

Maidstone and Tunbridge Wells NHS Trust







Quality report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

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

Letter from the Chief Inspector of Hospitals

Maidstone and Tunbridge Wells NHS Trust is a medium sized acute trust with two main clinical sites and other small community and satellite services. The trust underwent a reconfiguration of services in maternity, gynaecology, paediatrics, trauma and orthopaedics and surgery in 2011. The trust has around 700 beds across two sites and employs around 4,700 staff. The trust is working towards achieving foundation status, however predicts a 12million deficit in 2014/15.

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

Overall, the trust requires improvement. We rated the trust as good for caring, however we rated the trust as requires improvement for providing safe care, providing effective care, being responsive to people's needs. We rated the trust inadequate for 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 trust.

- 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 hospitals were found to be visibly clean. Infection rates across the trust were noted to be falling when compared to previous years. There was however, some localised poor performance of hand hygiene practices which had been identified through audit data and the trusts performance for surgical site infection rates for those undergoing total hip 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; this posed a potential risk to patients. In the lead up to the publication of this report, we have written to the trust's medical director to advise them of our concerns in this area in order that they can start to address the issues we have discussed within this report.
- 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. 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.
- Some junior medical staff were not aware of their statutory duty of candour; this had been recognised as an area of risk by the trust and there was a plan in place to heighten staff awareness.

Effective:

- The use of national clinical guidelines was evident throughout the majority of services. 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 Specialist Palliative Care Team had introduced an end of life pathway to replace the existing Liverpool Care Pathway.
- 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.
- The Accident and Emergency and the maternity service at Maidstone hospital consistently 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 trust 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 trust was poor.
- There were insufficient numbers of single rooms at Maidstone hospital to meet people's needs which impacted on the privacy and dignity of patients, especially for those patients who were on an end of life pathway.
- Capacity issues within the trust 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 trust had responded to this by introducing additional surgical lists on Saturday mornings.

Well-led:

- High quality care was not assured by the governance processes or the culture in place in some areas of the trust.
- The governance and risk management systems used throughout the trust were unclear, not robust and did not demonstrate consistent and effective management of the risks throughout the organisation.
- 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.
- The system for identifying, capturing and managing issues and risks at team, directorate and organisation level through risk registers was not consistent or effective. Risk registers were poorly applied in some clinical areas which led to some risks not being escalated to the executive board.
- There were examples where there were isolated specialities who demonstrated values and behaviours which were not aligned to the trusts values and despite this being an ongoing issue, there was not clear action being taken by the trust to address this effectively.
- Some staff did not feel there was an open culture that allowed them to express themselves freely in raising concerns. The CEO was beginning to take steps to ensure all staff felt able to raise concerns in a proactive manner.
- Staff engagement was something that was recognised that required improvement in the trust and the executive team described how they were engaging with staff in relation to the future strategy of the trust to ensure it was 'owned' by staff.
- Innovation was seen to be encouraged in the trust; however there was some confusion among staff about how innovation combined with the cost improvement plan and sustainability of the services in the longer term.

We saw areas of outstanding practice including:

- The Maidstone Birth Centre had developed, designed and produced the Maidstone birth couch, which was used by women in labour.
- On Mercer Ward, the role of dementia care worker had been created to focus on the needs of people with dementia and their families. An activities room had been designed, furnished and equipped to meet the specific needs of people with dementia, and was widely used. This project was the subject of an article published in the professional nursing literature.
- The breast care service provided very good care from before the initial diagnosis of cancer through to completion of treatment. Good support and holistic care was provided to patients requiring breast surgery.
- 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**:

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- Ensure that care and treatment provided to service users has due regard to their cultural and linguistic background and any disability they may have.
- 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 Consultant cover at weekends for ICU
- Ensure patients are not delayed more than 4 hours once a decision has been made to admit them to the intensive care unit (ICU).
- Ensure discharge from the ICU takes place within 4 hours of decision.
- 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 service users are 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.
- 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. Its use must be standardised across the children's directorate (excluding neonates).

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- Make arrangements to make sure contracted security staff have appropriate knowledge and skills to work safely with vulnerable patients with a range of physical and mental ill health needs.
- Ensure that intensivist consultant cover at weekends is adequate.
- Ensure that sufficient numbers of ward rounds take place in the intensive care unit (ICU) to ensure the department complies with national standards.
- Ensure that once a decision to admit a patient to the ICU is taken, the patient is admitted within four hours.
- Ensure that patients are discharged from the ICU within four hours of a decision being made.
- Ensure that discharges from the ICU to other wards do not take place at night.
- Ensure that the governance structure within the ICU supports a framework to ensure clinical improvements using a multidisciplinary approach.
- Review the existing management arrangements for the Riverbank Unit to ensure that the unit operates effectively and efficiently.
- Take action to ensure that medical and nursing records are accurate, complete and fit for purpose.
- Ensure that staff and patients have access to a competent and independent translator when necessary.
- Ensure that the water supply is tested for pathogens and that appropriate systems are in place for monitoring water quality and water safety.
- Take action to ensure that all patient clinic letters are sent out in a timely manner.

In addition the trust **should**:

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- 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 SI 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.
- Improve management of non-gynaecology outliers placed on the ward, including review by consultants, ward rounds and patient discharges.

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- Arrange for the safe storage of medicines so that unauthorised access is restricted.
- Make sure that all medical staff in the A&E department have completed training in safeguarding children at the level appropriate to their grade and job role.
- Make sure that a sufficient number of consultants are in post to provide the necessary cover for the ED.
- Ensure that up-to-date clinical guidelines are available in the ED
- Review the arrangements for meeting the needs of patients presenting with mental health conditions, so they are seen in a timely manner.
- Review the way complaints are managed in the ED to improve the response time for closing complaints.
- Review the governance arrangements for nursing staff in the ED to ensure effective leadership and devolution of responsibilities.
- Review the current provisions of the ICU outreach service, to ensure that the service operates both day and night, in line with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations.
- Ensure that medical care services comply with its infection prevention and control policies.
- Develop robust arrangements to ensure that agency staff have the necessary competency before administering intravenous medicines in medical care services.
- Develop systems within the directorate of speciality and elderly medicine to ensure that the competence of medical staff for key procedures is assessed.
- Ensure that systems are in place to ensure that the system of digital locks used to secure medicines storage keys can be accessed only by authorised people.
- Develop systems to ensure that medicines are stored at temperatures that are in line with manufacturers' recommendations.
- Ensure within medical care services that patients' clinical records used in ward areas are stored securely.
- Ensure that the directorate of speciality and elderly medicine further monitors and embeds a robust

system of medical handover that ensures patients' safe care and treatment.

- Review the ways in which staff working in medical care services can access current clinical guidance to ensure it is easily accessible for them to refer to.
- Review the way in which in medical care services it authorises and manages urgent applications under the Deprivation of Liberty Safeguards.
- Ensure that patients have access to appropriate interpreting services when required.
- Ensure that the directorate of speciality and elderly medicine reviews its capacity in medical care services to ensure capacity is sufficient to meet demand, including the provision of single rooms.
- Consider reviewing the processes for the capturing information to help the service better understand and measure its overall clinical effectiveness.
- Consider reviewing the current arrangements for the providing elective day case surgical services to ensure parity of services across the hospital campus.
- Ensure that the provider reviews the quality of root cause analysis investigations and action plans following a serious incident or complaint and improves systems for disseminating learning from incidents and complaints.
- Ensure that the provider monitors transfers between sites for both clinical and non-clinical reasons. The monitoring process should include the age of the patients transferred and the time they arrived after transfer.
- 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.
- Reduce delays for clinics and reduce patient waiting times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Background to Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust is a medium sized acute trust with two main clinical sites and other small community and satellite services. The trust underwent a reconfiguration of services in maternity, gynaecology, paediatrics, trauma and orthopaedics and surgery in 2011. The trust has around 700 beds across two sites and employs around 4,700 staff. The trust is working towards achieving Foundation Status, however predicts a 12million deficit in 2014/15.

Maidstone and Tunbridge Wells NHS Trust is in the boroughs of Maidstone and Tunbridge Wells, and serves the population living in south west Kent. The population is mainly white (97.3%), and the highest ethnic minority is Asian, making up 1.1% of the local population. Maidstone ranks 117th 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.

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.

