purchased.
- Women have access to a Healthy Weight clinic which is facilitated by two midwives, referrals to the clinic can be made to support obese and bariatric women. Bariatric women with a co-morbidity were reviewed by an anaesthetist and a resource folder has been developed for staff.
- There is no dedicated Obstetric Anal Sphincter Injury Service OASIS clinic for follow up of women with third and fourth degree perineal tears. Women are seen were seen for postnatal follow up between six to eight weeks in a gynaecology clinic.
- There were a wide range of informative leaflets available, they appeared to be available in English we could not see them printed in other languages.

Access and flow

- The maternity day unit (MDU) had recently extended its hours to be open from 8 am to 8 pm. The benefit to women using the service has been an appointment to be seen at a specific time and has reduced the demand on triage.
- The triage unit assess mothers in labour; they can have between 17-20 mothers who they direct to the appropriate pathway. All calls came through triage, a history sheet was completed then the women were tracked and directed to the appropriate care pathway.

- The induction of labour was conducted on the antenatal ward; there were normally six inductions per day. Feedback from women from Birth Voices survey 2014 highlighted that women felt they did not have enough information about the induction process.
- In order to improve the patient's journey, an Induction of Labour co-ordinator (IOL) role had been created. The IOL had responsibility for women undergoing IOL, to keep them informed and co-ordinate their care.
- There were elective caesarean theatre lists daily, occasionally emergency activity on delivery suite interrupted elective list. When this occurred a second theatre was opened so that there would be no impact on elective activity.
- On the day of the inspection the gynaecology ward had 11 beds occupied; of these five were non-gynaecology outliers. Review of patients on the gynaecology ward by medical staff, timing of ward rounds and discharge plans could impact on patients being discharged. Bed occupancy was between 89%-95%.
- There were concerns raised about the delay in referral from the diagnosis of cancer to the gynae-oncology service, meaning that some patients were close to breaching at referral.
- It was documented in the gynaecology ward meeting minutes held on the 2nd September 2014, that there was ongoing work around elective patient's admissions processes.

Meeting people's individual needs

- The handheld records of women showed that their individual needs were addressed through assessment.
- There is no access to language line or similar interpretation services. This was not identified as being a problem, we were told there were small numbers of non-English speaking service users. The solution was to be able to normally find a member of staff to interpret.
- In reading the conclusion from the Gynaecology ward audit, those non-gynae patients being looked after on the ward did not have their individual needs met. Many did not having nursing assessments completed or have individual risk assessment completed.
- On the day of the inspection one set of post- operative notes was reviewed, the notes contained WHO checklist, consent, as well as good medical and nursing documentation.

Learning from complaints and concerns

- Throughout the maternity unit and gynaecology ward there was information available in the form of leaflets, advising women or patients/carers how to make a complaint.
- On the maternity unit any concerns were dealt with informally if possible. There was the opportunity for a postnatal de-brief, firstly with the ward manager specific to the area of concern. The postnatal de-brief was with a consultant if it involved a caesarean section or instrumental birth.
- Complaints were co-ordinated by governance lead for Women's and Children's health services. Themes were included in the Risk Management Newsletter on a monthly basis.
- Individual staff members seen and statements obtained, anonymised copies of complaints put into clinical areas for staff to read.
- At the clinical monthly governance meeting a summary of complaints with action plans and updates were provided.

Are maternity and gynaecology services well-led?

Requires improvement

Staff within the maternity service shared the trust's values; being proud of the service they offered to women. Women were at the heart of everything they did. This was not as evident in the gynaecology service where there was a more fragmented view and staff did not feel respected, valued or supported.

Staff raised concerns regarding the behaviours and attitudes amongst the consultant workforce. Whilst the trust executive team had acknowledged that they were aware of problems existing within the obstetric and gynaecology team, a recommendation for the trust to commission an external review to address the fragmented working relationships amongst the consultant workforce had yet to take place.

Vision and strategy for this service

- Staff within the maternity service shared the trust's values; being proud of the service they offer to women. Women were at the heart of everything they did.
- There was a strategy in place to develop maternity services, proactive in supporting women's choices and promoting normal birth. There was a normal birth newsletter.
- The gynaecology ward had an interim matron who produced a weekly update for staff which included a focus on weekly priorities for the ward.

Governance, risk management and quality measurement

- Senior staff in both services had a good understanding of the risks that could impact on the safety and effectiveness of the service. The risks were recorded on the trust's risk register and monitored at monthly risk meetings.
- The service continued to raise the midwifery supervision by the Supervisors of Midwifery (SOM) profiled and encouraged staff to access resources for help and advice. SOM meeting minutes fed into the clinical governance meeting. The SOM sat on the risk management / clinical governance meeting and participated in their capacity as a supervisor of midwives.
- There was a specialist midwife- risk manager and governance lead whose responsibilities included conducting audits, following up on any incidents, conducting root cause analysis and monitoring any identified risks for both the maternity and gynaecology services.

Leadership of service

- Concerns had been identified about the working relationships amongst the consultant body. There was also concern expressed about bullying and harassment taking place. An external review was approved to look at concerns and issues raised, but at the time of the inspection, this review had not been commissioned.
- Aside from the concerns raised about the working relationships amongst the consultant team, there were concerns raised about staff behaviours and nursing care on the gynaecology ward.
- All midwives had a named supervisor who conducted an annual review, as well as monitoring performance on an ongoing basis.
- The midwifery to supervisor ratio is 1:12, as recommended by the local supervisory authority (LSA) to allow for periods of absence and attrition.
- Staff viewed the head of midwifery with respect within the trust.
- In 2013 there was a leadership programme for Band 7 senior midwives, to develop and empower them to be effective leaders. The programme entailed a process called 360 degree appraisal, questionnaires were given out and completed anonymously by staff. The questionnaires were based on ten questions with elements of leadership; in October 2014 the same exercise was extended to the Ward Managers and Matron. The completed questionnaires would be collated and feedback would be given on a 1:1 basis by the head of midwifery services.

Culture within the service

- There was a clear directive from staff that they all felt that they had a role to play in providing quality care to women and their families.
- Some maternity staff were proactive and responsive. From the staffs perception there was some division amongst the consultant body.

Public and staff engagement

- Feedback from women's experience of care was used to drive improvements in the maternity service. Feedback was collected through a variety of different methods.
- A Maternity Questionnaire was given to all mothers once a week, so that a snapshot of how well the service was performing. Changes were made to improve awareness of food availability, especially during the night.

- Other sources used to gain feedback, included surveys FFT and the CQC maternity services 2013. The maternity service developed a 'You said – We did' action plan for inpatient maternity services.

Innovation, improvement and sustainability

- A tongue tie service has been introduced to meet the needs of local mothers. Previously parents would have had to travel to regional centres outside of the locality. An innovation to meet the needs of the local population was for an infant feeding specialist to complete the relevant training. The tongue tie service is now established. Negotiating with CCG, tongue tie and breast feeding rates help to improve cost improvement programme (CIP).
- There was little evidence of innovation, improvement or sustainability in gynaecology. There was a new interim matron to oversee the service. Staff expressed that there was poor communication and staff shortages that impacted on them feeling supported, they felt their voices were not heard and there was poor engagement.
- In gynaecology there was no time to do audits. There was a lack of consultant leadership. There was a heavy reliance on bank and agency nurse who were not familiar with gynaecology as a speciality, so required continued supervision.

Services for children and young people

Safe	Requires improvement	●
Effective	Requires improvement	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Requires improvement	●
Overall	Requires improvement	●

Information about the service

Tunbridge Wells Hospital provides a range of services to neonates, children and young people. The 18 cot neonatal unit provides level 2 neonatal care for both pre-term and term neonates born from 27 weeks gestation. The neonatal unit is divided into 5 separate areas each of which are specifically designed to accommodate neonates depending on their acuity and level of care required.

Hedgehog ward comprises of 23 beds and accepts children aged from 0 to 16 years who are admitted via both the emergency and elective care pathway. The Woodlands unit, located directly opposite Hedgehog ward is a 10 bedded unit and hosts a range of elective day-case surgical services. An additional five ambulatory care beds are also located on the Woodlands Unit; the unit accepts a range of children including those that have presented to the emergency department and subsequently referred to the paediatric team for further assessment and monitoring.

The most recent data supplied to us by the trust demonstrated that year to date occupancy for the neonatal unit was 63%, hedgehog ward 77% and the Woodlands Unit 71%. Actual year to date numbers for day cases equated to 53 children between April and July 2014, 139 elective inpatients and 1,160 non elective inpatients.

Children's outpatients hosted a total of 4,619 visits between April and July 2014, an increase of 1,142 on the same time period the previous year.

We talked with 6 parents and their children, 12 members of staff including nurses, matrons, play specialists, doctors, consultants and support staff. We observed care and treatment being provided.

Summary of findings

There was a collaborative approach to ensuring the nursing and medical needs of children were met. However, the relationship, engagement and management of children requiring surgical intervention required significant improvement. The children's directorate lacked any formal governance framework which incorporated the surgical directorate; this led to some surgical patients not being offered pre-assessment appointments, the post-operative management of patients was inconsistent and written information was neither age specific or appropriate.

The directorate used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. However, there were discrepancies with the pre-operative management of children undergoing surgery with regards to nil-by-mouth guidance.

Performance against national audits was varied. The NNU performed well when compared nationally and although the NNU did not always meet national benchmark standards, action plans had been generated to improve services. However, children admitted for suspected febrile neutropenia could not always expect to receive antibiotics within an hour of arrival.

Parents and children were generally complimentary about the care and treatment provided. However, there were mixed reviews about the attitudes and behaviours of some surgical teams.

Where children and/or parents/carers had cause to complain, these complaints had been acknowledged, investigated and action plans generated to help improve services for the future.

The children's directorate lacked a formal vision or strategy and some staff were unaware of the trust's values. Day to day leadership within the directorate was good although the visibility of some senior managers needed to be improved. Whilst the directorate operated a risk register, we found this to be heavily underutilised. Whilst directorate leaders were aware of the issues which posed a potential risk to the operational effectiveness of the service, these risks were not always escalated to the trust board, nor were there any robust action plans in place to resolve issues.

Are services for children and young people safe?

Requires improvement

Whilst the trust had a system in place for the management of incidents, we were concerned that the threshold for reporting incidents amongst staff was exceptionally high. We found occasions whereby incidents had occurred but had not been reported through the correct process.

Equipment and the environment were suitably maintained and visibly clean. Medicines were stored appropriately however there was a standardised practice amongst nursing staff of applying prescription only topical anaesthetics to children without a valid prescription being in place. Furthermore, the use of Patient Group Directives (PGD's) was heavily underutilised within the children's wards.

The number of eligible staff trained in level 3 safeguarding children was lower than the trusts standard of 85%.

Children admitted to Hedgehog ward were monitored and observations were recorded on a Paediatric Early Warning Score system. However, patients admitted for day surgery were not; staff utilised a standard observation tool and staff told us they would rely on their experience and knowledge should they have concerns about the condition of a child. Furthermore, we were not assured that the PEWS system in place had been appropriately validated nor supported by robust escalation criteria to ensure a timely response was provided upon a child triggering the tool.

Nursing and medical staffing levels were, in the main appropriate. However, there were occasions when nurse levels fell below the set established requirement. Furthermore, concerns were raised with regards to the recruitment of appropriately qualified middle-grade doctors.

Incidents

- A total of 80 incidents attributed to children's services were reported on the trust's electronic incident reporting system between 1 April 2014 and 19 October 2014. Due to the nature of the way the data was provided, it was difficult for us to identify the locations that some incidents referred to and so the quoted number is inclusive of incidents that occurred within the children's and young person's service at Maidstone hospital.
- During our inspection we spoke with 12 members of staff. Each staff member was able to describe the incident reporting system. Each staff member was able to describe the process for reporting incidents although there was a common theme amongst staff that the process of incident reporting was time consuming.
- However, we were concerned that from having spoken with staff, a number of incidents were unlikely to be reported because they were not perceived to meet the criteria of a "clinical incident" or were considered too insignificant to report. We also found that there were alternative reporting systems in place which fell outside the trusts policy on incident reporting.
- For example, during the inspection we noted that an elective day surgery list had still not commenced at 10:00am. When we spoke with staff they reported that the list was scheduled to

start at 08:30. Whilst the children had been consented by the surgical team, the anaesthetist had not been to assess the children. The nurse responsible for overseeing the care of the children made contact with the theatre department. Following a short conversation the nurse was advised that the theatre team would be sending for the first child imminently and that the anaesthetist would see the children in the anaesthetic room. We asked the nurse whether the delayed start would be reported as an incident; they confirmed that it would. However, following the inspection, we asked for a summary of all clinical incidents attributed with children services up to and including 19 October 2014. There was no incident reported which described the events we observed on 15 October 2014.

- Furthermore, during a discussion with the senior management team for the children's and young person's service, it was reported that an informal process was in place whereby upon delay of the commencement of a theatre list, the theatre team would send a notification of delay via email to the general manager responsible for the surgical team to whom the delay was attributed. This meant that the reporting of some incidents fell outside the trusts risk and governance process.
- There were however, processes in place for the investigation and analysis of incidents which were reported. In the majority of cases, there was evidence that investigations occurred and that lessons learnt were generated. However, there was no apparent process for disseminating those lessons learnt in order that all staff were engaged with the risk management strategy.
- We asked staff whether they received feedback from incidents. Almost every staff member reported that they would receive individual feedback if they had been involved in an incident. Some staff reported that they were informed of incidents at their monthly team meetings whilst others reported receiving emails from the band 6 nursing team who were responsible for investigating incidents.
- Incidents such as unexpected deaths were discussed at one of the 10 clinical governance meetings which occurred throughout the year. These meetings were used as a forum to discuss clinical issues, complaints and child protection issues. 5 of the 10 meetings were also attended by the maternity team in order that ante, peri and post-natal issues could also be discussed.

Safety Thermometer

- Children's services routinely participated in the trust wide; harm-free care 'Safer, Smarter' initiative (a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care). This was complemented by completion of the NHS Safety Thermometer tool.
- The directorate dashboard for children's services indicated that the service was 100% compliant with providing harm free care (NHS Safety Thermometer) between March and July 2014 (most recent data that was made available to us).
- With regards to the safer, smarter initiative, 1 slip, trip or fall had been reported in July 2014 and 6 drug administration errors had been reported between May and July 2014.

Cleanliness, infection control and hygiene

- During our observations of the immediate environment in which children and neonates received treatment and care, we found all areas to be visibly clean. There was engagement between the matrons and domestic staff working on the NNU to ensure that cleaning of all areas was carried out; we observed the domestic staff cleaning door frames and skirting boards as well as non-clinical areas such as store rooms.
- Where cleaning took place, domestic staff were using colour-coded equipment items for different parts of the ward. Domestic staff reported that they had access to policies and visual guides including the "Clean to dirty" protocol which provided clear visual instructions to staff on how to safely clean areas such as toilets.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons. Staff routinely washed their hands both before and after patient contacts within the NNU.
- Audit data demonstrated that 100% compliance with bare below the elbows policy was achieved in both the NNU and on Hedgehog ward between July and December 2013. In January and February 2014 compliance with bare below the elbows dropped to 90% and 84% respectively on Hedgehog ward and to 85% in February 2014 on NNU. Both units attained 100% compliance in March 2014.
- Staff and visitors were observed to be washing their hands before they entered the NNU.
- There were systems for ensuring that the play room and toys were cleaned on a regular basis.

- Results from cleaning audits were displayed throughout the ward areas. The NNU, which was listed as a high risk clinical area, had attained a five week average cleaning audit compliance score of 98.63% (1 September – 29 September 2014). Hedgehog ward, which was listed as a high risk clinical area attained a score of 98.56% during the week the audit was carried out (week commencing 8 September 2014).
- There had been no reported cases of Clostridium difficile or Methicillin Resistant Staphylococcus aureus bacteramia's between April 2013 and July 2014 for children's services (most recent data available).
- Audits for both hand hygiene and saving lives high impact interventions demonstrated 100% compliance between April and July 2014 (most recent data available).

Environment and equipment

- The department had a range of equipment, which was seen to be visibly clean. Labels were in use to indicate when items of equipment had been cleaned.
- The rooms on Hedgehog ward and the Woodlands Unit consisted of individual rooms, each with en-suite facilities.
- Rooms were found to be visibly clean, and equipped with emergency equipment such as oxygen and suction; we saw evidence that rooms were checked each day to ensure they were appropriately equipped.
- Consumable equipment was found to be in date. Staff told us there was usually sufficient equipment available at all times. They would borrow from other wards when necessary.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.
- We saw evidence that regular checks of resuscitation trolleys were carried out.
- It was noted that some equipment had service labels attached whereby service dates had lapsed. This included, as an example, an ECG machine located on Hedgehog ward which stated that the machine was next scheduled for a service on 26 September 2014; it was not clear whether or not this service had taken place.

Medicines

- There were processes for ensuring medications were kept securely. Medication fridges were found to be locked. Fridge temperatures were routinely being recorded to ensure that medicines were stored as per the manufactures' recommendations.
- Controlled drugs were stored according to legal requirements. Staff were observed to be carrying out routine stock checks of controlled drugs.
- The eight drug charts we reviewed showed that medicines were prescribed by registered medical practitioners. However, we found that some medications such as local topical anaesthetic creams were not always being prescribed prior to them being applied to children and young people who required venous cannulation and blood sampling. Whilst the trust provided us with a copy of a patient group direction for the administration of a range of medications including topical anaesthetic and analgesics such as paracetamol and ibuprofen, the staff who had applied the topical anaesthetics informed us that they had not completed any training with regards to patient group directions, nor had they received authorisation to use the direction in line with trust policies.
- Staff had access to national formularies such as the British National Formulary for Children and a local electronic formulary detailing the preferred antibiotics for specific infections including but not limited to, respiratory tract infections, urinary tract infections and suspected sepsis in the neonate.
- Clinical areas were supported by daily and weekly visits from a paediatric pharmacist.

Records

- The preoperative checklists we reviewed for children who had gone to theatre were completed following the trust's policy for pre-operative management.
- The eight patient care plans on the medical ward we reviewed were comprehensive and were modelled on family centred care. Relevant risk assessments had been completed and there were daily evaluation records of whether people's health and emotional needs had been met.

- During our inspection, we noted that records were kept securely.
- We found evidence that the department was utilising the World Health Organisation (WHO "Five Steps to Safer Surgery" Checklist.

Safeguarding

- Staff had a good understanding of their roles and responsibilities when reporting safeguarding concerns.
- A policy relating to safeguarding children and young people was available and accessible and had been reviewed in October 2013 and ratified by the Quality and Safety Committee in November 2013. The policy was cross referenced with national policies, procedures and guidance including information from the Kent and Medway Safeguarding Children Procedures 2007, Royal College of Paediatrics and Child Health: Safeguarding Children and Young People 2010 and the Department of Health: Working Together to Safeguard Children 2013.
- The trust also provided us with a copy of the Kent and Medway Safeguarding Children Procedure, reference RWF-OWP-APP113; this document was dated September 2007. In line with national recommendations, amendments are made to this document every six months, with the most recent having taken place in October 2014. Therefore, the version held by the trust is likely to be out-of-date and should be updated to ensure staff have access to the most recent guidance.
- The hospital had a named nurse and named executive for safeguarding children.
- There were systems for referring children and adolescents to the local Child and Adolescent Mental Health Service (CAMHS).
- The care records we reviewed were all fully completed with family and patient demographics and composition being recorded; this was consistent with recommendations from Lord Laming's report into the death of Victoria Climbé in 2000.
- The areas within children's services were supported by a safeguarding nurse who was further supported by two part-time nurses.
- 83%, 84% and 63% of staff had completed training in level 1, 2 or 3 safeguarding children, respectively.

Mandatory training

- Compliance with mandatory training by staff in the children and young person's directorate at Tunbridge Wells was below the expected range of 85%. Data provided by the trust demonstrated that 75% of staff working in the directorate were up-to-date with their mandatory training.

Assessing and responding to patient risk

- For children admitted to Hedgehog ward, the trust used a bedside Paediatric Early Warning Score (PEWS) system to ensure the safety and wellbeing of children. This system enabled staff to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required.
- However, we found that children admitted for elective day case surgery were having their observations recorded on an age specific PEWS chart. In a number of cases on the Woodland Unit, a standard paediatric pain assessment and observation chart which had been integrated into a paediatric multi-disciplinary surgical care document was being used. We case tracked three patients who had returned from theatre. The observations for each child had been plotted on the standard chart. The nursing and auxiliary care staff explained to us that they would rely on their own knowledge to determine whether observations were abnormal and would then escalate accordingly. One member of staff told us that if a child's observations were abnormal, they would plot their observations onto a PEWS chart to then determine whether the child's condition should be escalated according to the local policy. Section 1 of the trust's resuscitation policy states "A patient charting system that facilitates the regular measurement and recording of early warning scores should be in place to identify patients at risk". The observation chart included in the surgical care pathway document did not meet this requirement of the policy.
- Staff on Hedgehog ward were aware of the appropriate action to be taken if patients triggered a high PEWS; patients who needed close monitoring and action were identified and cared for

appropriately. However, the criteria for escalation required further clarity; there were no defined times in which nursing and medical staff should review a child. For example, the action to be taken when a child scored 3 or more on their PEWS was listed as "Nurse in charge and doctor to review"; the pews process lacked sufficient detail to ensure that staff actions were defined by a trust policy which specified time limits as an example of how quickly a specific health care professional should respond.

- It was also noted that the PEWS observation chart for each of the various age groups (1-4 years, 5-11 years and over 12 years) stated "Blood pressure to be recorded on admission and then as required. This does not form part of the total PEWS". Guidance from the Resuscitation Council (UK): Prevention of cardiac arrest and decisions about cardio-pulmonary resuscitation: 2010 states "There is already evidence of marked, often untreated, abnormalities of common vital signs in the 24 hours prior to the admission of children to an ICU, similar to those reported in adults. Recognition of the seriously ill child relies on determination of the normal and abnormal age related values for vital signs, and reassessing them in the context of the progression of the child's condition. As in adults, serial measurement of heart rate, respiratory rate, temperature, blood pressure and conscious level, particularly following any clinical intervention, must be performed and acted upon. Intervention at any early stage in an unwell child reduces significantly the risk of developing irreversible shock". Of the three charts we reviewed, none of the children had undergone blood pressure monitoring post-operatively.
- The trust confirmed that they had not completed an audit to determine whether the PEWS charts in use were effective and they were unable to provide supporting evidence to help determine whether the PEWS tool had been validated.
- We were provided with an audit which had been carried out in May 2013 in which the trust had reviewed it's clinical management of bacterial meningitis in children to determine whether they were meeting national standards as set out in NICE Clinical guideline 102: Bacterial meningitis and meningococcal septicaemia – Management of bacterial meningitis and meningococcal septicaemia in children and young people younger than 16 years in primary and secondary care. It was noted that the trust had not met standard 1 of the clinical guideline in that "Symptoms signs & initial assessment; children & young people with suspected bacterial meningitis should have the following monitored & recorded at least hourly: Heart Rate, respiratory rate, oxygen saturations, blood pressure, temperature, perfusion and neurological assessment. In each case, compliance was 33% (heart rate), 33% (respiratory rate), 33% (pulse oximetry), 0% (blood pressure), 22% (temperature), 0% (perfusion), and 11% (neurological assessment). It was noted that the existing observation chart did not allow staff to record perfusion as an observation. A resulting action plan to address those standards not met included "Perfusion (Capillary refill time) to be documented in the observation chart" and "Current observation chart does not have space for documenting CRT. It should be documented currently in an unused space and in future, separate row should be included when redesigning". This action was listed as being completed on 15 May 2013.
- The observation charts currently in use did not allow for visual and sensual observations such as respiratory distress (tracheal tug, costal and sub-costal recession) and perfusion as examples to aid in the assessment of a child, to be recorded.

Nursing staffing

- Information provided by the trust indicated that, as of July 2014, the establishment for the children's wards directorate (including NNU, Outpatients, Woodlands and Hedgehog ward) was 99.7 whole time equivalent (WTE) posts, with an overall vacancy rate of 5.2 WTE (5%). We found that the department was spending more money than had been budgeted on temporary staffing so as to ensure that shifts were appropriately covered.
- Whilst the overall vacancy rate was low, the directorate management team considered that nurse recruitment could be problematic due to the trust's close proximity and easy access links to London hospitals where nursing salaries were generally higher due to London weighting payments.
- We found that the nurse-in-charge of the clinical area did not always have supernumery status; that is, the nurse in charge was occasionally required to take charge of patients whilst also being responsible for the management of the shift. The Royal College of Nursing guidance: Defining staffing levels for children and young people's services 2013 suggests that "The shift supervisor in each clinical area will be supernumery to ensure effective management, training and supervision of staff". We found that on the Woodland Unit, one junior nurse was responsible for the clinical area

whilst also being the named nurse for four children. In the Woodlands ambulatory unit, the senior nurse had accepted a patient case load. We were told, and found that a senior nurse of Hedgehog ward was supernumery and was tasked with overseeing each of the three clinical areas.

- Between April 2014 and 19 October 2014, 2 incidents were reported which referred to staffing incidents. The first incident was reported as "…the nurse in charge described the ward as being very short staffed due to two staff members calling in sick." Whilst action was taken to resolve the short-notice sick leave by seeking agency staff to fill the vacancies, the agency nurse was reported as only being available from 3pm and so the ward remained short of staff for a period of the day. The incident report then states "There was a period of up to 5 minutes when a bay with babies in open cots was not being watched/supervised by any staff members. There was no nursing staff at the nurse's station outside the bay at this time. There was one child who was not supervised by his/her parents. There were other adults in the room at this time with their own child". The incident was investigated and immediate action was taken to resolve the issue, as well as being escalated to the chief nurse.
- Whilst there were occasions when staffing ratio's fell below the set establishment, we found that there was a sense of cohesive team-working in the department. Parents/carers commented that nursing staff and health care assistants responded quickly to call bells and that staff were attentive to their needs when they responded.

Medical staffing

- Consultant cover was provided daily from 08.00hrs to 18:30hrs on weekdays. Two consultants provided on-call cover overnight during the week. We noted that all bar one of the consultants lived within close proximity of the hospital and so could respond within the required 30 minutes. One consultant, who lived outside the 30 minute timescale radius, resided overnight in the hospital during their on-call period.
- Two separate consultant led ward rounds took place each day, each facilitated by different consultants; one on Hedgehog ward and one on NNU.
- Concerns were raised about the on-going difficulties the department faced with regards to the recruitment of middle grade doctors. The clinical director acknowledged that the issue was one of a national issue; increased consultant cover was instigated as a means of managing the risk. However, some staff raised concerns that overnight junior doctor cover could be problematic, especially if the senior trainee doctor was involved with an emergency within the NNU or other department.
- Junior doctors spoke positively about working in the department and said they were very well supported. They told us that In-house teaching was well organised and comprehensive.
- The NNU was supported by a team of 11 consultants, all of whom had experience of neonatology.
- Surgical patients who were admitted to the ward were reviewed by the medical team to ensure that their health and care needs were being fully met.

Security

- There was a security system for entry to the wards. We observed staff politely challenging visitors to determine the reason for their visit. The trust also had an up-to-date child abduction protocol to support staff.

Major incident awareness and training

- There was a hospital-wide major incident plan, which included intensive care and anaesthetic response. The policy referred staff to an action card that would be used in the event of a major incident. There was a large folder, easily accessible with the nurse in charge's action card. We spoke with two members of staff who were clear with regards to what a major incident was and their role is responding to it.

Are services for children and young people effective?	Requires improvement

Care was provided in accordance with evidence-based national guidelines from organisations such as NICE and the Royal College of Paediatrics and Child Health. However, there was some disparity regarding the arrangements for the management of pre-operative children who were required to be nil-by-mouth.

Staff followed specific care pathways and used pain assessment tools to ensure that patients received appropriate care and treatment and effective pain relief. They ensured that patients' nutritional and hydration needs were closely monitored and maintained.

The ward managers carried out appraisals for nursing staff, identified training and development needs and maintained records of staff training. However, staff were not routinely offered clinical supervision sessions in line with the trust policy.

A 24-hour, consultant-led service was provided across the clinical specialities. The service was supported by a range of clinical nurse specialists and allied healthcare professionals.

The NNU performed better than other NNU's nationally in a number of outcomes measured within the National Neonatal Audit Programme. Where the service had not met national benchmark standards, action plans were in place to resolve the issues and to enhance performance.

The hospital's performance against other national paediatric based audit programmes was varied. The hospital was identified as a negative outlier in 4 or 12 clinical standards relating to the management of children with epilepsy. Furthermore, performance against national standards with regards to the management of neutropenic sepsis patients was poor, with only 32% of eligible children receiving antibiotics within one hour of admission.

Whilst multidisciplinary working was an embedded concept across the delivery of general paediatrics, relationships between the adult surgical team and the general paediatricians was poor. There was a lack of engagement from the adult surgical team; communication was poor with regards to the management of patients admitted under the auspice of the general surgical or urology team.

Evidence-based care and treatment

- Children's services used a range of guidelines which had been produced by NICE and the Royal College of Paediatrics and Child Health to define the treatment they provided.
- There were pathways and protocols for the management and care for various medical and surgical conditions however there was some inconsistent approach to the way post-operative urology and general surgical patients were managed (we have discussed this further within the section "Multi-disciplinary working" within this domain).
- The NNU was seen to use a range of NICE guidelines including NICE clinical guideline 149: Antibiotics for early-onset neonatal infection.
- There were processes for ensuring that clinical services complied with national standards. Examples included the review of the neonatal jaundice guideline against the standards set within the NICE clinical guideline 98: Neonatal jaundice. Action plans were generated where areas of improvement were required.
- The paediatric team reported that they were not able to fully meet the standards for NICE clinical guideline 137: Epilepsies, because there was no available funding for a clinical nurse specialist. It was also in the process of developing a business case to resolve the issue.
- A retrospective audit into the management of oncology patients admitted to the hospital between January and June 2013 had been carried out to determine whether children received the appropriate level of care which was in line with national standards. The audit identified that 92% of children were reviewed by a nurse within 1 hour of arrival. 64% of children were reviewed by a doctor within 1 hour. 32% of children received intravenous antibiotics within 1 hour of arrival and 31% of children did not have their blood pressure documented. NICE clinical guideline 151: Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients: 2012, recommends that patients who are receiving anti-cancer treatments and who are suspected of having neutropenic sepsis should be "managed as an acute medical emergency and offered antibiotic therapy immediately". We were not provided with any follow-up audit information so we are unable to report whether any improvements have been made in this area.

Pain relief

- There was a process for ensuring that neonates received oral sucrose to reduce pain during procedures such as heel prick blood screening and lumbar punctures.
- We saw that the NNU used kangaroo care (a technique where the baby is held skin-to-skin with the parent) as a means of helping to stabilise neonates.
- Children admitted to the ward had age-appropriate pain assessments, including a faces, legs, activity, cry, consolability (FLACC) assessment for children aged two months to seven years and a visual analogue scale for children aged eight years and over. A review of five care records demonstrated that staff routinely assessed children's pain levels.
- The department had access to a draft policy titled 'Guideline for the management of Pain on the Neonatal Unit'. The policy had been reviewed in September 2014 and was awaiting final ratification by the Paediatric Directorate. The policy was evidence-based and provided staff with guidance on managing varying levels of pain including information explaining the use of sucrose, paracetamol and opiates. This policy was further supported by two supplementary polices: 'Paralysis and Sedation on the Neonatal Unit' (ratified December 2013) and 'The use of Sucrose Analgesia on the Neonatal Unit' (ratified December 2013). The NNU also utilised an adapted neonatal pain assessment tool.
- We asked the trust to provide us with a copy of the paediatric pain management policy but this was not provided.
- There were numerous distraction techniques throughout the children's services to help reduce patients' pain and distract them from painful procedures. Play specialists were available to assist the medical and nursing teams, as required.

Nutrition and hydration

- We noted that drinks, snacks and an appropriate choice of food were available for children and young people. Multiple faith foods were available on request.
- Although the NNU did not operate a donor milk service, there were arrangements to source specialist donor milk from the external level three units as required. The NNU team were in the process of submitting a business case in order that they could establish a donor breast milk service from the Tunbridge Wells NNU.
- Neonates, children and young people admitted to the children's wards and the NNU underwent nutritional screening assessments. Dietetic referral pathways were available for any child or young person identified as being at risk of malnutrition, or for children who had specialist requirements such as high-calorie meals, as an example.
- We found that the requirements for children to be nil-by-mouth pre-operatively did not meet with the recommendations of the Royal College of Anaesthetists. Advice provided to families within an information leaflet titled “Your child is having an operation; information for families” advises that children admitted for morning surgery could not eat or drink any milk from 02:30 and that they could drink water or weak squash prior to 06:30 but should then be nil-by-mouth. Information for children being admitted for afternoon surgery were advised that their child could have a light breakfast (e.g. toast) which needed to be finished by 07.30 and that they could have clear fluids up to 11:30am but should then be nil by mouth. The guidance made no reference to babies who were breast-fed. A second information leaflet titled “Your child is having a general anaesthetic: information for families” advised that “Usually food can be taken no later than six hours before surgery but water or clear drinks can be given up to three hours before surgery”. Guidance from the Royal College of Anaesthetists advise that babies may have breast milk up to four hours before their surgery and that children can eat a light meal up to 6 hours before and can drink water or dilute cordial up to 2 hours before surgery.

Patient outcomes

- There was no evidence of risk that the trust was an outlier regarding paediatric and congenital disorders and perinatal morbidity.
- Children's services submitted a range of data to national audit programmes. This included the National Neonatal Audit Programme, British Thoracic Society Paediatric Asthma Audit, Childhood

Epilepsy Audit and the National Paediatric Diabetes Audit.

National Neonatal Audit Programme performance

- When comparing the data from the national neonatal audit programme, we have considered that the Neonatal Unit at Tunbridge Wells Hospital to fit the criteria as being a Local Neonatal Unit (LNU); that is, the unit is able to provide care to neonates from their own catchment population, except for the sickest of babies who are stabilised and the transferred to a regional Neonatal Intensive Care Unit.
- In 2013, the NNU performed better than the national average and also met the NNAP standard for ensuring that babies born at <29 weeks gestation had their temperature recorded within an hour after birth. They trust attained 100% compliance with this standard for ensuring a temperature was recorded.
- However, the number of eligible babies admitted to the NNU with a core temperature between 32.0 and 35.9ºC was 22%. This was worse than the national average of 16%. The NNAP standard recommends that 90% of eligible babies should have a recorded temperature within an hour of birth as being between 36.6ºC and 37.4ºC and the remaining 10% should have temperatures of between 36.0ºC and 36.5ºC
- 56% of eligible babies had recorded temperatures of between 36.6ºC and 37.4ºC within an hour of birth; this was better than the national average of 45% but did not meet the NNAP standard of 90%.
- In 2013, the NNU performed better that the national average, and also met the NNAP standards for ensuring that 85% of mothers who deliver their babies between 24+º weeks and 34+6 weeks gestation are given at least one dose of antenatal steroids. The trust attained 88% compliance with this standard versus a national average of 85%.
- In 2013, the NNU performed better that the national average for ensuring that babies born with a gestational age of less than 32 weeks or weighing less than 1,501grammes at birth underwent 1st stage Retinopathy of Screening (RoP) in accordance with the current national guideline recommendations. The trust attained a screening rate of 95% (versus a national average of 94%) with 91% (national average 88% of all eligible babies being screened on time and 2% being screened early (national average 5). 5% of babies did not have any screening data available (6% nationally). Whilst the trust had not met the NNAP standard, they had made significant improvements in this area when compared to the previous year.
- Standard four of the Neonatal audit programme asks unit to monitor the number of babies who were born at less than 33 weeks gestation who were receiving any of their own mother's milk at discharge from home from the neonatal unit. In 2013, the NNU discharged 49% of eligible baby's home on complete maternal enteral feeds. This was better than the national average of 37% for similarly classified units and also better than the regional neonatal networks performance of 34%
- 12% were discharged home on mixed feeds which included at least some of their own mother's breast milk. This was lower than the national average of 25% and also the regional network performance of 18%
- 40% were discharged on feeds which did not include any of their own mother's breast milk. This was marginally worse than the national average of 35% but was better than the regional performance of the neonatal network (Kent performance for 2013: 48%).

National Paediatric Diabetes Audit

- Data from the 2011/12 audit showed that the target HbA1C rates for Tunbridge Wells Hospital were better than the national average. For example, the percentage of patients who were managed with an HbA1c target of less than 7.5% was 17.9% of the total caseload, as compared with a national average of 17.4%.
- It is however, important to note that the total number of patients data submitted into the national audit programme was relatively low (35 cases submitted) of which, only 28 patients were used to analyse HbA1c outcomes. This meant 20% of cases were not considered. The NPDA audit team have placed an advisory note within the annual report which reads "Where the percentage of incomplete HbA1c data is high, or the number of patients submitted low, the validity of the percentage with an HbA1c <58mmol/mol (7.55), mean and median HbA1c for an individual paediatric diabetic unit should be interpreted with caution, as it may not truly represent that unit's overall outcome".

Epilepsy 12 Audit

- Staff raised concerns that the hospital had been identified as a negative outlier in 4 of the 12 performance indicators associated with the Epilepsy 12 audit. Specifically, the hospital had been listed as negative outliers for the number of paediatricians with expertise in epilepsies, the number of children who had evidence of appropriate first clinical assessment, the number of children with convulsive seizures who had undergone an ECG by one year and the number of children who had an EEG in whom there were no defined contraindications.
- There were also concerns raised regarding the availability of a clinical nurse specialist to support the unit; at the time of the inspection, children requiring support from a specialist nurse were referred to the nursing team at a tertiary centre. This meant that whilst children and families could access a nurse, there was no local provision available to support additional nurse run clinics or to facilitate handover, transitional care clinics as examples.

Readmission Rates

- The rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (April 2013 – March 2014:
- For asthma, the multiple readmission rates amongst 1-17 year olds was 7.2%. This was better than the national average of 17%.
- For diabetes, the multiple readmission rates amongst 1-17 year olds was 5%. This was better than the national average of 13.9%.
- For epilepsy, the multiple readmission rates amongst 1-17 year olds was 21.1%. This was better than the national average of 27.8%. However, the multiple readmission rates amongst children under 1 year of age was 50% which was worse than the national average of 39.1%.

Competent staff

- The paediatric database reported that, as of July 2014, 83% of nursing staff had participated in an appraisal. The staff told us that they considered the appraisal system to be beneficial to their personal and professional development.
- Whilst staff reported that they received annual appraisals, there was a consistent theme that they were not provided with any form of clinical supervision. We asked five staff whether they had ever engaged in, or signed a ‘Clinical supervision contract’; we were informed that they had not done either.
- Staff working in the various clinical settings had access to educational practitioners and staff working in the NNU also had the opportunity to work alongside the advanced neonatal nurse practitioner. Staff told us this was received positively and helped them to develop their competency.
- 75% of staff had completed basic life support training in the previous 12 months.
- Two of the eleven consultants had attended training in European Paediatric Life Support during the preceding four years.
- 28 nurses working within the children’s directorate had completed an advanced paediatric life support course in the preceding four years.

Multidisciplinary working

- Parents shared with us examples of input their children received from physiotherapy, dietetics and speech and language therapy.
- Play specialists were available on the wards and provided valuable support to the wellbeing of the child. Parents and other clinical staff valued their contribution and spoke highly of them.
- Children and young people who were in need of mental health or psychological support had access to specialist input from the local Child and Adolescent Mental Health Service (CAMHS). Contact details for these specialist services could be found within the trust ‘Missing Child’ policy.

- Concerns were raised that engagement with a number of surgical teams was poor. This was especially noted for the general and urology specialities. Whilst efforts had been made to resolve the poor communication amongst some surgical specialities, including the paediatric team facilitating one multi-disciplinary surgical care pathway meeting, this meeting had not been repeated due to an inability of healthcare professionals to organise a suitable date and time to meet. Staff reported that the poor communication amongst some specialities had led to inconsistent post-operative management of patients, with examples of nursing staff being required to manage patients undergoing circumcisions differently depending on the practices of the individual surgeons.
- Both the medical and nursing staff reported that communication with some surgical teams could often be challenging when patients were involved. One parent said “We feel very much in the dark; we are in limbo, waiting to be seen by the surgeons. The poor nursing nurses are also in the dark. We are in the hands of the surgical team”.
- Staff were however complimentary about the engagement with the orthopaedic surgical team, but this was likely attributed to the fact that two orthopaedic surgeons specialised in the management of childhood orthopaedic abnormalities.

Seven-day services

- Patients had access to allied healthcare professionals such as physiotherapists outside of normal working hours including weekends. In addition, staff were able to access radiology services 24 hours per day.

Consent

- Staff obtained consent from patients and or their parents/carers appropriately. The staff explained how consent was sought and involved both the child and the person with parental responsibility.
- We noted that verbal and/or written consent was obtained for both medical and/or surgical interventions, with signatures to confirm.
- Two parents told us that the staff had fully explained the proposed procedure and possible complications before they gave consent. We saw that children were encouraged to participate in the consent process and some were encouraged to sign their consent form alongside their parent or carer if they were able to understand the procedure, its risks, benefits and alternative options.

Are services for children and young people caring?

Good ●

People who used the service were positive about the way they were treated by nursing staff. People said they were treated with compassion and respect. We saw staff ensuring that people’s dignity and privacy were upheld.

People were mostly involved in making decisions about their care and treatment. Families and children were encouraged and supported to manage their own care where possible and to maintain their independence; the service adopted a family-centred care model.

However, we received mixed reviews regarding the engagement and attitude of some members of the surgical teams. Two parents described the surgical team as ‘dismissive’ and ‘brash’ whilst two others said the surgical team were “Attentive” and “Responded very quickly when my child was in pain post-operatively. They liaised with the nursing staff and acted to resolve my child’s pain”.

Due to historic practices, children attending theatre were not offered with consistent emotional support from a familiar health care professional. Ward staff routinely escorted children to the main theatre reception area where the care of the child and their accompanying parent was then handed to an unfamiliar theatre practitioner. Following the induction of anaesthesia, parents/carers were required to return to the ward unaccompanied, or were asked to wait in the theatre reception area; this practice falls outside the recommendations of national guidelines which encourages familiar staff to support parents/carers once they have left the anaesthetic area.

Compassionate care

- Throughout our inspections on all wards, we saw staff treat patients and their parents with dignity and respect.
- We saw that doctors and nurses, in the main, introduced themselves appropriately and that room doors were close during consultations and ward rounds so as to maintain the privacy of patients.
- All of the parents and relatives we spoke with were positive about the caring, friendly nursing staff. They said the nursing care they and their child received was kind, compassionate and supportive. One parent said "The nursing team have been great. The care they have provided has been excellent so far". One child said "My nurse is a little hard to understand because of their accent but they have been very friendly and they have listened to me".
- Two parents that spoke with us were less complimentary about some of the surgical teams. Comments included "The bedside manner of my child's surgical team was very dismissive. They arrived en-mass; some were not wearing their name badges and they were not introduced so I did not know who they all were" and "The surgeon was very brash with me this morning when I asked them questions about my child's procedure".
- Two parents however reported that the surgical teams were "Attentive" and "Responded very quickly when my child was in pain post-operatively. They liaised with the nursing staff and acted to resolve my child's pain".
- Other comments from patients and their parents/carers included: "Overall, I have been very impressed. We have no issues. We recognise our nurse looking after us but we do not know their name, however we have not long arrived".
- Whilst the children's directorate dashboard had a range of CQUINS (Commissioning for Quality and Innovation) relating to patient experiences including "Positive response to: Were you involved as much as you wanted to be in decisions about your care", "Did you find someone on the hospital staff to talk to about your worries and fears" and "Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital" we found that there was no data entered to determine the departments performance. Data for April, May and June was listed as N/A (Not applicable) and 0% for July 2014. The planned benchmark according to the dashboard for each of the above measures was 90%.
- Comments from children and family members collected through the trust's patient satisfaction questionnaires and surveys included: "The nursing team have been great. The care they have provided has been excellent so far". One child said "My nurse has been very friendly and they have listened to me".

Patient understanding and involvement

- The NNU provided support to parents/carers whose baby was scheduled to be discharged home after having received treatment in the unit.
- Patients and their parents were included in discussions surrounding their treatment and ongoing care. One parent stated that she felt comfortable in asking staff questions and confident that she would receive an appropriate answer.
- The trust used a paper based system to seek feedback from children and their families. A 'Childs voice' questionnaire was handed to age appropriate children. Comments included "When everyone introduced themselves I felt more comfortable for the operation", "The staff were friendly and helpful" and "Thank you to my surgeon and staff who put me at ease before my operation".

Emotional support

- The process of escorting a child to theatre pre-operatively was poor and children and families were not provided with the assurance that they would receive continuous support from the same healthcare professional during the pre-operative stage. Whilst children were admitted by a children's nurse or a health care assistant to the ward, at the time the child was called to the operating department, the child and a family member/carer were transferred to the care of a theatre practitioner. The ward nurse then returned to the ward, leaving the parent/family member/carer to find their own way back to the ward, without the emotional support of a children's nurse or other suitably skilled staff member. Guidance from the Royal College of Nursing: Transferring children to and from theatre, recommends that "The parent/carer is supported following handover". Furthermore, the presence of a children's nurse or other staff member with whom the parent/carer and child are familiar with, helps to ensure that the child has an advocate who is able to support the child during induction of anaesthetic, as well as being able to offer distraction therapies in order to reassure the child and family.

- We found that those parents who had experienced a bereavement were required to pay for counselling as this was service was neither commissioned by local commissioners nor funded by the trust.

Are services for children and young people responsive?	Requires improvement ●

Accommodation for children requiring day-case surgery or overnight care and treatment was provided by way of individual patient rooms which were equipped with en-suite facilities. Accommodation was provided for parents/carers whose babies were admitted to the Neonatal Unit (NNU).

Some senior staff raised concerns regarding the lack of inpatient capacity on Hedgehog ward; we found that occupancy for this unit was documented as 77% which was better than the upper national threshold of 85%. Paired with a reduction in the number of children attending as 'ward attenders' when compared to the previous year, and also a lack of incidents reporting capacity issues, we were unable to corroborate those concerns.

The directorate had identified issues with clinical letters being dispatched to health professionals such as general practitioners within a defined timescale. The trust had acknowledged this and had introduced additional resources to address the issue.

We found that whilst the majority of children being admitted for elective surgery were offered pre-assessment appointments during which questions could be asked and the child prepared for theatre, those attending for urology surgery were not offered such appointments. Furthermore, due to the poor communication and relationship between the surgical and paediatric directorate, standardised, age appropriate patient information leaflets for urology patients were not being provided to parents/carers and their children.

A sweets and snack vending machine was located in an area which children who were nil-by-mouth prior to surgery had access; toys were located in this area and we observed children playing next to the vending machine. The parents of children who were receiving treatment told us that they considered the location of the vending machine to be inappropriate.

Service planning and delivery to meet the needs of local people

- Hedgehog ward was devised of 23 individual patient rooms and the Woodlands Unit had 15 rooms divided into a 5 bedded assessment unit and a 10 bed day-case unit. Each room had en-suite facilities, patient televisions and offered a high level of privacy. Parents and children that we spoke with were complimentary about the accommodation.
- Parent/carer accommodation was available to those families whose babies were being cared for on the NNU.
- We noted that the children's outpatient area, whilst bright and visibly clean, was a shared area in that children and families were required to wait with adults who were also waiting to be seen by specialists such as gynaecologists and obstetricians. We noted that a number of women were waiting to be seen following recent miscarriages or who were experiencing problems during their pregnancy.

Access and flow

- Some staff raised concerns that following the commissioning of the new hospital on the Tunbridge Wells campus, the overall capacity for inpatient children had reduced from 40 to 23 beds. Staff felt that this had led to the overall occupancy for Hedgehog ward being consistently high. From the data we were provided, the trust reported that between April and July 2014, the average occupancy rate for Hedgehog ward was 77%.
- Staff reported that the Woodlands day unit would be operated as an escalation area during peak time periods but that this could only be opened when there were sufficient numbers of nursing staff. Some staff reported that they were required to work on the Woodland unit on their own overnight if sufficient staff could not be sourced. One incident dated 17 October 2014 was reported via the incident reporting system which referred to the Woodland Unit being kept open until 00:30 due to increased activity. It was reported that due to a lack of escalation, the unit had not been staffed so that it could remain open past its standard closing time of 21:00 and therefore one nurse had been redeployed from Hedgehog ward to lone work, providing care to 5 children.
- Staff spoke anecdotally about children having to remain in the ED overnight due to a lack of beds on Hedgehog ward. On the day of our inspection we found that a child had remained in the ED for a prolonged period of time whilst capacity was being made on Hedgehog ward. We asked three staff whether such incidents were reported via Datix. They each reported that they were not reported so it was not possible for us to fully assess the extent to which transfer delays were occurring with the above mentioned incident being the only incident of this type being reported between April and October 2014.
- In order to address the lack of capacity, Woodlands unit provided a ward attender service. From the data we had, between April and July 2014, 1,575 children had attended as a 'ward attender'. This was a reduction of 3,241 when compared to the same period during the previous year.
- Year-to-date data provided by the trust indicated that the average occupancy for the NNU was 63%. We noted that, as with other NNU's, the occupancy of the NNU fluctuated, with some month's occupancy being as low as 51% whilst other months it increased to 78%. Senior staff spoke positively about the fluctuations and the need to work pro-actively to ensure the NNU was always appropriately staffed. During the inspection, we observed the team appropriately managing a new admission; there were sufficient levels of staff and we observed good team work throughout the department.
- As of July 2014, year to date rates for children not attending for their first outpatient appointment were 11.6% of total new-appointments. This was a marginal increase on the same period the previous year which was reported as 11.1%.
- As of July 2014, year to date rates for children not attending for their follow-up outpatient appointments were 11.7%. This was an increase on the same period the previous year which was reported as 9.5%.
- The directorate had acknowledged this increase in DNA's and had instigated remedial actions including introduction of a clinic call reminder system which had been implemented in May 2014.
- A risk entered onto the directorates risk register on 20 February 2014 indicated that the trust had a backlog of letters requiring typing and sending to relevant health care professionals including General Practitioners. This had been listed as a moderate risk. Data from the children's directorate dashboard indicated that as of July 2014 approximately 62% of letters were being sent to GP's within 10 days and the remaining 38% were being sent between 11 and 30 days.
- Remedial actions to address the issue included the use of additional administrative staff and the outsourcing of dictation to an external company to help reduce the backlog.

Meeting people's individual needs

- The wards operated flexible visiting times to allow for families to support the parents/carers whose children were on the wards.
- Translation services were available for patients and families who did not speak English as their first language.
- Information boards were sited around the hospital and in the relative's room, providing a range of information.

- The directorate offered a range of pre-assessment clinics for those children who were scheduled to be admitted for elective surgery. However, some parents/carers raised concerns that they were not offered pre-assessment appointments; we found that this mainly affected those children who were to be admitted for elective urology procedures. We also found that whilst parents/carer's were offered written information about surgical procedures, these leaflets were often directed towards adults; we found examples where parents/carers of pre-pubescent children admitted for circumcisions, had been provided with information leaflets which provided advice about having sex following a circumcision. The parents/carers told us that they considered this to be inappropriate.
- Children admitted to hospital for prolonged periods of time were not supported to access education services. One parent that we spoke with, whose child had a long-term condition which required repeated hospital admissions told us that they themselves were responsible for having to organise for their child to have educational activities in order that their learning needs could be met whilst in hospital.
- We also noted that a sweet and snack vending machine had been located in an area which was used by children who were awaiting surgery and were therefore nil-by-mouth. The vending machine included large packs of sweets which were visible to children. On the day of our inspection one theatre list had still not commenced at 10am; one child who had been nil-by-mouth of fluids since 06:30 and who had not had breakfast, was using the play area and had noticed the sweets and snacks; it was fortunate that the child was of an age whereby they understood the reasons why they could not eat or drink. However, we considered that this may not always be the case, especially for younger children.
- Children requiring support for mental health conditions were routinely nursed on a one-to-one basis. Staff told us that, while the service did not employ specialist mental health nurses, shifts could be covered with bank or agency nursing staff.

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the Patient Advice and Liaison Service (PALS). A dedicated member of staff within each of the clinical areas, including the matrons and clinical director, reviewed all formal complaints received and concerns raised with PALS. All concerns raised were investigated and there was a centralised recording tool to identify any trends emerging. Learning from complaints was disseminated to the whole team to improve the patient experience within the department.
- Information was readily available for patients who wished to make a complaint, but who may have needed support to do so.
- Overall, the ratio of complaints lodged against the department versus the number of admissions and attendances was low. Trends arising from complaints were discussed as part of the clinical governance system within the department. The directorate were noted to have responded to 100% of complaints within the timescales set by the trust's policy.

Are services for children and young people well-led?

Requires improvement

The paediatric directorate had neither a short or long term vision nor did it have a directorate specific strategy. Some staff were able to speak about the trust-wide values however some staff, whilst they were aware of the PRIDE values, they were not able to speak with any authority or knowledge such as the meaning of the acronym.

Whilst the directorates' senior management team were personally aware of the issues which posed risks to the operational effectiveness of the directorate, these issues had not been transferred to the directorate level risk register, which we considered to be heavily underutilised. We found that where risks had been placed on the register, there were suitable governance frameworks in place to ensure those risks were escalated to board level and actions had been taken to resolve or mitigate the risks.

Leadership, on a day-to-day basis was good however some staff raised concerns about the visibility of the nursing lead and also of the trusts' executive team. Furthermore, staff working within children's outpatients considered that they were disconnected from the operational function of the children's directorate and had little managerial oversight and support.

Staff spoke positively about working at Maidstone and Tunbridge Wells NHS Hospital. Morale was seen to be good, especially within the NNU whereby staff retention rates were seen to be exceptionally high.

Whilst the directorate sought feedback from patients, there were no systems in place to effectively engage with members of the public or staff in order that a robust long term strategy could be developed.

Vision and strategy for this service

- The clinical director confirmed that the children's directorate did not have a written vision or strategy. We were told that whilst there was no formal vision or strategy, the directorate was keen to improve the quality of care provided to children and their families/carers.
- Four staff were able to speak of the trusts values: PRIDE (Patient first, Respect, Innovation, Delivery and Excellence). Three staff reported that they had heard of the concept of PRIDE but were unable to offer any detail or clarity regarding the initiative.

Governance, risk management and quality measurement

- A monthly report from the children's directorate was provided to the Quality and Safety Committee and minutes of these meetings and a copy of the report were kept.
- The children's directorate was represented at board level. Arrangements were in place for ensuring the board received reports on safeguarding children; the Chief Nurse sat as the lead for the Safeguarding Children's Committee which provided reports to the Quality and Safety Committee. From the information we were provided, we found that the quality and safety committee received a brief from the safeguarding children committee in July 2014.
- The directorate held governance meetings which took place ten times each year; there was discussion regarding incidents and complaints. From the minutes we were provided, it was not apparent whether an attendance record was kept. The clinical director reported that all consultants, safeguarding lead nurse, and the matrons for NNU and paediatrics attended. The meetings were also open to all grades of staff working within the directorate. It was reported that any residual action plan from the governance meetings were disseminated to all those who attended the meeting; there was no clarity, or assurance provided which ensured that the action plan was disseminated to individuals who had sent their apologies or to those health professionals who routinely did not attend the meeting.
- Risks associated with the provision of services were logged on the directorate risk register, of which two risks were logged: the paediatric emergency care pathway and a backlog with regards to the dispatch of clinic letters to external health care professionals. There was evidence that these risks had been escalated within the trust and there were remedial action plans in place. However, we considered that the risk register was an underutilised resource.
- During our discussions with staff, we were repeatedly told that issues existed with the timely transfer of patients between hospitals or to their home address; this was because of the poor service provided by the commissioned transport provider. The issue of patient transport had been discussed during the paediatric governance meetings in January, March, June, July and September 2014. Whilst this issue had been recognised by the trust and had been reported on during the May 2014 Quality and Safety Committee meeting, it was unclear whether the paediatric directorate had taken any remedial action to mitigate the risks associated with the poor transport provision. There was no local action plan and the issue was not recorded as a risk on the directorate's register. We did however note that according to the 2014 Paediatric Clinical Governance Annual Report, a patient transfer audit was underway and so whilst not supported by a rationale or identified as a risk to the operational effectiveness of the directorate, it had been acknowledged that further review of patient transfers was required.
- We were also told of the poor relationship with a number of surgical specialities. Between January and September 2014 a number of incidents relating to surgical patients had been reported and discussed at the paediatric directorate governance meeting. It was unclear whether these issues had been referred back to the surgical directorate for investigation. The issue of the poor communication and fragmented relationships with surgical specialities was not listed as a risk on the directorates register and we were not provided with the necessary assurances that the matter was likely to be resolved in a timely way.

- Whilst senior staff had raised issues regarding capacity on hedgehog ward, there had been no review undertaken to assess the extent of the issue. There had been no challenge from the leadership team with regards to the lack of incident reporting in which capacity had generated problems and again, capacity was not listed as a risk within the directorate; it was therefore again unclear as to whether this issue had been escalated to the board and whether any remedial action, other than the introduction of the 'ward attender' initiative, was being taken to resolve the issue.
- A dashboard was used by the directorate to help monitor the overall quality of services being provided to neonates, children and young people.

Leadership and culture within the service

- We considered that leadership within the NNU was strong. The ward manager on Hedgehog ward had only been in post for a short period of time, but was already considering new ways of working to enhance the service.
- Some staff voiced concerns that visibility of the senior management team within the directorate could be improved with more engagement from the matron. Furthermore, staff reported that they rarely saw members of the executive team.
- The staff we talked with were proud to work at the trust and overall, morale was seen to be good. This was especially noted within NNU which was indicative of the extremely high staff retention rate within the unit.
- Overall staff turnover rate, year to date was 6.6%; this was better than the anticipated rate of 10.5%.
- Staff working within children's outpatients reported that they felt detracted and isolated from the inpatient and ambulatory unit.

Public and staff engagement

- Patient feedback was sought and discussed at local governance and directorate meetings. However, there was a lack of systems or processes to seek the engagement of members of the public including parent groups to help shape the future of the service.

End of life care	Safe	Requires improvement	●

	Effective	Requires improvement	●
	Caring	Good	●
	Responsive	Requires improvement	●
	Well-led	Good	●
	Overall	Requires improvement	●

Information about the service

The Maidstone and Tunbridge Wells Specialist Palliative Care Team (SPCT) is a trust-wide service encompassing both hospital sites.The service provides care for patients with non-curative illnesses and also supports those closest to them. End of life care (EoLC) was not seen as the sole responsibility of the SPCT.

The SPCT consist of 1.2 Whole Time Equivalent (WTE) palliative care consultants and 3.9 WTE Clinical Nurse Specialists (CNS) and an EoLC facilitator (15 hrs per week). The team works in association with their respective community palliative care teams and in partnership with local voluntary sector hospice providers. In addition, a chaplaincy team provided multi-faith support.

The SPCT were available five days per week, Monday to Friday 9-5 pm.Outside these hours the SPCT service was covered by telephone support from the hospice in the Weald at Pembury.

During the inspection we visited a variety of wards across Tunbridge Wells Hospital including Wards 10,12,20,21,22, the Stroke Unit,Intensive Care Unit , chemotherapy day unit ,mortuary, bereavement office and the chaplaincy to assess how EoLC was delivered. We spoke with a wide variety of staff including palliative care leads, medical and nursing staff, patient liaison officers, porters, mortuary staff, hospital chaplain, patients and relatives.

We reviewed the medical records of four patients who were receiving EoLC and observed the care provided by medical and nursing staff on the wards, and spoke with a family members whose relative was receiving EoLC. We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed performance information held about the trust.

Summary of findings

The SPCT were available five days a week for face to face contact and a local hospice provided telephone out-of-hours and weekend cover. Medicines were provided in line with guidelines for EoLC, but DNACPR forms were not consistently completed in accordance with trust policy. There were no standardised processes for completing mental capacity assessments.

The SPCT provided four study days per year for trained nurses And staff were able access palliative care study days provided by the Hospice in the Weald. Medical end of life training was delivered as part of the doctors formal education programme.This was delivered by the palliative care consultant and the trust clinical ethicist. Palliative care link nurses were present on the wards we visited but training had reduced recently due to staff shortages in the SPCT. Leadership of the specialist palliative care team was good and quality and patient experience was seen as a priority.

All patients requiring EoLC were referred to the SPCT, but often no input was required by the team. Referrals to the team supported audit processes within the trust. There was a multidisciplinary team (MDT) approach to facilitate the rapid discharge of patients to their preferred place of care.

Patients were cared for with dignity and respect and received compassionate care. Relatives of patients receiving end of life care were provided with free car parking.

Are end of life care services safe?

Requires improvement ●

No adequate medical support from a junior doctor was available on the chemotherapy out-patients unit to manage any issues that arose during chemotherapy treatments. However, medical support could be sought from doctors in the endoscopy and rheumatology departments. We were told by the unit manager that during palliative chemotherapy nursing teams were unaware of the patients DNACPR statuses as the patients' hospital medical records were not available during chemotherapy treatments.

Accurate coding of EoLC issues was an issue (very low reporting) therefore members of the coding team were being invited to the EOL Steering Group to develop methodologies on how EoLC incidents could be coded to improve oversight across the hospital.
The wards and mortuary viewing area we visited were visibly clean and well maintained.

Incidents

- There were no 'Never Events' relating to end of life care services in the past year.
- Systems where in place across the trust to deal with incidents. At the EoL steering group it was agreed that incidents related to EoL care would be submitted to the lead palliative care nurse who would be involved in any investigation. The lead palliative care nurse will inform any action plan to ensure issues identified as relating to EoL care would be shared across the trust to embed the learning so as to improve the quality of care.
- We were told by the palliative care consultant that accurate coding of EoL care issues was an issue (very low reporting). Therefore members of the coding team were being invited to the EOL steering group to develop methodologies on how EoL care incidents could be coded to improve oversight across the hospital. A true picture of EOL incidents across the trust was not available.
- In all the areas we visited we found that staff were encouraged to report incidents. Porters told us that there had been one incident reported in the last 6 months that involved a deceased patient. The assistant facilities manager told us that the incident was reported on the trusts electronic incident reporting system and the outcome from the incident was that further training was delivered to staff and protocols had been updated to ensure similar incidents did not occur in the future across the trust.

Cleanliness, Infection control and hygiene

- We saw that the wards and mortuary viewing area we visited were visibly clean and well maintained. In all the patient areas the surfaces and floors were covered in easy to clean materials which allowed high levels of hygiene to be maintained throughout the working day.
- We saw that ward and departmental staff wore clean uniforms with arms bare below the elbow. Personal protective equipment (PPE) was available for use by staff in all clinical areas. In the mortuary we observed adequate supplies of PPE for use by undertakers, porters and the police when visiting the mortuary.
- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or caring for people after death. Guidance was available to staff in the 'Care of the dying policy and procedure, the last offices checklist and the communicable disease report '. On the wards staff were able to describe the care of patients after death and the infection control measures taken to protect themselves and other patients from harm.

Environment and Equipment

- Up to date service records were available for the serviceable equipment in the mortuary. Servicing was contracted out to a third party. We were told that the fridges in the mortuary were alarmed so that any faults could be identified in a timely manner. On the day of the inspection all equipment was working correctly and there were no issues about getting equipment repaired or replaced in a timely manner.
- Access to the mortuary was secured to prevent inadvertent or inappropriate admission to the area. Access out of hours was via security staff who would contact the porters. The forensic fridge was locked at all times but the other fridges were not locked out of hours as porters would require

access to the fridges.
- Only one concealment trolley is available in TWH. We were unable to establish the systems in place should this trolley break down. Transferring patients to the mortuary was via the back corridor which meant the porters avoid the main public walkways.
- Syringe drivers were available across the trust to support EoL care patients with complex symptoms to deliver consistent infusions of medication. We saw evidence of training records that staff attended the training sessions on how to use the syringe drivers.

Medicines
- Medication guidance had been agreed and implemented which clearly set out the medicines necessary to support the management of dying patients. These covered the five recommended areas including pain, agitation and restlessness, nausea and vomiting. The guidance was in easy to follow flow diagrams as part of the 'Best Practice Guidance for Care of the dying' pathway. The guidance prompted ward teams to get the necessary anticipatory medication prescribed in accordance with the patient's medical condition.
- The guidance included 'supportive information' which sign posted staff to the SPCT or pharmacists where complex medical conditions existed such as renal failure. This was to ensure patient safety was paramount and specialised skills supported the prescribing process.
- We were told by staff on the Ward 12 that protocol medication for EoL care was available on the ward and was easily accessible. The ward manager told us they had access to the on-call pharmacist if non routine EoL care drugs were needed out of hours. This would prevent EoL care patients unduly waiting for the necessary medication.
- On Ward 11 we observed that an EoL care patient had had their Pro re nata (PRN- as the occasion arises) medication appropriately written up. The SPCT CNS reviewed the medication prescribed and was able to talk to the medical and nursing staff around the medication that was no longer required. This meant that EoL care patients were receiving specialist input around their care needs and were receiving only care that was required to support their medical needs.
- The choice of medicines at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers. A 'Community nursing drug authorisation and administration card' was used within the hospital to prescribe the 'Just in case' medication that was part of the patients discharge package to ensure patients medication was available when the patient was discharge from hospital.
- The SPCT CNSs at Tunbridge Wells Hospital were not trained as non-medical prescribers which meant they were unable to prescribe medication however they were able to advise the medical staff.

Records
- Across the wards we visited we found evidence that paper medical and nursing records were in use which documented the patient's personalised care and treatment. The SPCT entered patient reviews into the patients' medical records and input their findings into individualised palliative care notes which were kept with the SPCT CNS. Information gathered by the SPCT included Preferred Place of Care (PPC), DNA CPR status, reasons for the referral along with the review findings and care needed to meet the patient's individual needs. This enabled T to record activity and keep accurate care and treatment records for each patient for discussion at the multi-disciplinary team meetings.
- The SPCT lead nurse told us EoL care patient's had an initial holistic assessment which identified their individual needs such as previous medical history, physical, psychological, social and family concerns. We reviewed one EoL care patient's medical records on Ward 11. An assessment was clearly documented, signed and dated which included a symptom and a medication prescription review. We observed that information such as clinical information and conversations undertaken with the family were recorded in detail.
- On Ward 11, we observed an EoL care patient had been reviewed by a physiotherapist, Dietician and Speech and Language Therapist (SALT) to assess the care needs of the patient such as oxygen and nutritional needs. All entries were clearly documented, signed and dated and gave clear instructions for both the medical and nursing teams.
- On the chemotherapy unit we were shown the electronic patient's record system used to record personalised patient information. This system provided a comprehensive overview of the patients' oncological history, medical and nursing review clinics assessments, consent forms and the

electronic request form. Nurses could access this information and complete the necessary assessments at the end of each patient contact. This meant that personalised records about care and treatment were kept for each person who used the service. However during the chemotherapy treatments the hospital medical records were not available.

- We were told by the unit manager that during palliative chemotherapy nursing teams are unaware of the patients DNA CPR status as their hospital medical records were not available during chemotherapy treatments. This meant that if the patient has a reaction to treatment or disease progression the team will not have the necessary information at hand regarding the patient's DNA CPR status.
- The mortuary manager told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger type book that contained the required information. We observed that the book was completed appropriately and neatly and was completed in a respectful way. Confidentiality was maintained at all times.

Assessing and responding to patient risks

- On Ward 10 and the stroke unit patients who were receiving EoLC had tissue viability assessments on admission. On the stroke unit we observed that these were reviewed regularly. Depending on the score and the nursing staff's clinical judgement a selection of preventative aids, would be allocated to the patient such as air mattresses to prevent pressure ulcers developing. Staff told us that air mattresses were available for patients when required.
- The hospital used the 'PAR' (Patients at Risk) system to identify patients who were at risk of sudden deterioration in their condition. The tool monitors the patient's heart rate, blood pressure, temperature and urine output to name a few. Nursing staff on the wards we visited told us they would use this system to monitor deteriorating patients.
- On the wards we visited we reviewed the medical notes of four EoLC patients. We found that patients were regularly reviewed by the SPCT depending on the needs of the patient. The level of intervention will vary depending on the needs of the patients and may be a level 1 intervention where there was a one off discussion with health professionals to a level 3 where advice and support will be given over a short period of time. This meant that systems were in place to support EoLC patients with specialist input when required. On Ward 11 we observed that the EoLC patient was being reviewed daily by the SPCT CNS. Documented entries in the medical records confirmed regular reviews were being undertaken. One EoLC patient had a turning chart in place. We saw completed records that the patient was turned every two hours. A symbol on the door identified to nursing staff when the patient was due to be turned.
- Systems were in place to monitor and assess patients before and during the administration of palliative chemotherapy. This included reviews in medical and nurse led clinics prior to each cycle of chemotherapy and continuous assessments of the patients whilst receiving chemotherapy by the nursing team.

Nurse Staffing

- The trust 'Care of the Dying Policy and Procedure' outlined the expected standards of care for people and their carer's as patients approach the end of their life. EoLC care was the responsibility of all staff, and was not limited to the SPCT staff and Clinical Nurse Specialists (CNS).
- The SPC nursing team included two palliative care CNSs. The SPC CNSs were highly trained in specialist palliative care. This brought a level of expertise and good understanding of current issues within the nursing team. This expertise was available for face to face contact five days per week across the trust.
- On the chemotherapy unit we were told by the unit manger that they had to use agency nurses to support the service to ensure the safety of patients and cope with the demand being placed on the service.
- During our inspection we asked ward managers about their staffing levels and whether they had enough staff when they had to nurse EoLC patients. The ward manager on Ward 22 that they had enough staff when nursing EoLC patients.
- The chemotherapy out-patients unit was a nurse led service. In the day to day running of the unit, medical support was sought from the endoscopy and rheumatology departmental doctors however no allocated medical support from a junior doctor was available on the unit to manage any issues that may arise during chemotherapy treatments.

Medical staffing

- SPCT medical consultant advice and support was available five days a week. Out of hours support was via a telephone advice service provided by the palliative care consultant on call at the Hospice in the Weald.
- At TWH the palliative care medical consultant worked Monday am and all day Thursday. Ward rounds were undertaken to review EoLC patients with complex symptoms.
- Two palliative care consultants from the Hospice in the Weald attended two sessions per week at TWH, on Tuesday afternoons and Friday mornings. This promoted continuity of care and facilitated communication between the different local providers of the palliative care service.

Major incident awareness and training

- The mortuary had systems in place to ensure that if a sudden surge in demand for refrigerated mortuary space (such as following a major incident or utility failure) the trust had a contract with a local undertaker to support the hospital if this situation occurred.
- The SPCT had procedures in place to support the trust's 'Winter Weather Protocol' to ensure that clinicians within the trust will have access to verbal palliative care advice should the team be unable to reach the hospital. This meant that even in emergency situations EoLC patients had support in place to manage their care.

Are end of life care services effective?

Requires improvement

The SPCT provided evidence based advice to other professionals as required. The Liverpool Care Pathway (LCP) had been removed from the trust on the 1st July 2014. Staff were asked to follow the guidance set out in the 'Best Practice Guidance for the care of the dying' and use this to support the care delivered to all patients approaching the end of their life. On reviewing medical records of four EoLC patients across the wards we visited, we did not find individualised care plans related to end of life care. We saw evidence that care was delivered and recorded but we did not see any information on how individualised care would be delivered around patients needs and preferences.

There were variations in the completeness of DNACPR forms across the hospital. Results from the 2013 DNA CPR audit showed improved compliance from 2011 but the trust standards were still not being met. There was no evidence that mental capacity assessments were carried out when it was debatable whether a patient was able to make decisions around their treatment, care or DNA CPR.We saw no evidence of mental capacity assessments being completed with there were concerns about people's ability to give informed consent.

Evidence-based care and treatment

- Maidstone and Tunbridge Wells NHS Trust (MTW) had implemented National Institute of Health and Care Excellence's (NICE) quality standards for improving supportive and palliative care for adults with the introduction of a SPCT that demonstrated a high level of specialist knowledge and provided wards and departments across the trust with up-to-date holistic symptom control advice for patients in their last year of life.
- The trust had responded to the national recommendations of the Liverpool Care Pathway (LCP) review by targeted work being undertaken following the national review of the LCP. MTW had formulated guidance for all staff caring for patients at EOL called the 'Best Practice Guidance for the care of the dying' which contained the steps necessary to create an individualised care plan, specialist palliative care contact details and medication guidance.
- The palliative care consultant told us that the LCP had been removed from the Trust on the 1st July 2014. Staff were asked to follow the guidance set out in the 'Best Practice Guidance for the care of the dying' and used this to support the care delivered to all patients approaching the end of their life. Due to the short time scale to get the guidance in clinical use members of the SPCT visited the wards along with an internet launch to inform the trust's clinical teams. The EOL Steering Committee minutes (June 2014) confirmed that the palliative care consultant had attended medical and surgical governance meetings to promote the care of the dying guidance.
- The "Best Practice Guidance for the care of the dying'" listed a number of core principles which

were felt to be crucial to good care in the last few days of life incorporating the NICE Quality Standard 13. The guidance was a checklist, which aimed to support healthcare workers as an aide memoire. We saw evidence during the inspection of the guidance being used on Wards 10, 12, 20, 22 and the stroke unit. On Ward 10 the palliative care link nurse told us that they had been using the guidance since it came in July 2014 and that the ward will be a pilot ward for the new updated version of the guidance.

- Staff we spoke to told us the SPCT or medical teams sought verbal consent from patients and /or families before moving a patient onto the 'Best Practice Guidance for the care of the dying''. On the wards we visited we found that the guidance had been signed and dated and completed by the health care staff involved in placing the patients on the EoLC pathway. On Ward 10 the palliative care link nurse told us that when the decision by the medical consultant that patients required EoLC, the nurses approached the medical teams on the ward to start patients on the guidance and prompt the medical staff to discuss DNACPR, PPC and guidance with the patients and family. This showed that staff were working together to deliver effective care that suits people's needs.
- We were told by the palliative care lead nurse that the 'Best Practice Guidance for the care of the dying' (version2) was being developed into an individualised care plan with prompts to ensure all areas of good EOL care were addressed and the wishes and preferences of the EoLC patient were readily accessible to all healthcare professionals. The individualised care plan template was being taken to the medical records committee and standards committee before being piloted on wards 10, 11, 21 and one other ward over the coming months.
- On reviewing medical records of four EoLC patients across the wards we visited, we did not find individualised care plans related to EoLC. On Ward 11 we saw evidence that care was delivered and recorded but we did not see any information on how they intended to deliver EOL individualised care.
- While reviewing the notes, we saw evidence that demonstrated that the SPCT had supported and provided evidence-based advice for example, on complex symptom control and psychological support for the patients and families. On the stroke unit we saw evidence that a comprehensive assessment was carried out by the SPCT and this was undertaken within 24 hours of the referral being made. This specialist input by the SPCT ensured that a high level of expertise was used to ensure the best possible care is delivered to EOL care patients and people had a positive experience of health care.
- The Leadership Alliance for the Care of Dying People published 'One Chance to Get it Right' (July 2014); this was a response to the recommendations set out in 'More Care, Less Pathway', the independent review of the Liverpool Care Pathway. With this in mind, an updated version of the 'Best Practice Guidance for the care of the dying' version 2 will incorporate national recommendations set out by the Leadership Alliance.
- We were told the trust was not actively engaged in the NHS Improving Quality 'Transform Programme' (Phase 2).This programme aims to encourage hospitals to develop a strategic approach to improving the quality of end of life care. However the trust had expressed an interest in the use of AMBER (Assessment Management Best practice Engagement Recovery uncertain) Care Bundles (ACB) which were used to support patients that were assessed as acutely unwell, deteriorating, with limited reversibility and where recovery was uncertain and Advance Care Planning (ACP). However due to a shortage of staff these had not progressed within the trust.
- The trust took part in the National Care of the dying Audit Hospitals (NCDAH) in May 2013.The information gathered did offer some insight into the practices at that time and areas that would benefit from improvement strategies as well as aspects of care they were delivering well. Areas highlighted for improvements included bereavement leaflets that explain the grieving process for families, clinical protocols promoting comfort and dignity, spiritual needs identified and met and seven day working of the palliative care team. The clinical section was reviewed in detail and an awareness of the need for good documentation and communication were highlighted.
- An NCDAH action plan had been developed and updated (dated 6/10/14) around the key findings and we saw evidence during the inspection that it was in the process of being actioned. We found on the wards we visited the new bereavement booklet from Macmillan and Marie Curie Cancer Support had been introduced and the EOL facilitator was developing a new local EOL information booklet which we observed was in draft format at the time of the inspection.
- In the NCDAH the trust performed poorly on the spirituality support offered to patients and relatives. To address this, the draft copy of the new individualised care plan for the dying patient had a section that asked healthcare staff to ask if patients required spiritual support. The chaplain

told us that Accident and Emergency and Maternity were good at involving the chaplaincy when a baby or child died to support the family. The introduction of the prompt will remind staff to offer support to patients and their relatives.

- Within the chemotherapy out patients unit we observed that all palliative chemotherapy was based around a care pathway approach with all protocols /guidelines based on national recommendation's and developed within the Kent and Medway Caner Network. For example we saw a copy of the care pathway used for breast cancer patients including the sections relevant to palliative chemotherapy. The document had been reviewed in June 2014 with a new review date in June 2016.
- The SPCT had recently registered with the EOLC Quality Assessment tool (ELCQuA).The palliative care team can use this tool to self-access and track their progress against the NICE Quality Standards and develop a service improvement programme around the outcomes.
- The trusts did not perform a local bereavement survey but they had undertaken a patient's satisfaction survey.

Pain relief

- Effective pain control was an integral part of the delivery of effective EoLC and this was supported by the SPCT. On reviewing an EoLC patient's medical records on the stroke unit we saw that the SPCT CNS and palliative care consultant were actively involved in daily reviews of the patient's pain management. We observed that the medical teams on the stroke unit and Ward 12 were proactive in prescribing the EOL care medication following best practice guidance.
- Best Practice Guidance for Care of the dying included guidance on prescription of anticipatory pain relief for patients at the end of life. The guidance had been developed from the 'Kent Palliative Medicine Forum, University of Kent (2009) symptom control and caring for the dying patient. The palliative care consultant told us that incidents around medication were referred to the 'Drugs and Therapeutics Committee'. Feedback was given to teams following the incidents being investigated.
- The SPCT CNS was involved in giving advice to the medical teams around the prescribing of EOL medication. We were told by staff on the wards we visited that all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly. Information for patients and relatives on EoLC medication was available in the 'End of Life: a guide' booklet which had been introduced onto the wards across the trust to support patients and families.
- On Wards 12 and 22 we found in the patient's notes we reviewed, pain was being managed appropriately with all the necessary medication written up so this could be delivered when the patient required it. On Ward 12 we spoke to an EOL patient who told us that 'the nurses always ask if I have pain. Yesterday I needed pain relief for breakthrough pain; the nurses were with me quickly and sorted the pain out'. We were told by staff that if pain was not being managed appropriately a syringe driver would be attached. However we learnt that a complaint had been made to the trust regarding the poor management of pain in an EoLC patient. An investigation was underway at the time of the inspection. We saw no evidence of patients in pain during the inspection.
- On Ward 12 we observed that a pain assessment tool was being used for patients with dementia. Facial, vocal, body language, behavioural and physical signs were used to monitor pain.

Nutrition and hydration

- In the 'Best Practice Guidance for the Care of the Dying', section 10, 'multi professional teams must pay specific attention to the patient's nutritional and fluid requirements'. The guidance included a prompt to ensure patient and family views and preferences around nutrition and hydration at the end of life were explored and addressed. We were told that separate menus were available such as soft and pureed food.
- On the Ward 21, the ward manager was able to explain that Malnutrition Universal Screening Tool (MUST) assessment was carried out on admission and weekly; this identified patients at risk of poor nutrition, dehydration and swallowing difficulties. A red tray system was used on the ward which identified patients who required additional help at meal times. We observed the use of food charts in use and were completed appropriately.
- Patients identified as high risk were directly referred to the dietician and Speech and language Therapist (SALT). Meal times were protected which meant staff ensured people could eat uninterrupted except for urgent clinical care. EoLC patients were supported to eat and drink

normally if they were well enough and were able to swallow following a SALT assessment. We saw food charts were in use and being completed on the ward. All mouth care was documented in the patients nursing notes.

- On Ward 11 we reviewed the records of an EoLC patient who was not tolerating a nasogastric tube (NG). The patient was reviewed by the SALT and the dietician and we observed that comfort measures were put in place. The patient was supported with fluids and a mouth care plan. We observed that the necessary systems were put in place to support this patient who was receiving EoLC.

Patient outcomes

- The trust supported patients to achieve their Preferred Place of Care (PPC) either through rapid discharge to home, hospice or nursing home or by delivering high quality care for patients who wished to die in hospital. We were unable to review how the trust was achieving EoLC patients PPC as the data had not been consistently collected during 2013/14 due to staffing constraints.
- The trust contributed to the NCDAH 2013.On the key indicators the trust was performing in line with other trusts however the audit highlighted the need for better documentation and communication with patients and families. The trust recognised the importance of improving communication and documentation and had included these into the NCDAH action plan.
- The ward sister on Ward 12 confirmed that the LCP was no longer being used within the ward. This showed that the trust had responded to concerns regarding the LCP and informed staff of the replacement guidance to ensure patients were treated safely and being compliant to National Guidance.
- Data on referral patterns, patient demographics and patient activity is collected manually and sent to the National Council for Palliative Care Minimum Data Set (NCSPC MDS) to collate for local and national comparison. Information collected included number of people using the service, breakdown of diagnosis and mean length of care. The trust can use this information to benchmark their service and use the report to negotiate with commissioners around service provision.
- The trust supported patients to achieve their Preferred Place of Care (PPC) either through rapid discharge to home, hospice or nursing home or by delivering high quality care for patients who wished to die in hospital. We were unable to review how the trust was achieving EOL patients PPC as the data had not been consistently collected during 2013/14 due to staffing shortages
- The trust contributed to the NCDAH 2013. On the key indicators the trust was performing in line with other trusts however the audit highlighted the need for better documentation and communication with patients and families. The trust recognised the importance of improving communication and documentation and has included these into the NCDAH action plan.

Competent staff

- EOL training was not mandatory across the trust. The NCDAH action plan under ‘update of progress ’, states that EoLC will not be included in mandatory training for nursing staff. The trust was looking at an E learning package for EoLC. The palliative care consultant told us that SPCT’s role was to help empower staff to manage EOL care patients and prevent the de skilling of the frontline medical and nursing staff by talking through any processes with them.
- The palliative care consultant had been re-validated by the General Medical Council last year. We were told that the consultants Continuing Personal Development diary was up to date and recent courses attended included ‘advanced symptom control and neurological palliative care.’
- The CNS’s from the SPCT were highly qualified in palliative care with all team members having completed the advanced communications skills course Two2 members of the team were now undertaking study at Masters Level. One CNS had attended the ‘Sage and Thyme’ Facilitator course and was now able to support patients who may become distressed. One member of the team had completed the training necessary to enable them to practice at level 2 for the psychological support of patients and their carers. The palliative care consultant told us that the SPCT supported the clinical process and would get involve in the transition from active treatment to the supportive phase of care.
- The SPC team were actively involved in the training of staff in EoLC providing four study days per year for trained nurses, two at level 1 with emphasis on symptom control, complex discharge and EOL care issues. In addition two study days were at Level 2 with emphasis on communication, spirituality and ACP. Trust staff had access to palliative care study days provided by the hospice. During the inspection we were unable to see records to confirm the number of staff across the trust

who had attended training in EoLC.

- The SPC CNS's and the palliative care consultant provided support to all grades of staff across the hospital to ensure that ward staff felt confident to deliver EOLC by providing visits to the wards and communicating recommendations to clinician's. The team participate in induction days for new staff.
- We were told that FY1, FY2 and CMT doctors receive training as part of their formal education. The Training was provided by the palliative care consultant and the trust clinical ethicist. The training included role play such as breaking bad news, conflicts within families and collusion. The palliative care consultant told us the feedback from the training sessions was good. During the inspection we were unable to confirm the percentage of doctors that had received training in the last year.
- Syringe driver pumps to deliver analgesia continuously were available to all EoLC patients. We saw that staff were trained to use the pumps. Training records were available and showed that sessions ran regularly. In 2013 staff training on syringe driver pumps was delivered during in IV study days. In 2014, this was changed to being delivered via medical devices training. However, because staff attendance had dropped, the trust has reverted back to the training being delivered at IV study days.
- Across the TWH palliative care link nurses were present on the wards we visited. On ward 10 we spoke to the palliative care link nurse who told us that they met with the SPCT to reflect and receive palliative care updates. They attended the palliative care study days. Information from the SPCT updates were cascaded to the frontline staff on the ward through updates at ward meetings and newsletter. A folder was available on the ward for staff to refer to if required. We were told that due to recent staff shortages in the SPCT palliative care link nurse study sessions had not taken place but plans were in place to re-instate the study sessions.
- The porters told us that they had received training to support the movement of deceased patients to the mortuary .The 'on the job training' included the use of the mortuary out of hours to ensure that mortuary procedure were maintained. The porters we spoke to were able to describe the process in a knowledgeable manner and were able to demonstrate how they treated deceased patients with dignity and respect. Competency assessments were undertaken for all patient handling and equipment. We saw the training record of one porter which confirmed training was up to date.

Multidisciplinary Team working

- We saw evidence across the wards of MDT (multidisciplinary team) meetings taking place throughout the week to review patient's management plans. On the Intensive Therapy Unit we were told by the sister that a MDT meeting took place every morning and included nursing and medical staff, physiotherapists and occupational therapist and dietician. By reviewing the patients daily any decisions that needed to be made can be made in a timely manner. The ITU team made referrals to the SPCT who can support the team with symptom control advice for EoLC patients.
- On Ward 20 the sister told us that board rounds take place daily with the nursing and medical staff, physiotherapists, speech therapist and occupational therapists. This meant that timely decisions could be made regarding the care of EOL patients to ensure wishes and preferences were achieved.
- The SPCT were visible to staff across the hospital. Nursing staff in all the departments and wards that we visited were aware of how to contact the SPCT and could cite examples of their involvement with specific patients. Junior doctors were able to book sampler weeks with the palliative care consultant.
- The SPCT held a weekly MDT meeting (Thursday am) at TWH to discuss treatment plans for new and current patients. The SPCT told us that an ongoing challenge was to provide a useful forum that incorporates a range of practitioners involved in caring for the palliative care and EOL patients. Following the weekly MDM a management plan will be agreed and formulated and will then be documented in the patients individual palliative care notes. This can be given to the patient if they required a record of the discussion or plan.
- The SPC CNS worked closely with the cancer and non-cancer site specific CNS's to support with complex symptom management at EoLC. A SPC team member attended the Lung MDM but they were unable to attend other MDT meetings due to staffing shortages.
- The SPCT told us they worked alongside other specialities including the acute oncology team, community and hospice teams. Two visiting palliative care consultants worked one session each at

the hospital .This provided streamline care across care providers and provided a more standardised model of care across the local healthcare economy. On Ward 12 the ward manager told us that they had contacted the hospice for support out of hours. The hospice nurses would visit EoLC patients prior to them being transferred to the hospice. This showed good MDT working across service providers.

Seven day services

- No seven day face to face specialist care was available from the SPCT. However systems were in place to provide timely telephone SPC advice from 5pm onwards for people approaching the end of life from the palliative care consultant on call at Hospice in the Weald in Pembury. Clinicians were advised of this service via the information page on the intranet and a message with details of how to access this service left on the office answer phones. In addition, yellow stickers with out of hours contact phone numbers were placed in the medical notes of patients who may deteriorate between reviews.
- The specialist palliative care team based at the Tunbridge Wells Hospital offered services Monday to Friday 9am – 5pm. Staff on the wards told us that they felt confident in the support mechanisms in place for EoLC patients outside these hours.
- Chaplaincy cover was provided 24 hours per day; outside the hours of 9am and 5pm it was for emergencies only. The multi-faith centre was open 24 hours a day for prayers.

Access to information

- All Staff had access to the 'Care of the dying policy and procedures' version 2.2. This gave guidance to all staff on all aspects of caring for dying patients from care of the dying, caring for relatives, care after death and care of the dying child. Patients that were recognised as deteriorating or dying would be commenced on EoLC using guidance set out in the 'Best Practice Guidance for the care of the dying.' We were told by staff that this would be commenced after discussion with the consultant and multi professional team including the SPCT, patient and relatives.
- We were told by the ward manager on the stroke unit that part of the ongoing discussion with EoLC patients and their relatives the ceiling of care would be discussed and documented. Patients who might respond to some treatments such as antibiotics for an acute infection would receive these.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- We were told by ward staff that if there was any question around whether a patient was able to make decisions around their treatment/care or DNA CPR a 'mental capacity assessment' would be completed by the admitting doctor and a best interest's decision would be made. We saw no evidence of this process during the inspection. On Ward 12 a consultant told us that they reviewed DNACPR orders on the ward round. If they were unable to discuss the orders with the patient they will always discuss with the relatives.
- We spoke to a junior doctor on Ward 12 who was able to explain that with patients that lacked capacity to complete a DNACPR order, a team discussion took place and a best interest's decision was made. The decision was discussed with the family or lasting power of attorney. The doctor was unsure when formal MCAs were undertaken. The SPC CNS told us that if they a complex mental capacity assessment was required the SPCT asked for support from the clinical ethicist who supported the team along with the patient and family.
- The trust had a Resuscitation Policy which was available to all staff that set out the use of DNA CPR orders. We were shown data of the last two audits undertaken across the trust in 2011 and 2013. We were told the 2014 audit was still draft form. Results from the 2013 audit showed improved compliance from 2011 but the trust standards were still not being met. On visiting the ward areas; we randomly checked 12 DNA CPR orders. We saw that all decisions were recorded on a standard form with a red border placed at the front of the notes, allowing easy access in an emergency.
- Where DNACPR orders were in place we saw that patients with capacity were involved in discussions. Where the patient lacked capacity we saw no evidence of assessments being undertaken or documentation of any mental capacity assessments. We found that trust policy was adhered to and a review took place as the patient condition improved.
- All orders were countersigned by a consultant however we found that patients and families were

not consulted on four of the orders we checked and in one case no review date was evident where the patient's condition was improving. We concluded that there were variations in the completeness of the forms across the hospital our findings showed that DNA CPR orders did not always provide evidence that trust policy had been followed. This indicated that more work was required in this area.

Are end of life care services caring?

Good ●

Staff at Tunbridge Wells Hospital provided compassionate EoLC to patients. Staff demonstrated a strong commitment to empathy and enhancing the environment for dying patients. A patient's relative told us 'the nurses were lovely and we get good information from the doctors. One SPC Nurse Specialists had completed the training necessary to enable them to practice at level 2 for the psychological support of patients and carers. Other forms of support included referral to the cancer counsellor which can be helpful when children were involved. Families were encouraged to participate in care such as mouth and personal care.

Compassionate Care

- Hospital staff we spoke with demonstrated a strong commitment to empathy and enhancing the environment for dying patients. The' Care of the dying policy and procedure ' stated that staff 'will approach the dying process in a caring and sensitive manner paying attention at all times to the spiritual and cultural needs of the patient and their relatives and carers.'
- On visiting Ward 22 we spoke with a patient who was receiving EoLC. The patient told us they were receiving 'absolutely brilliant care. I can't speak highly enough. Staff are polite, kind and caring. They are a good team that work well together'. The patient's relative told us 'the nurses were lovely and we get good information from the doctors. The nurses will always follow up. A brilliant team.'
- On Ward 12 we observed nursing staff supporting a distressed family with good open interactions with the staff being attentive and supportive. The family were taken to a quiet, private area to be supported. This demonstrated the caring element of the nursing staff and how families were supported by the staff during this difficult time.
- The porters explained to us the procedure undertaken to remove a deceased patient from the ward to maintain the person's dignity and respect. When the porters arrived on the ward, the nursing staff asked all patients and relatives to stay in their rooms while the porters quietly and respectfully brought the concealment trolley in to the ward. During the transfer, a member of the nursing team would be available to support the porters.
- On visiting the mortuary, the mortuary technician told us that all deceased patients that come from the wards arrive prepared in accordance with the trusts 'Personal care after death' policy. If a patient was to arrive not prepared correctly, the technician would raise an incident report and offer the ward in question extra training around the care of deceased patients.

Understanding and involvement of patients and those close to them

- We saw evidence in the medical records that the SPCT CNSs were actively involved with both the patient and the relatives, providing support and keeping families involved in the management of patients with their consent. On Ward 11 we observed that the SPCT CNS had spoken to a family and was due to update the family the next time they were in the hospital.
- On Ward 12, we were told by the ward manager how important it was to get families involved in the care and that staff encouraged relatives to get involved. We were given an example where the family were involved in care that were being undertaken, for example pressure relief and oral care.
- Decisions regarding patients commencing palliative chemotherapy were consultant led and we were told by the unit manager that patients were fully involved in decisions regarding their treatment. At any point patients could stop their treatment if they no longer wished to continue.

Emotional Support

- One SPCT CNS had completed the training necessary to enable them to practice at level 2 for the psychological support of patients and carers. Other forms of support included referral to the cancer counsellor which could be helpful when children were involved. Complex cases could be referred to the Hospice in the Weald team who could offer emotional support to patients and their families.

- On the chemotherapy unit we were told by the unit manager that systems were in place to support patients during their chemotherapy. These included a referral made to the cancer counsellor and nurse led chemotherapy clinics where patients could discuss any worries they may had.
- The chaplain was available to provide spiritual and religious support across the hospital. On Ward 11, the SPCT CNS told us they would ask EoLC patients if they required support and if they did, a referral would be made by the ward team to the chaplain. Volunteers were available from the chaplaincy to provide emotional and spiritual support when asked by the patient/families and medical and nursing staff. The nursing team in the ITU confirmed they used both the chaplain and the SPCT if emotional support was needed. However the ward manager was not sure of the services available within the hospital to support children whose parents may be dying.
- The minutes of the EOL Steering Committee (8/9/14) stated that the team would approach the commissioner to explore what bereavement services could be provided locally. Bereavement services for the trust as a whole were provided by either the oncology counsellors (if patient had a cancer diagnosis) or by the local hospices when a patient had been previously known to them. There was also chaplaincy support across the trust. The SPCT acknowledged a deficit in the service for patients under their care who do not have a cancer diagnosis or who were not under hospice care. In such circumstances, bereavement counselling would have to be accessed through GPs or by referral to CRUSE.

Are end of life care services responsive?

Requires improvement ●

All patients requiring EoLC could access the SPCT. The SPCT supported complex and fast track discharge processes so that patients achieved their Preferred Place of Care (PPC)
All EoLC patients at TWH received care in a single room. The majority of Medical Certificates of Cause of Death (MCCD) took longer than five days to be released to the family which meant delays to families having the death registered and the deceased being released to the funeral directors.

Patients undergoing palliative chemotherapy were not supported by a CNS after they left the care of the surgical teams. This meant that arrangements had not been made to minimise disruptions in care as patients had lost their point of contact and the support as they entered a new phase of the disease management.

There was no EoLC alert system in place that informed the SPCT of any emergency admissions to the emergency department of palliative care patients previously known to the team.

Service planning and delivery to meet the needs of local people

- As referrals for EoLC increased, plans needed to be made on how the trust will support an increase in demand. The minutes of the EOL Steering Committee (July 2014) identified that discussions were being undertaken and a business case was being written to increase the workforce.

Access and flow

- The SPCT was widely embedded in all clinical areas of the hospital we visited and we were told by staff on the wards they would refer a high percentage of their patients commencing EoLC. However, often SPCT input would not be required.
- All patients within the trust, requiring EoLC had access to the SPCT. Referral could be made by the nursing and medical staff within the trust. The medical team and wider members of the multi professional team were required to document the reasons for referral in the patient's notes and complete a referral form. Urgent advice was available from the CNS who was available to give telephone advice prior to reviewing the patient.
- The SPC team aimed to review urgent patients within 24 hours however this time may extend at busy times such as when one CNS was away. We saw data that confirmed the SPCT saw the majority of the referral on the same day. The staff we spoke to across the wards we visited reiterated to us the availability and effectiveness of the SPCT.
- We were told that systems were in place to facilitate the rapid discharge of patients to their preferred place of care. We observed that in the minutes of the EOL Steering Committee a trial for rapid discharge would be undertaken; this would be attached to fast track referrals. Although this

document had formed part of the Care of the Dying Policy the SPCT had found it had not been well utilised. A re-launch of best practice guidance and individualised proforma is planned for autumn.

- Patients discharged from the acute setting who did not have specialist palliative care needs were initially followed up by district nurses who acted as their keyworker. The option was available to refer to the community palliative care team at any time.
- The rapid discharge pathway sets out clear instructions for staff to follow such as ward doctor tasks which included prescribing medication and completing a valid DNACPR orders. Tasks for 'on day of discharge' were clearly set out and included 'after discharge, call the GP, DN/Nursing Home, hospital palliative care team and family to confirm patient had left the ward'. Ward staff ensured contact was made with district Nurses, GP's, community and hospice palliative care teams before patients were discharged.
- We were told by the SPCT that systems were in place to rapidly discharge patients to their preferred place of care. The discharge procedure was led by the staff caring for the patient on the ward and was supported by the SPCT, the discharge liaison team, community liaison team, physiotherapist and occupational therapist. However on Ward 22 a nurse told us that it could take 24 hours to organise oxygen and two days for a bed to be made available. The ward manager on ward 21 told us that they could get patients home quicker than patients who were being discharged to a nursing home where CHC funding was required.
- We were given two examples where the rapid discharge pathway process was not adequate which resulted in two patients not achieving their PPC. On Ward 21 we observed that an EoLC patient was identified as 'wanting to go home', however the continuing healthcare form took five days to be submitted. This identified that nursing team members needed to be aware of the processes in place, as slow processes reduced the chances of the patient achieving their PPC. We were told on Ward 22 by the nurse that a family wanted their unconscious relative home. The form to complete was complicated and the relative wrote in the wrong box which meant the form was returned. This resulted in the patient not achieving their PPC.
- The trust is not part of an Electronic Palliative Care Co-ordinating System (EPaaCS). This system would support better care by recording patients PPC and prevent inappropriate admissions to hospital.
- There was no EoLC alert system in place that informed the SPCT of any admissions to the emergency department of palliative care patients previously known to the team. Such a system would support the early assessment and management of patients and sometimes prevent an inappropriate admission.
- At the time of the inspection, 11 chairs were being used instead of the standard 8 in the chemotherapy unit in order to keep waiting times to a minimum.
- Referrals to the SPCT could be made by completing a referral form, which could be accessed via the internet. Any member of the multi professional team could make a referral. The team aimed to see patients within 24-48 hours of referral. We saw data that confirmed that the integrated SPCT were reviewing 95% of patients within two working days. Of these 88% were responded to within 24 hours (many of which will have been on the same day as receipt of referral) and 7.5% within 48hrs.
- We were told by the SPCT CNS that referrals had increased during 2013/14 and that 400 referrals were made for patients entering EoLC. The SPCT supported patients with cancer and those suffering from other conditions. All patients commencing on the 'care of the dying guidance' were referred to the SPCT for audit reasons. On Ward 11 we reviewed the medical records of a patient under the care of the SPCT. We observed that the medical team had made the decision that the patient should be placed on EoLC on the Tuesday. We noted that the patient was reviewed on the Wednesday by the SPCT and placed on the 'best practice for the care of the dying guidelines'.

Meeting people's individual needs

- We were told that patients at EOL would be assessed by the medical and nursing teams to develop individualised care plans to meet their individual needs. The SPCT did not have direct responsibility for patient management but made recommendations with the appropriate team and documented this contemporaneously in the medical notes. The SPCT updated the relevant clinicians as necessary but also encouraged them to accompany the team on consultations to provide an educative and inter-professional approach. However on the wards we visited we did not see any individualised care plans specific for EoLC patients.

- In the chemotherapy unit we were told that patients receiving palliative chemotherapy were given verbal and written information and access to 24 hour telephone advice as well as access to emergency care.
- The manager on ITU told us that systems were in place to contact the organ liaison nurse if a patient was not expected to live and fitted the organ donation criteria. The organ donation team spoke to the family, who were given the opportunity to stay with their relative while the appropriate tests were undertaken. The family were offered any keep sakes from the patient such as hair. The ITU manager told us that at no time were families were pressured into making decisions they did not want to make.
- We visited the mortuary viewing suite where families could spend time with their relatives. The viewing suite was divided into a reception and viewing room. The suite was neutral with no religious symbols which allowed the suite to accommodate all religions. We were told families were supported during the viewing by the mortuary technician. Appointments could be organised through the bereavement office or ward, Monday to Friday. The viewing times were available all day between 8am and 4pm, but we were told that viewing timings were very flexible.
- Information leaflets for families whose relatives were receiving EoLC were available and were given out by ward staff. The information leaflets included ‘End of life care; a guide ‘and ‘Guidance following bereavement’ were given out by ward staff. Ward staff we spoke to told us they would give relatives these leaflets and a brief overview of the information and offer to explain anything they did not understand. In the EOL steering Group (sept 2014) discussions took place around developing a leaflet explaining the facilities that were available for relatives and friends.
- The patient liaison officer carried out the administration of a deceased patient’s documents and belongings, providing practical advice and signposting relatives to support services such as funeral directors and registering the death. The office was open, Monday to Friday, 10am to 3.30 pm. The service manager we spoke with told us that they were able to support the repatriation of deceased patients by organising ‘freedom from infections’ and ‘out of England certificates’. Systems were in place to support deceased patients who did not have family in the UK. In such cases, the bereavement team liaised with the chaplain and coroner to organise a funeral.
- Six weeks after a person’s death, a card was sent out to relatives with relevant numbers of support bereavement services.
- Families require Medical Certificates of Cause of Death (MCCD) so that a death can be registered. We were told that the majority of certificates take five days to be released as the doctors liked to wait for the ward round to happen first. During this time the bereavement office kept the families involved. However during this time the families cannot get the death registered and the deceased patient’s body cannot be released to the funeral directors. We were told that when MCCD had to be ready for religious or cultural reasons the certificates were processed quickly and were always completed on time. However, we were told that MCCD certificates cannot be released over the weekend, so it was unclear how rapid release of the deceased was managed. No audit information was available to monitor how responsive the trust was around completing MCCD certificates.
- A variety of religious and spiritual meetings took place in the hospital during the week which included Sunday and Friday prayers. These took place in the multi faith room. The chaplain is the contact for other faith leaders such as the Imam. We were told that the Imam did not visit the hospital on a regular basis however Friday prayers were led by one of the hospital doctors. The multi faith room was large enough to be divided in order that differing faiths can pray.
- The chaplains were on call across the trust and were the point of contact for other faith leaders. One chaplain and approximately 20 volunteers were available at each hospital. Volunteers had regular areas to visit with some available on call. A file of multi faith prayers were on display for use by those requiring prayers. A quiet room was available in the multi faith centre for reflection, prayers and comforting bereaved relatives.
- The mortuary technician told us that the trust was in the process of looking into developing an area within the mortuary where Muslims could perform ceremonial washes on the body of their deceased. At the time of the inspection various options had been suggested and were being worked through by the mortuary team. In the multi faith centre the chaplain told us that facilities were in place to support washing prior to prayers.
- We noted that there were no social workers who were available to support EoLC patients.
- The ‘Care of the Dying policy and procedure’ sign posted staff to take into consideration the multi-cultural needs of their patients and the importance of the specific requirements related to the care of the EOL patient before and after death. A ‘Spiritual and Religious Care Directory’ was available

to healthcare staff to ensure EoLC patients were managed in line with their culture/faith. The directory covered the care of the EOL patient, diet, post mortems and organ donation.

- Guidance was available on wards and on the intranet to support staff in providing care in accordance with peoples religious and cultural preferences (Spiritual and Religious Care Directory). Staff had access to specialist advice from the chaplaincy were clarification was needed. The chaplain told us that he taught on both the induction training and palliative care study days on spirituality.
- The chaplaincy volunteers attended training days and twice a year a cross site chaplaincy meeting took place to update the volunteers and providing any training necessary. The chaplain told us that on the 4th Thursday each month a service was held in the dementia café. This allowed the team to develop skills around worship and the support people living with dementia.
- We saw evidence of good communication with the family and the patient was asked if any religious or spiritual support was required.
- The SPCT CNS reviewed EoLC patients depending on their needs; offering support and reviewing their care needs. Patient contacts depend on the need of the patient and their families, with many EoLC patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases and spoke to medical teams and carers. On ward 11 we observed that the EoLC patient was receiving daily visits from the SPCT CNS.
- Nursing staff involved in delivering palliative chemotherapy felt that systems were in place to ensure that any patient they felt were too ill to receive active treatment were discussed with the relevant medical team and alternative care was offered. In the chemotherapy unit, 75% of the chemotherapy was palliative. The unit manager told us that nursing assessments were carried out prior to starting chemotherapy. This allowed nursing staff to run through the chemotherapy drugs and the risks associated with them. Good team working allowed concerns to be raised with the medical oncologist. Patients not proceeding with chemotherapy would then be referred to the community palliative care team for supportive care.
- As the TWH was made up of single rooms all patients including EoLC patients were nursed in a single room.
- We saw the relative's facilities in the ITU which included a waiting area where relatives could sit in surroundings with comfortable seating and tea and coffee facilities. We saw a range of information leaflets were available for relatives who wished to find out more information on a subject such as organ donation. We were shown that two relative rooms were available for relatives who wished to stay overnight and included beds, toilets and shower rooms. In other wards in the hospital, put up beds were available for relatives to stay by their relative's bed side.
- The SPCT worked collaboratively with the cancer and non-cancer CNSs across the hospital to provide seamless EoLC. Cancer and non-cancer EoLC patients received support from site specific CNSs and the SPCT CNS supported patients when complex symptoms developed. However we found that patients undergoing palliative chemotherapy were not supported by a CNS after they left the care of the surgical teams. This meant that arrangements had not been made to minimise disruptions in care as patients had lost their point of contact and the support as they entered a new phase of the disease management.

Learning from complaints and concerns

- We were shown a number of complaints relating to end of life care. There had been six complaints relating to EoLC in the last 14 months across the trust. The palliative care lead nurse had asked to be involved in the complaint responses and will be sent details of all complaints in the trust pertaining to EoLC so trends and patterns could be identified and inform the EOL Steering Committee. This allowed for strategies to be devised addressing any issues identified. However, learning from EOL complaints were not being cascaded through the trust which meant all staff were not learning from the complaints made.
- The patient liaison officer told us that if relatives were unhappy with any aspect of care they would contact the patient experience matrons who contacted the medical and nursing team involved in the patients care to discuss any issues raised. Relatives were directed to the PALS team if they wished to make a formal complaint. We were told by the patient liaison officers that no complaints had been made over the last year.

Are end of life care services well-led?

Good ●

An EOL Steering Committee had been set up to develop and implement and EOL strategy to meet the needs of the patient population. The committee had a wide membership which ensured that EoLC was the business for all across the trust and not just the SPCT.

An action plan had been developed which set out the key areas the trust would like to develop around palliative care in 2014/15. This included exploring the options for a seven day service across the trust and review the model of service delivery.

There was good leadership of the SPCT led by the palliative care consultant and lead nurse. The team worked well together which supported improved patients outcomes. Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility and this was very evident by the SPCT in their patient-centred approach to care.

Vision and strategy for this service

- An EOL Steering Committee had been set up to develop and implement an EoL strategy to meet the needs of the patient population. We found reference to this strategy in the minutes of the EOL Steering Committee (September 2014) and in the action plan for the palliative care team for 2014/15. However, the trust's vision around EOL care remained unclear in which terms of the direction the trust was heading and what stakeholders should expect.
- The action plan developed for palliative care in 2014/15 included exploring the options for a seven day service across the trust. It also included review the model of service delivery including education programmes to facilitate, support and develop clinicians to provide high standards of palliative/EoLC, improve the process of rapid discharge home for EoLC patients, appointment of development posts (band 5/6 nurses) to rotate through the team and obtain patient feedback. These objectives were at varying stages of implementation at the time of the inspection.
- The trust had developed a 'Care of the Dying Policy and Procedure Version 2.2' (reviewed August 2014) which provided the trust with a comprehensive policy related to the care of the dying patient. This was presently being updated by the relevant team members across the trust. Staff we spoke with who were delivering care knew about the policy but were unable to tell us what the trust's vision was around EoLC was.
- We were told by the chaplain that weekly CEO updates were emailed to all staff. The values and vision of the trust were well known especially the 'Pride' value. Listening days were arranged throughout the year for teams to attend.

Governance, risk management and quality measurement

- The SPCT's operational policy stated that all team members were required to adhere to all relevant trust's policies and procedures to ensure compliance with the organisation's governance requirements.
- EoLC was discussed at the EOL Steering Committee which was set up in July 2014 and was chaired by the director of nursing. This group reported to the 'Standards Committee' chaired by the medical director. The medical director was the trust's lead for EoLC with the director of nursing reporting on EoLC matters to the trust board.
- The SPC Teams Annual report was submitted to the CNS meeting and the oncology directorate meeting.
- The palliative care consultant told us that a team member attended the EOL Strategy Implementation Group. Although the hospital and the hospice were different organisations they worked closely together to ensure streamline processes were in place as patients moved across service users. The palliative care lead nurse attended the Acute Palliative Care Nursing group which was held twice a year and was where the lead nurses shared practice.
- The palliative care medical consultant chaired two committees; these being the trust's Resuscitation and Clinical Ethics Committees. It was the Clinical Ethics committee report into the LCP which was fed to the trust board and it was this committee that drew up a trust response to the report. This prompted the development of the 'Best practice guidance for the care of the dying' which the trust implemented in place of the LCP.
- The End of Life Care Steering Committee reviewed any risks associated with EoLC across the

trust. The committee membership included key clinical leads in EoLC, specialist palliative care, senior representatives from surgery, medicine, dementia care, the chaplaincy and the trust ethicist. This wide membership ensured that EoLC was the business for all across the trust and not just the SPCT.

- The SPCT implemented the action plan for the palliative care team led by the palliative care lead nurse. Updates fed into the EOLC Steering Group which reported directly to the Standards Committee which scrutinised its work, highlighted issues and challenged their processes.
- In the development work of the SPCT we observed the use of other committees in the trust to support the development of the service. This included an EoLC update sent to the Patient Experience Committee to include life after the LCP. The committee will be asked if a volunteer would like to attend the EOL care Steering committee. The new individualised EoLC plan needed to be ratified at the Medical Records Committee.

Leadership of service

- There was good leadership of the SPCT led by the palliative care consultant and lead nurse. We observed that the team worked well together which supported improved patient outcomes. In the team's operational policy, its mission statement included: 'facilitating a high standard of EOL care for dying patients within the Trust' and 'providing EoLC education and training within the trust.
- All the staff we spoke with felt their line managers and senior managers were approachable and supportive. They were also able to name members of the SPCT and gave examples of their involvement in optimising patient care.
- We were told that the palliative care CNSs had regular meetings chaired by the team leader (approximately every six weeks). In addition, the SPCT had an annual Operational Policy Meeting, where the policies and procedures of the team were reviewed and, were appropriately revised, in order to provide the most effective, efficient service in line with national recommendations.
- The chaplaincy volunteers were well supported by the chaplain with monthly update meetings and twice yearly cross site training days.

Culture within the service

- All staff we spoke with demonstrated a positive and proactive attitude towards caring for people who were dying. They described how important EoLC was and how their work impacted on the overall service.
- We spoke with staff about how supported they felt in their roles. They all described that they felt supported and told us how approachable their managers were.
- We asked the mortuary staff whether the staff working in their department felt a sense of belonging to the wider hospital team. They told us that they had lots of contact with non-mortuary staff. There were frequent visitors such as the chaplain, porters and undertakers who they got to know quite well. They were able to see where their work fitted into the provision of EoLC services.
- All staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility and this was very evident in the SPCT in their patient centred approach to care. Staff had a 'can do attitude'. Which meant that the staff were very patient-centred and wanted to deliver good care through good training and support.
- Across the wards we visited we were told by ward staff that the SPCT worked well together with nursing and medical staff and there was obvious respect between the specialities and disciplines.

Public and staff engagement

- The trust did not receive feedback on EoLC and no bereavement surveys were undertaken across the trust.
- A patient satisfaction survey was completed during December 2012-January 2013. A total of 30 surveys were sent out and the team received 21 back via the PALS, achieving a response rate of 70%. This was a good return considering that survey responses were notoriously low within the field of palliative care. The results of the satisfaction survey were presented at one of the SPCT MDT meetings where an action plan would be formulated to address any issues that had been highlighted as a result of the survey.

Innovation, learning and improvement

- The SPCT gave examples of practice for which the team were proud and included; prompt responses to referrals, standard assessment within 24-48 working hours and increasing referral profile of non-malignancy patients.

- All palliative care CNSs had now completed the advanced communications training.
- The SPCT had been networking with other providers, community services and GPs for better care closer to home.

Outpatients & Diagnostic Imaging

Safe	Good	●
Effective	Inspected but not rated	●
Caring	Good	●
Responsive	Requires improvement	●
Well-led	Requires improvement	●
Overall	Requires improvement	●

Information about the service

Outpatient services at The Tunbridge Wells Hospital at Pembury are mainly located in one area on the ground floor and served by one reception desk. There is an ophthalmology day case service alongside. The Tunbridge Wells Hospital at Pembury offers clinics across medicine such as cardiology, neurology, rheumatology, diabetes, respiratory and elderly medicine. There are surgical clinics such as ear, nose and throat, colorectal, vascular, orthopaedics and trauma. The ophthalmology clinics serve a considerably wider population than the rest of the outpatient services. Blood test services are provided within outpatients. The radiology department supports outpatient clinics as well as inpatients, emergency and GP referrals. The sonography service is located within the Women's and Children's outpatient area.
During our inspection we spoke with more than 15 patients as well as some of their relatives. We spoke with over 10 members of staff that included reception and booking staff, secretaries, managers, cleaning staff, nurses of all grades, doctors and consultants.

We observed care and treatment. We received comments from our listening events and from patients and the public directly. We also reviewed performance information about the department and the trust.

Summary of findings

All the patients we spoke with told us that they had been treated with dignity and their privacy protected. They spoke highly of the staff in outpatients and radiology. They found staff polite and caring. However, many patients complained to us about the waiting times in the outpatient clinics.

Staff were reporting incidents and these were discussed at the clinical governance meetings within the directorates. There were systems in place to reduce the risk and spread of infection. Medicines were stored and administered safely. The department held its own training records which were up to date and demonstrated that most staff had attended mandatory training.

The trust had met their national targets and consistently performed higher than the national average in regard to radiology waiting times. There had been a backlog in reporting CT and MRI scans for several months but there was evidence at the visit that these were reaching resolution. There was an ongoing backlog in clinic letters being sent out that was not resolved. There was risk to patients receiving delayed or inappropriate treatment and considerable stress caused to the staff.

Staff demonstrated a commitment to patient centred care and we found many examples of such care and attention to patient conditions and preferences.

Are outpatients & diagnostic imaging services safe?

Good ●

Staff were reporting incidents in line with trust policies and demonstrated knowledge and understanding of the system. Incidents were investigated with feedback and learning at the monthly clinical governance meetings. Wider trust learning was through the intranet and monthly Governance Gazette.

There were systems in place to reduce the risk and spread of infection. Medicines were stored and administered safely.

Training was managed and monitored within the outpatients department. The records were up to date and demonstrated that most staff had been trained and had updates within the required timeframes.

Incidents

- The trust used an electronic incident reporting system to record accidents, incidents and near misses. There was training on use of this system..
- Staff we spoke with demonstrated knowledge and understanding of the trust incident reporting system. They knew what to report and had reported incidents. We were given examples of reporting in phlebotomy, radiology, outpatient nursing and clerical staff including lack of patient records, delayed transport and where a tourniquet had been left on a patient's arm.
- Staff told us that learning from incidents was discussed at team and departmental meetings. We saw various examples of minutes that demonstrated learning discussions at the meetings. However, not all individual staff who reported incidents felt that they received feedback from investigations.
- At the unannounced visit we found that four day case patients for ophthalmic surgery had been cancelled on the day. The decision had been made by the surgeon in main theatres. The senior sister was in the area as she had been managing the cancellations to support patients and staff. She had requested that the theatre manager come to offer an explanation to the patients. She described the full discussion with the patients and we saw that they had all been rebooked for three days later as a group. We were told that cancellations were very rare and usually down to unavoidable staff sickness. While we were there, the sister checked with the theatre manager that this had been reported as an incident for investigation and this was confirmed. The incident had already been escalated to the matron.
- Following the implementation in July 2014 of a Kent-wide radiology imaging reporting system we were told a back log in reporting CT and MRI scans had developed. This was due to reduced reporting time, vacancies and training on the new system. The backlog was outsourced but, due to continuing issues with the new system, has taken some months to reduce. We saw five examples of serious incidents reported regarding these delays. There were full investigations and the issues with the new system have been logged. Weekly meetings with the system provider and all hospitals in Kent involved in the new system were put in place to manage the issues and share learning and good practice. The trust had instigated checks to search for any delayed reports and took action when these incidents were identified.
- The radiology department had specific patient information and event report forms for identified risks in some procedures, such as extravasation of x-ray contrast media and contrast reaction incidents. Staff demonstrated awareness of the importance of reporting any occurrences.

Cleanliness, infection control and hygiene

- All the outpatient areas we visited were visibly clean.. We were told there were designated cleaners for the area. Most areas had cleaning schedules displayed.
- Patients we spoke with felt that the areas were always clean. The outpatient survey carried out scored 99% for cleanliness.
- Mandatory training records showed that all staff had received infection prevention and control training within the last two years. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- Hand gel was available in all clinical areas. There were notices displayed regarding hand washing and infection control.
- We saw examples of hand hygiene audits in a variety of clinics such as audiology, ophthalmology and orthopaedics with results displayed on the department notice board.
- There was personal protective equipment such as gloves and aprons readily available in clinical areas.

- There were processes and pathways for decontaminating flexible scopes used in various clinics such as gynaecology and ear, nose and throat (ENT). Following use they were taken to the endoscopy suite for cleaning. There was good separation of dirty and clean areas with all appropriate equipment available for staff.

Environment and equipment

- The areas of outpatients that we visited were tidy and well lit, including corridors. There was a calm atmosphere even where the clinics were very busy.
- Electronic information screens were in all waiting areas informing patients of the staff working that day and whether there were any delays.
- The signage to the different clinic areas was fairly small and we observed some patients looking for the area they were to go to. Staff we spoke with were aware and changes had been discussed but there was no known time frame for this. However, some patients we spoke with felt that the signage was clear and did not feel there was an issue.
- The electronic checking in system was accessed by nursing and reception staff. There was a colour coding system that showed staff whether patients had arrived. For example, if the name went orange it showed the patient was late, red meant the patient had not arrived in the hospital 30 minutes after the appointment time and yellow meant the patient had been seen.
- Procedures such as cataract surgery were undertaken in the ophthalmology day case theatre. We saw that all theatre checks were in place. The waiting room for patients was always staffed and was comfortable with patient information provided. There were tea and coffee facilities as well as magazines.
- We saw evidence of daily performance checks for equipment.
- Single use equipment was available in the clinical areas.
- All equipment we looked at was clean and stored appropriately.
- The emergency resuscitation equipment had been checked appropriately in all areas we visited.
- The trust electrical maintenance engineering department (EME) were responsible for annual portable appliance tests (PAT). We found a few examples where this was not up-to-date and discussed this with staff in the department at the time.

Medicines

- Medicines were stored in locked cupboards in the department. All medicines were ordered by nursing staff through the hospital pharmacy. Two nurses checked medicines taken from the locked cupboards. There was a lockable medicines fridge with daily temperature checks in place.
- The majority of medicines were administered by doctors. Where nurses administered medicines such as analgesia these were prescribed by the doctor and recorded in the patient record. Once administered, nurses signed and dated the medicine record.
- FP10 prescription pads were stored in locked cupboards. The department also had a supply of trust pharmacy prescription pads that were locked in the same cupboard. We were told that the hospital pharmacy had requested that the trust prescriptions were not used for the last few weeks due to staff shortages in pharmacy. Therefore outpatients were using the FP10 prescriptions for patients to take to an external pharmacy to avoid long waits for patients at the hospital pharmacy.
- Emergency trollies were checked every day.

Records

- Risk assessments were carried out in the patient records we looked at. Staff described the risk assessments which varied in accordance with the patient's condition and complexity.
- Pathways of care were in place for cancer patients and other conditions such as stroke and cardiac care.
- In some areas of the general medicine outpatient department there was a lack of suitable storage for patient records and we were told that lockable notes trolleys had been ordered.
- We were told that sometimes patient records were not available for their outpatient appointment, particularly if patients with complex conditions were visiting both hospital sites in a short space of time. Clerical staff created a temporary set of notes and the electronic patient system meant that the referral letter and any previous clinic letters were available. However, on rare occasions, a

patient could not be seen if the full set of notes was not available. Staff reported occurrences as an incident. We saw reported incidents on the outpatient incident log and that action had been taken such as sending out a trust-wide email to locate a set of notes.
- The trust outpatient incident log in respect of patient records from April 2013 to March 2014 showed 24 incidents that included misfiled records, inaccuracies identified and missing records. These were investigated and the actions demonstrated that the incidents had been discussed with the patients concerned and rectified.

Safeguarding

- Staff told us that they received training in safeguarding for both children and vulnerable adults. We saw evidence of training undertaken.
- Staff demonstrated knowledge and understanding of safeguarding and the trust process for reporting concerns. They understood their role in the protection of children and vulnerable adults.

Mandatory training

- All staff we spoke with told us that they were able to attend mandatory training Staff held their own mandatory training records. Managers monitored training and chased up staff where required. We saw that mandatory training was discussed in team meetings.
- We were told there were good e-learning packages as well as face-to-face training on both hospital sites.
- We saw examples of staff training records showing completed training. We also saw examples of the monitoring showing all mandatory training, such as health and safety, infection prevention and control, blood transfusion and basic life support. The last training date was recorded and the system flagged up when an update was due or overdue.

Assessing and responding to patient risk

- There was evidence of risk assessments included in the patient pathways in the patient records we looked at. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for elderly or frail patients with more than one medical condition.
- We saw that staff received annual basic life support training, that this was monitored with those that were coming due in the next couple of months flagged up on the system.
- There was adult resuscitation equipment stored within the department. We saw evidence that this was checked regularly and signed by staff that the equipment was checked and within the expiry dates.
- We saw completed pre-assessment documentation for ophthalmology day case patients. Pre-assessment included a check for any infections or other reasons that the procedure should not be performed that day. We were talked through the handover procedures from the outpatient staff to the theatre staff and back to the outpatient staff following the procedure.

Nursing, allied healthcare professionals and other staffing

- There was one matron for the outpatients department. On each hospital site there was a senior and junior sister supporting the staff nurses, clinical support workers and plaster technicians in the department.
- Nursing staff told us that although they were busy they felt they provided good and safe patient care. They felt staffing was generally sufficient and there was rare use of bank staff with many areas saying that they never used bank staff. Where there were staff absences there was an escalation process that enabled reallocation of staff.
- The sisters managed the process for booking annual leave so that staffing numbers and skill mix remained at safe levels.
- There was a low turnover of nursing staff. There were a few vacancies with recruitment well underway.
- There were vacancies in the radiology department with recruitment underway. Staff felt that they generally managed the workload by working extra hours.
- There was a larger phlebotomy service than at Maidstone Hospital with 34 whole time equivalent

staff. In addition to providing services to all hospital wards and outpatients, phlebotomists supported GP surgeries in the area. Whilst there were three staff on long term sickness staff we spoke with felt that they provided a good service within outpatients and were able to cover the absent staff by doing extra hours. There was management reconfiguration underway with recruitment going through the appropriate trust processes. Senior management was based at this hospital.

Medical staffing

- The individual specialties arranged medical cover for their clinics and this was managed within the clinical directorates who agreed the structure of the clinics and patient numbers. Some clinics, such as ophthalmology and ear, nose and throat, were completely managed by the clinical specialty and run by their doctors and nurses. Other clinics, such as cardiology and respiratory, were managed by the outpatient nursing staff.
- Doctors we spoke with felt they had a good relationship with outpatient nursing and clerical staff. They said that they could discuss issues and were well supported by staff.
- Generally doctors worked on both hospital sites. We were told that traffic between the hospitals could be heavy and sometimes caused delays to the start of clinics.

Major incident awareness and training

- Senior staff had completed major incident training and were able to describe the department's role in a major incident.
- We saw that regular exercises were carried out across the trust.
- The trust had Major Incident Cascade systems in place. We saw examples for radiology that included 'in hours' and out of hours and weekends. Learning from exercises was evidenced such as ensuring contact numbers were also available as paper copies in appropriate areas.

Are outpatients & diagnostic imaging services effective?	Inspected but not rated ●

There was evidence of staff competency checks and appraisals with opportunities for further training. We found examples of good multidisciplinary working both within and across teams. Additional clinics were run at weekends when required.

Evidence-based care and treatment

- We saw examples of National Institute for Health and Clinical Excellence (NICE) guidance cascaded to outpatient teams.
- There were protocols in place for radiology examinations such as cervical spine and orthopaedic x-rays.
- We saw protocols in place to ensure fast tracking where there were significant imaging findings for known or unknown cancer diagnoses, as well as severe abnormalities related to benign or malignant pathology. These were reported to the referrer and passed immediately to the multidisciplinary team for review and action. Clerical and electronic system procedures were included in the protocol.

Competent staff

- All staff we spoke with told us they had annual appraisals where training and development needs were discussed. We saw examples of completed appraisals and the monitoring process in place.
- There was an induction process in place for new staff and we saw an example of one completed.
- In addition to mandatory training, nursing staff undertook training such as catheterisation and wound care. We also spoke with medical staff and saw an example of the electronic training records of completed learning for a doctor in training.
- Nurse practitioners provided face-to-face training in addition to e-learning courses.

- Clerical staff told us they had weekly team meetings where issues such as availability of patient records were discussed.
- We saw several examples of various team meetings that included medical records, sonographers, superintendent radiographers. All minutes we saw showed that relevant clinical updates and training requirements and opportunities were discussed.
- Radiography staff told us that they were encouraged to participate in further education and advanced practice training. We saw evidence in a weekly staff update where an opportunity for a radiographer to train in the cardiac catheter laboratory was offered to staff.
- Some staff had six monthly competency checks, such as phlebotomists and radiographers. We saw examples of completed competency checks.
- Spot checks were in place for nursing staff.
- Junior doctors that we spoke with told us that they felt well supported by their consultants.

Multidisciplinary working

- All staff we spoke with told us how well they worked together. This was within specific teams as well as with others such as therapists, medical records service and the CAU. For example, we observed nurses communicating with both doctors and reception staff to facilitate the smooth running of a clinic or mitigate delays that had occurred.
- We observed and were told of strong multidisciplinary working within the radiology department, working closely with, for example, physiotherapists and occupational therapists.
- We heard how pathology worked with outpatients to ensure that results were available for the clinics. This meant that required information was available for the patient's appointment.
- We also saw evidence of cross site working where patients were attending clinics at more than one hospital to ensure information was available at the other site. However, on some occasions we heard that it was difficult to get patient records from one site to the other if appointments were too close together and not known about by both specialties.

Seven-day services

- The trust monitored the demand for outpatient appointments and the utilisation of the clinics available. Cancelled clinics and the reasons why were also monitored. Where the demand for appointments is greater than clinic availability we were told that further clinics would be created. At the time of the inspection, for example, Saturday clinics were being arranged to accommodate a backlog of hearing aid patients.
- Radiology and pathology provided seven day services.

Access to information

- We found access to relevant patient information in all areas of outpatients that we visited. These included a map of the hospital, general outpatient information, personal data confidentiality and coming into hospital. There was also information on the Patient Advice and Liaison Service (PALS) and how to make a complaint. In addition there was information on infection prevention and control as well as MRSA and Clostridium Difficile Diarrhoea.
- Condition specific information such as hormone replacement therapy, cataract surgery and Barium swallow and meal investigation was available in the relevant clinical areas.
- Condition specific information such as hormone replacement therapy and cataract surgery was available in the relevant clinical areas.
- Patients we spoke with told us they felt well informed. The patient survey confirmed these findings.
- Each outpatient area had a board that displayed the names of the nurses, the staff numbers there should be and the actual staff numbers. There was also the waiting time for individual clinics written up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence that staff had undertaken Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.
- Staff demonstrated knowledge and understanding of MCA and DoLS.
- We saw examples of MCA assessments undertaken.

- A patient survey undertaken for the CT colonography service showed that 46 out of 50 (three 'no' and one 'don't know') patients stated they were asked for their consent for the procedure.
- Staff told us that treatment options were discussed by the doctors during consultation. Where written consent was required this would be completed in the outpatient clinic or at pre-assessment clinics. We saw examples of completed consent forms in some of the records we looked at. However, in others we did not find either written or verbal consent recorded, for example one patient who had a sigmoidoscopy (examination of the large intestine) performed in outpatients.

Are outpatients & diagnostic imaging services caring?	Good ●

All the patients we spoke with were complimentary about the way the staff had treated them. We observed staff constantly checking on patients and updating them on waiting times. The area was calm and patients felt well informed about their care and treatment.

Compassionate care

- Patients we spoke with told us the staff were pleasant and "very professional".
- We observed good rapport between staff and patients. One patient told us they were very happy with the way they had been received at reception.
- We spent some time observing in clinic areas and saw examples where staff knew patients and that the care provided was very individual to that patient. One example was where a patient was reminded about equipment they needed and how this was provided. Another example was where a member of staff was aware of the bus a patient needed to catch and was supporting their outpatient pathway to enable this.
- Patient survey results we saw demonstrated high satisfaction with information provided and opportunities to ask questions.
- We saw that clerical staff in clinics assisted patients promptly and were friendly and efficient in what were busy clinics.
- Staff were trained and expected to keep patients informed of waiting times and the reasons for delays. We observed this happened in all areas of outpatients during our inspection.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt well informed about their care and treatment. Patients understood when they would be seen again and when they needed additional tests or x-rays. We were told their care was discussed with them in detail and in a manner that they could understand. They felt included in decisions made and that their preferences were taken into account.
- The trust scored in the top 20% of the 2013 Cancer Patient Experience Survey regarding explanations and information provided in respect of possible side effects. They also scored as highly in providing good information about diagnostic tests.
- Patient survey results we saw demonstrated high satisfaction with information provided and opportunities to ask questions.

Emotional support

- Patient survey results we saw showed very positive responses to questions regarding provision of privacy and 100% of respondents stating that they were supported by staff during the procedure.
- Patients told us that their privacy was protected at all times with curtains pulled across and doors closed.
- Patients told us that staff asked whether they were happy to have relatives present for consultation.
- The outpatient department was calm and well ordered. We saw staff constantly checking on patients and updating on waiting times.
- However, the trust scored in the lowest 20% of the 2013 Cancer Patient Experience Survey when asked if staff definitely gave patients enough emotional support.

Are outpatients & diagnostic imaging services responsive?

Requires improvement

Some patients arriving for their appointments waited a considerable time to be seen. The trust patient survey results and regular monitoring showed this as an ongoing issue. We also received some comments regarding difficulty parking.

Many clinic letters did not get sent out in a timely manner with a huge backlog for some clinics remaining ten months after the restructure of the clerical and administration teams. This was being monitored and reported on regularly with some extra resource being found for some teams.

There had also built up a backlog in CT and MRI reporting following the introduction of a county wide electronic reporting system. The trust had put in place solutions but these had taken some months to resolve the backlog. Trust data showed that this was almost resolved at the time of the inspection.

We observed that staff in the clinics were responsive to patients' individual needs.

Service planning and delivery to meet the needs of local people

- The trust provided various outpatient services at a number of other sites so that patients could be seen closer to home for such things as ophthalmology and hearing aid replacement and ear care. These clinics did not form part of this inspection.
- The trust took the decision to decentralise the clinic booking teams and in January 2014 the Clinical Administration Unit (CAU) was implemented. This meant that the medical secretaries and booking teams became part of their clinical specialty directorates. There were considerable staff office moves. The consultants' offices are also in the same area as the respective clerical staff. Without exception, clerical staff we spoke with told us that despite some difficulties with travel the CAU was a much better way of working. It enabled strong and rapid communication for problem solving and improving the service. A new IT system was also introduced.
- During the process we were told that secretarial staff had been reduced and this, together with problems with the IT systems, had resulted in some very long delays in the clinic letters being typed in some specialties. There was an action plan in place that identified all the risks and concerns but at the time of inspection these had not been resolved. Staff told us of their high anxiety levels and extra, unpaid hours some of them were working to try and reduce the backlog. We also heard of the workaround staff had to use to ensure that urgent and high priority patients, such as the cancer urgent referrals, did get their letters typed in line with key performance indicators. This involved listening to the whole of the downloaded recording in order to pick out and type the urgent letters which added to the time secretaries spent on each clinic. Trialling dictating into different electronic folders was just being started. We found huge goodwill and hard work from staff to try and reduce the impact for patients but the volume of work in some areas made this very difficult. Late clinic letters also resulted in more patient telephone enquiries for staff to deal with which further exacerbated the situation. Some bank staff hours had been provided in some areas but the bank staff were not experienced in the clinical specialty which again impacted on the permanent staff.
- Trust information provided to us at 6 October 2014 for both sites showed that urology, vascular and ophthalmology services had letters still outstanding 41-50 days following the clinic date. In addition to these, trauma and orthopaedic, upper gastrointestinal and ENT had letters outstanding 21-30 days following the clinic date. Only gastroenterology, cardiology and breast services had all clinic letters being sent out within 0-10 days. This puts patients at risk of not receiving care and treatment, including prescribed medicines, in a timely manner.
- We reviewed patient records and saw examples where cancer patient pathways worked well. For example, colorectal patients were seen within the required two weeks from referral with the clinic letters were being typed up one week later.
- The outpatient department provided services for all clinical specialties with the matron managing all non-medical staff including the plaster technicians.
- The outpatient dashboard collected monthly data on activity and a set of key performance indicators (KPI). This showed that total outpatient utilisation across the service was consistently below that planned with the year to date percentage in August 2014 at 79% rather than the planned 85%. We also saw the breakdown of activity for all outpatient locations for August 2014. This

showed that actual attendance for both first and follow up appointments below capacity. The minutes of the outpatient committee meeting where these figures were discussed suggested that late cancellations may be contributing to low utilisation. We saw that cancellations between zero and three days were approximately 5% and that patients who did not attend (DNA) was approximately 8% during that month. There was ongoing work across the trust with trials of different processes such as partial booking for some follow up clinics to improve utilisation

- The trust data for both first and follow up appointment DNAs were consistently above their 5% and 7% standard respectively. There were new initiatives in place, such as texting reminders to patients with mobile telephones but no reduction in failures to attend was evident as yet.
- The radiology department provided out of hours services for the hospital.
- Patients we spoke with were generally positive about the service provision.
- Doctors and nurses told us that the results service from the pathology department was very good.
- There was a large backlog of MRI and CT scans that required reporting. This had caused delays for patients and the reports were not always available for the patients' follow up appointments. Staff in outpatients "chased" the results the day before in an effort to reduce the impact on patients.
- The trust provided information on the work and progress on this issue. This demonstrated the reasons for the backlog and the various actions taken in response, such as outsourcing outstanding MRI reports. The trust board were kept informed and this was closely monitored. The information demonstrated a significant reduction and at 16 October 2014 the department were approaching normal levels.

Access and flow

- Patients and relatives we spoke with told us that the bus service to the hospital was good. However, patients with appointments later in the morning told us that the car parks were very full.
- The independent patient transport services had been commissioned county-wide. Issues with the quality of the service had been identified and all hospitals concerned were working with commissioners and the service towards improvements. Staff in outpatients were aware of this and were vigilant in supporting patients where there were delays. We were told that the service was improving. Patient transport meetings included the matron and the transport provider. The trust transport manager reviewed issues monitored by the outpatient teams.
- Patients generally felt that they received appointments in a reasonable time. We were given some examples where patient's appointments had been cancelled but always rebooked.
- Patients checked in on screens that read the bar code on their appointment letters on arrival at the main entrance of the hospital. They then went to the main reception desk for the majority of the clinics and let the staff know they had arrived. Nursing and clerical staff had access to the system so knew when patients had actually arrived in the department, not just in the hospital.
- Patients waited in the main waiting room where there were screens used to direct patients to the correct consulting room. The screens also displayed any delays to clinics.
- We observed that patients were initially called through quickly. However, by 10am the area was very busy with some patients standing. A nurse came out from one of the clinics to inform patients there was a delay and apologised. One parent was not happy with the long wait. By 10:45am the delays for three of the clinics had increased to 90 minutes, 70 minutes and 45 minutes. We saw outpatient data that showed that between March 2014 and August 2014 patient waiting times were over the 30 minute performance indicator every month.
- The trust carried out patient surveys of the outpatient departments in 2013 and 2014. The results were very positive except in respect of clinic delays. The results show no change in responses regarding delays with approximately 41% of patients stating their appointment had been delayed. Those patients who felt they had been kept informed showed some improvement from 62% to 66%.
- Some clinics were known to regularly run late due to staff breaking bad news to patients, such as in the breast clinics. Staff knew that the trust monitored and audited waiting times but did not feel that any changes were implemented as, "The patients need to be seen".
- Parking concessions were provided for patients who waited over an hour to be seen.
- The only complaints expressed by patients we spoke with were in respect of long waits in clinic and this was confirmed by a recent outpatient survey undertaken.
- Some clinics, such as cardiology, kept well to time and staff said the clinics were well set up with few delays for patients. We saw the timings for two respiratory patients. They had been brought through promptly from the main waiting area. However they then went to x-ray and had not

returned after 30 minutes to see the consultant. We followed up in the radiology department later and found that they had had delays but had caught up before midday. However, patients who did not require an x-ray were seen in good time.
- We saw examples of ‘one stop’ clinics such as for breast cancer patients. Patients would have an ultrasound and/or mammogram and then see the doctor all in one visit. This avoided patients waiting and travelling for different appointments.
- We saw other examples where administration and clerical staff worked around the system to try and reduce the waits for patients in clinic. For example, staff hand wrote the time patients should present at the x-ray department prior to their appointment time for the cystoscopy (examination of the inside of the bladder) clinic but were not able to alter the actual clinic time.
- We also saw examples where changes had been made. One clinic started half an hour later due to the time taken for medical staff to travel between hospitals. Another clinic had spread the appointments out to try and manage waiting times.
- We noted that the radiology department did not have access to the same IT system as the outpatient staff did. This meant that radiographers were unaware of the length of time a patient may have already been in the hospital before arriving in their area.
- The trust had consistently exceeded the national targets for patients who needed to be seen within two weeks over the past year and cancer patients we spoke with had nothing but praise for the staff and the service.
- The trust was achieving the 18 week targets and was in line with the England average. We looked at data from April 2013 to June 2014.
  The trust also demonstrated consistently good diagnostic waiting times with patients waiting much less time for an appointment than the England average

Meeting people’s individual needs

- Translation services were available on request and were generally planned in advance of the clinic appointment.
- The screens in the waiting areas displayed patient names when being called to be seen as well as other information. These would not be easily read by patients with poor or no vision and we asked how this was managed. We were told that the information held for patients indicated if a patient had poor vision or was hard of hearing and the nurse would come out to collect them individually. However we also observed that some patients took time to notice their names on the screen so nurses came out to call them after a given amount of time.
- We observed a patient with poor vision being assisted to the correct clinical area.
- Patients told us that when a blood test was required this contributed to long waits and caused delays in clinics. In addition, we were shown template outpatient letters where all patients were asked to come in 30 minutes early to have a blood test. However, once patients arrived some found they did not need the blood test. Booking staff told us that unless this is accurately completed by doctors and reception staff at the previous appointment the letters will not be altered. We saw one patient become agitated when told to see the consultant first. Despite the sister arriving quickly to help the patient left.
- We were told trust-wide there were five bone reporting radiographers, three chest reporting radiographers, one clinical specialist and one consultant radiologist to manage x-rays that required immediate reporting. This was a voice recognition report. If the appropriate member of staff was not available on one hospital site the x-ray was sent via computer link to the other site. This meant that the service responded to patients whose x-rays required immediate reporting to support diagnosis and treatment planning.
- We saw the pre-procedure questionnaire for patients undergoing x-ray that included information on allergies, medical conditions and pregnancy status for female patients.
- Following issues identified with the introduction of the electronic radiology reporting system weekly meetings were set up to ensure that patients were prioritised appropriately. The electronic system also had colour codes to identify urgent patients.
- In the different clinics we visited we were told that pathology results such as histopathology, microbiology or blood tests were generally available for patients’ clinic appointments.

Learning from complaints and concerns

- Complaints and incidents were discussed at the monthly clinical governance meetings. We were told that most complaints were about delays in clinics.
- We saw boxes inviting patients and their families to comment and provide ideas for the service.
- We were provided with examples of learning and change from patient feedback. One example was that middle grade doctors in training had been provided with communication training.
- We saw examples of clinical governance meetings where there were mortality and morbidity presentations for shared learning. Research was also presented. Trust finances were also discussed.

Are outpatients & diagnostic imaging services well-led?	Requires improvement ●

There was good monitoring, audit and data collection regarding waiting times and delayed clinics with staff proactively managing these during clinics. Some adjustments had been made but we did not find evidence of improvement over the last 12 months.

There were good forums for discussing issues and concerns and there was evidence of shared learning. Staff generally felt listened to and well supported by their managers. Corporate communication was well managed. Managers were visible in outpatients and staff evidenced a patient centred approach to everything they did.

The backlog of clinic letters remained an issue ten months after the restructure of clerical and administrative work. Staff had raised their concerns and worked hard to try and reduce the backlog. However, rapid support with quality extra resources had not been seen as a priority by the trust.

Vision and strategy for this service

- Trust wide communications were on the trust intranet and also we saw displayed in staff areas in outpatients.
- The matrons and sisters we spoke with were aware of the current strategy for the area.
- Staff said that the Chief Executive weekly communication was very helpful.

Governance, risk management and quality measurement

- We saw many examples where the trust and the outpatient department collected data and monitored activity and quality. The risk areas were identified and generally there were action plans in place. For example, some specialties had high rates of follow up appointments. This was monitored and investigated in line with best practice. Subsequently the rates were adjusted as part of the 2014/2015 contract with commissioners and the trust was able to demonstrate improvements by August 2014.
- We saw examples of audits carried out in various clinical areas and that the results had been discussed in clinical governance meetings together with recommendations and actions.
- Incidents, complaints, patient surveys and any new alerts or guidance were discussed at the monthly directorate clinical governance meetings. Staff described the meetings and the minute we looked at confirmed this.
- Patient satisfaction survey carried out in September 2014 in the radiology department demonstrated very positive results from participants. Posters were displayed in the department with the results and proposed improvements from patient feedback.
- The outpatient department clinical governance monthly meetings were open to the whole department.
- We saw that all the pathology departments had achieved external Clinical Pathology Accreditation (CPA) in May 2014. Certificates were displayed in the department.
- The trust had published the second issue of Governance Gazette. This monthly leaflet shares learning from never events, incidents and complaints. It also raises awareness of patient risks such as falls.

Leadership of service

- Staff felt that communication flows from the leadership was good. Several staff specifically stated that the weekly Chief Executive messages were helpful. Corporate information came by email and was accessible for all staff. This included such things as medical device alerts and National Institute for Health and Care Excellence (NICE) guidelines.
- Throughout the inspection outpatient staff were welcoming and happy to speak with us. Staff described their role and there was obvious pride about their department.
- Radiology staff were very positive about their service and their work to improve the patient experience.
- Clerical staff in outpatients told us that they could go to their line managers, "with anything – they are very understanding, helpful and approachable and not hard to get hold of."
- Nursing staff told us that they felt well supported by their managers and that they were always available to talk to. We observed that the managers were visible throughout the areas covered by their role and that staff were able to seek advice during clinics.
- We received varied responses from medical secretaries with regard to feeling supported by their managers. Some told us they felt very supported with accessible managers but others did not feel supported and did not feel able to raise their concerns with managers. There were clearly felt concerns about the continued backlog in clinic letters for many of the specialties.

Culture within the service

- All staff we spoke with clearly put the patient at the centre of the work they did. There were many references to the continuous discussions held in all specialties as to ways to improve the patient experience. Where patients needed specific support this was provided. We saw evidence where patients were well known to staff and their individual circumstances and pressures taken into account. Staff expressed the wish to provide local care for patients, avoiding unnecessary travel to a different hospital where possible.
- Staff we spoke with described very good team working and communication in the outpatient department, including radiology and phlebotomy. We saw this in practice during our observation periods.
- All the staff we spoke with in the outpatient and radiology departments said that they felt able to speak out and that there was a "no blame" culture in the organisation. Staff said they felt listened to.
- Staff told us they felt this was a learning organisation. We saw many examples of shared learning in the various team and governance minutes we looked at. The trust risk register reflected what audits and surveys carried out had identified and staff demonstrated awareness of the areas where they were working to improve.
- An outpatient survey was carried out earlier in the year. Over 1700 patients participated and the responses were very positive with 99% of patients stating they would be happy for their friends and family to be treated there. Other responses included 99% of patients who had time to express their concerns, understood explanations provided and felt their privacy and dignity was respected. The one exception was regarding delayed clinics. 39% of respondents said their clinic had been delayed. We saw examples of outpatient department meetings where delayed clinics were discussed. However it was not clear whether changes to clinic set up or timings were being considered.
- The fracture clinic carried out a "Reflections of a Perfect day" patient and staff survey where five questions were asked on one day. 28 patients and eight staff participated. Patient and staff feedback was included in the analysis and we saw an action plan had been developed from the survey. This demonstrated that staff and patient views were invited and listened to within the department.
- We saw other examples of patient surveys with very positive results regarding care, treatment and information provided. One example was the ophthalmology day case patient survey. Improvements made included providing crosswords and more magazines in the waiting area.
- Some staff felt that trust executives did not visit their specific areas of work, such as phlebotomy. However in general staff felt that the trust leadership were visible.
- The trust provided evidence of the consultation process undertaken for the proposed implementation of the CAU. There was a consultation document and meetings for staff to attend. There were expressions of concern that the service could be delivered with a reduction in staff.

CAU staff we spoke with felt that this was an ongoing concern with the continued backlog of clinic letters.
- There were Patient Advice and Liaison Service (PALS) leaflets available in waiting areas. These informed patients of the PALS service and invited patient feedback and comment.
- The trust has launched a patient and public membership scheme called "have your say". Leaflets were in outpatients describing the scheme and how to join. The purpose was for members of the public to have a greater say in trust developments.

Innovation, improvement and sustainability

- The trust leadership and staff we spoke with were aware of the issues in outpatients regarding long waiting times and delays for many of the clinics. Staff clearly found occasions when this was difficult to manage but we observed constant work to try and mitigate delays for patients by individual staff and team working. We saw some changes had been made but patient survey results did not evidence any improvement from 2013 to 2014 results.
- The trust and outpatient staff continued to work proactively in trying to reduce the number of patients who fail to attend their appointments. This is ongoing work and closely monitored.
- The risk register reflected concerns regarding follow up appointments for ophthalmology and head and neck patients due to lack of clinic appointments. New patient appointments were prioritised and we saw evidence of some work towards managing this with extra clinics planned and a business case for an extra ENT consultant. The ophthalmology service covers 1.8 million population and the numbers of patients reflects this. The satellite clinics (not included in this inspection) provide additional clinics locally.
- The trust performed well in respect of two week urgent cancer referrals.
- The trust performed consistently higher than the national average for diagnostic waiting times.
- The introduction of the CAU, a new electronic system together with reduction in staffing caused a huge backlog in clinic letters being typed and dispatched to GPs and patients. This has been monitored and reported on throughout the period. However, ten months following the changes there are still high numbers of delayed letters in many clinical specialities. We found some extra resources, e.g. bank staff, being provided in some areas but these staff were not necessarily trained in that clinical specialty so were of limited use. The risk of patient care and treatment being delayed is high. The stress on the staff trying to manage the backlog was very evident at the inspection. Without their goodwill and unpaid extra hours the situation would be even worse.

Outstanding practice

- On Ward 20 there was a focus on dementia care. All staff had been give the objective of completing relevant dementia care training and at the time of our inspection 60% had completed this. Staff had bid and won funds from the Dementia Challenge fund to create a Dementia Café for use by people living with dementia, their friends and families. This area was designed using current guidance to be dementia friendly and was equipped to meet the special needs of people living with dementia.

Areas for improvement

Action the hospital MUST take to improve

- The trust must make arrangements to make sure contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- The trust must make suitable arrangements to ensure the dignity and privacy of patients accommodated in the Clinical Decisions Unit.
- The provider must take action to ensure that medical and nursing records are accurate, complete and fit for purpose.
- The Trust must ensure that staff and patients have access to a competent and independent translator when necessary.
- Review the process for incident reporting to ensure that staff are aware of and act in accordance with the trust quality and risk policy.
- Review the clinical governance strategy within children's services to ensure there is engagement and involvement with the surgical directorate.
- Review the arrangement for the management and administration of topical anaesthetics.
- Review the children's directorate risk register to ensure that risks are recorded and resolved in a timely manner.
- Review the current PEWS system to ensure that it has been appropriately validated, is supported by a robust escalation protocol and is fit for purpose. It's use must be standardised across the children's directorate (excluding neonates).

Action the hospital SHOULD take to improve

- The Trust should consider collating performance information on individual consultants. Where exceptions are identified these should be investigated and recorded.
- The Trust should provide written information in a format that is accessible to people learning difficulties.
- The trust should make sure the protocol for monitoring patients at risk was is embedded and used effectively to make sure patients are escalated in a timely manner if their condition deteriorates.
- The trust should make sure that all medical staff in the ED have completed training in safeguarding children at the level appropriate to their grade.
- The trust should make appropriate arrangements for recording and storing patients' own medicines in the CDU to minimise the risk of medicine misuse.
- The trust should respond to the outcome of their own audits and CEM audits to improve outcomes for patients using the service.
- The trust should review the arrangements for meeting the needs of patients presenting with mental ill health so they are seen in a timely manner.
- The trust should review their management of patient flow in the ED to improve the number of patients who are treated and admitted or discharged within timescales which meet national targets.
- The trust should review the systems in place in the ED for developing, implementing and reviewing

plans on quality, risk and improvement.

- The trust should review the way complaints are managed in the ED to improve the response time for closing complaints.
- There was a lack of strategic oversight and plan for driving improvement in the department.
- The provider should review the quality of the root cause analysis investigations and action plans following a serious incident or complaint. Improved systems for the dissemination of learning from incidents and complaints should be developed.
- On the Medical Assessment unit the trust should ensure that point of care blood glucose monitoring equipment is checked. It should also consider how this checking should be managed to be integrated as part of an overall policy that forms part of a pathology quality assurance system.
- The trust should develop systems to ensure the competence of medical staff is assessed for key procedures.
- The trust should develop systems to ensure that medicines are stored at temperatures that keep them in optimal condition.
- The trust should ensure that patients' clinical records are stored securely in ward areas.
- The trust should review the ways in which staff can refer to current clinical guidance to ensure that it is easily accessible and from a reputable source.
- The trust should review its capacity in medical care services to ensure there is sufficient capacity to meet demand, including the provision of single rooms.
- Review current nil-by-mouth guidance to ensure that it is consistent with national standards; patient information leaflets should be standardised and reflective of national guidance.
- Review the process for the management of patients presenting with febrile neutropenia to ensure they are managed in a timely and effective manner.
- Standardise the post-operative management and guidance of children undergoing urology surgery.
- Review the process for the hand-over of pre-operative children to ensure they have support from a health care professional with whom the child and family are familiar with.
- Ensure that all staff introduce themselves and wear name badges at appropriate times.
- Review the location of the vending machine currently located between Hedgehog ward and the Woodlands Unit.
- Review the managerial oversight of staff working in children's outpatients.
- Review the current clinic provision to ensure that women who have recently miscarried or who are under review for ante-natal complications are seen in a separate area to those children awaiting their appointment.
- The provider should review the facilities and admission process for elective surgical patients.
- The provider should review the quality of the root cause analysis investigations and action plans following a serious incident or complaint. Improved systems for the dissemination of learning from incidents and complaints should be developed.
- The provider should monitor the transfers between sites, for both clinical and non-clinical reasons. The monitoring process should include the age of the patients transferring and the time they arrived after transfer.
- The Trust should consider collating performance information on individual consultants. Where exceptions are identified these should be investigated and recorded.
- The Trust should provide written information in a format that is accessible to people learning difficulties.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of Disease, Disorder or Injury	Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users **9.**—(1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user, (iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. The Regulation was not being met because: The PEWS system had not been validated and was not supported by a robust escalation protocol that was fit for purpose and was not standardised across the children's' directorate There was a lack of cover by consultants specialising in intensive care medicine at weekends; for example, one consultant covered more than 15 patients on two sites. The consultant was not always available within 30 minutes. There was only one ward round per day when there should be two to comply with core standards. Admissions were delayed for more than four hours once the decision was made to admit a patient to the intensive care unit (ICU). Discharges from the ICU were delayed for up to a week. Of all discharges, 82% were delayed for more than 24 hours. Overnight discharges take place from the ICU. All contrary to the core standards of the Intensive

	Care Society. The outreach service does not comply with current guidelines (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2011)). Regulation 9 (1)(b)(i)(ii)(iii)
Regulated activity	**Regulation**
Treatment of Disease, Disorder or Injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010: Safety and Suitability of Premises People who use the service were not protected against the risks associated with unsafe or unsuitable premises. Improvements are needed in relation to the environment in the Intensive Care Unit with regards to toilet/shower facilities for patients. Regulation 15 (1)(a)
Regulated activity	**Regulation**
Surgical Procedures Treatment of Disease, Disorder or Injury	Regulation 17 (1)(h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Respecting and involving service users The Regulation was not being met because: The provider did not ensure that care and treatment was provided to service users with due regard to their cultural and linguistic background and any disability they may have. Dignity and privacy of patients was not being met in the Clinical Decisions Unit. Regulation 17(1)(h)
Regulated activity	**Regulation**
Treatment of Disease, Disorder or Injury	Regulation 20 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Records The Regulation was not being met because: The provider did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. Regulation 20 (1) (a)
Regulated activity	**Regulation**

Treatment of Disease, Disorder or Injury, Surgery	Regulation 23(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010: Supporting workers The Regulation was not being met because: Contracted security staff did not have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs. Regulation 23(1)(a)
Regulated activity	**Regulation**
Treatment of Disease, Disorder or Injury, Surgery	Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision, The provider did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to: (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of these regulations; and (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. The Regulation was not being met because: The process for incident reporting did not ensure that staff were aware of and acted in accordance with the trust quality and risk policy. The clinical governance strategy within children's services did not ensure engagement and involvement with the surgical directorate. The children's directorate risk register did not ensure that risks are recorded and resolved in a timely manner. There were two incident reporting systems, the trust electronic recording system and another developed by consultant anaesthetists and intensivists one for their own use. The trust could not have an overview of all incidents and potentially there was no robust mechanism for the escalation of serious incidents. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons. There was a lack of engagement and cohesive approach to clinical governance. Mortality and morbidity reviews were not robust, not all deaths were discussed and there was no available

	documentation to support discussions. Regulation 10(1)(a)(b(2)(c)(i)(ii)
Regulated activity	**Regulation**
Treatment of Disease, Disorder or Injury	Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. The Regulation was not being met because: The arrangement for the management and administration of topical anaesthetics was ineffective. Regulation 13