CareQuality Commission

East Kent Hospitals University NHS Foundation Trust

William Harvey Hospital

Quality Report

William Harvey Hospital,
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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.

Ratings

Overall rating for this hospital	Inadequate
Accident and emergency	Inadequate
Medical care	Requires improvement
Surgery	Inadequate
Critical care	Good
Maternity and family planning	Requires improvement
Services for children and young people	Inadequate
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

William Harvey Hospital (WHH) is one of five hospitals that form the East Kent Hospitals University NHS Foundation Trust, which is one of the largest hospital trusts in England. The trust provides services to the whole of East Kent, which has a population of around 759,000 people.

William Harvey Hospital had approximately 476 inpatient beds. It provided accident and emergency (A&E) services, outpatient services and a range of other specialties. We spoke to more than 75 patients, 18 relatives, and 120 staff while visiting the wards and departments in the hospital. We also held a listening event on 5 March 2014 where we spoke with around 25 people who came to share their views on this and the other hospitals managed by the trust. We undertook unannounced visits to WHH on 19 and 20 March 2014 when we inspected A&E, ward areas and spoke with the estates department.

Before and during our inspection we heard from patients, relatives, senior managers, and other staff about some key issues that were having an impact on the service provided at this hospital.

An issue which dominated many discussions was the trust's recent proposal to centralise surgical services to this site. The staff we spoke with did not feel consulted in this decision and did not support the decision made by the Board on 14 February 2014. Clinical staff raised detailed concerns with the Care Quality Commission (CQC) and with executives within the trust.

This inspection was undertaken because the East Kent trust had been identified as potentially high risk by the CQC's intelligent monitoring system.

Overall this hospital was rated as good for caring, requires improvement for effective, inadequate for being responsive to patients' needs and being well led, and inadequate for safety. We therefore rated this hospital as inadequate overall.

Our key findings were as follows:

- We saw that staff in all areas of the hospital were caring and responsive to patients' needs.
- We found that there were not always enough appropriately skilled staff, which placed patients at risk of receiving inappropriate care.
- The records of patients' waiting times in A&E were not an accurate reflection of the time patients waited.
- The trust's major incident policy was up to date however staff referred to the out of date policy and there had been mock major incident practice event.
- Children's needs were not always being appropriately met at this hospital.
- Most patients on medical wards received care according to national guidelines.
- Clostridium difficile (C Diff) and Meticillin-resistant staphylococcus aureas (MRSA) for the trust were within expected statistical limits.
- Some equipment was not maintained in accordance with manufacturers' guidance and therefore may not be fit for use.
- There was not enough staff to provide a safe service to women during their pregnancy. The midwife to birth ratio was up to beyond 1:33. This was above the national recommended ratio of midwives to births of 1:28.
- Risk management and clinical governance relating to the care of children was not managed effectively. Areas identified as serious concerns had not been addressed for long periods.
- Some clinics were routinely overbooked because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times, although they were kept informed about the expected length of delay. Patients who required follow-up appointments often had these appointments cancelled, moved to a later date and often there was a significant delay in patients receiving a follow-up appointments.

We saw an area of good practice:

Summary of findings

- The critical care unit monitored its performance and data from Intensive Care National Audit and Research Centre (ICNARC) and showed that patient outcomes were good.

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

Importantly, the trust must:

- Ensure that there are always sufficient numbers of suitably qualified, skilled, and experienced staff to deliver safe patient care in a timely manner.
- Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.
- Ensure all staff are up to date with mandatory training.
- Protect patients by means of an effective system for the reporting of all incidents and never events of inappropriate or unsafe care, in line with current best practice and demonstrate learning from this.
- Ensure that paper and electronic policies, procedures and guidance referred to by staff in the care and treatment they provide to patients are up to date and reflect current best practice.
- Ensure that the assessment and monitoring of patients' treatment, needs, and observations are routinely documented to ensure they receive consistent and safe delivery of care and treatment.
- Ensure that the environment in which patients are cared for is well maintained and fit for purpose.
- Ensure that equipment used in the delivery of care and treatment to patients is available, regularly maintained and fit for purpose, and that audits for tracking the use of equipment are completed appropriately to reduce the risk to patients.
- Ensure that cleaning schedules are in place in all areas of the hospital, personal protective equipment for staff is in good supply and that in-depth cleaning audits are undertaken in all areas.
- Implement regular emergency drills for staff.
- Make clear to staff the arrangements in place for the care of patients at the end of life to ensure the patient is protected against the risk of receiving inappropriate or unsafe care.
- Review the provision of end of life care to ensure a coordinated approach.

In addition the trust should:

- Ensure that patients are informed of the reasons why their appointments are cancelled.
- Ensure that letters to patients' GPs are provided within the timescales established by the trust.
- Aim to reduce the number of transfers between wards experienced by patients.
- Review discharge arrangements for patients to reduce the risk of re-admissions.
- Ensure that strategies are developed and implemented, and that staff are fully aware of them in relation to escalation, emergencies, and dealing with patient capacity issues.
- Ensure that patients' privacy and dignity is maintained at all times.
- Manage patient documentation better to minimise risk of breaches to patient confidentiality.
- Introduce a policy to make clear the timescales for changing bed curtains.
- Ensure handwash and hand gel dispensers are kept topped up, as we found some that were empty or half full.
- Review the layout of the A&E majors area to provide improved visibility of patients from the nurses' station.
- Promote the Friends and Family Test (FFT) around the hospital to improve participation.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Inadequate 	We found that there were not enough appropriately skilled staff in A&E, which placed patients at risk of receiving inappropriate care. Patients' privacy and dignity were compromised at times. For example, extra chairs and trolleys were used to meet demand but at times this resulted in conversations being overheard or care being delivered in inappropriate areas of the department. Children attending A&E did not always receive treatment from appropriately trained and experienced children's staff.We saw that staff were caring and responsive to patients' needs. Staff did not always maintain the documentation needed to show this was happening. We saw examples of good individual leadership in the department, but there was evidence that ongoing safety issues, for example the issue of insufficient substantive staffing had not been resolved by the senior management team.
Medical care	Requires improvement 	Patients told us they felt well cared for, and that staff always respected their privacy and dignity. However, we saw that there were not always enough nurses to staff the increase number of beds that were made available in response to winter pressures. Patients told us there were not always enough nurses to care for them at night. We also noted that patients were unhappy about the length of time they had to wait for their medication before they could be discharged. Some patients told us they had been moved up to four times between wards, which could lead to inconsistent care and treatment. Most patients received care according to national guidelines. There was evidence of effective practice across the medical division at WHH but it was inconsistent and not fully embedded. Staff at all levels told us that they were well supported by their immediate line managers but were unclear about the wider vision and values of the hospital and the trust as a whole. Not all junior doctors felt supported by their consultants.
Surgery	Inadequate 	We found significant staffing issues on some of the wards we inspected, including inappropriate staffing

Summary of findings

levels at night. Some wards were cluttered and cramped, resulting in a potential hazard for people whose mobility was unsteady following surgery. Some equipment was not maintained in accordance with manufacturers' guidance and therefore may not be fit for use.
The surgical risk register, which identified potential risks, was dated August 2013. When we reviewed this document we noted area that had not been updated since February 2013. We could not be assured that any potential current risks to the department had been identified and steps taken to mitigate the risk.
Patients told us that they felt their care and treatment at the hospital was good, and they were generally happy with the standard of facilities.

Critical care — Good 

The unit was visibly clean, and there were systems in place to manage infection control. Infection control rates reported to be zero by the trust in the last two years. Staff said they felt well supported by their colleagues and that there was good team working.
There was a concern that a culture of bullying had not been addressed within the nursing staff.
There was a high number of vacancies within the nursing staff although a recruitment programme was underway. Junior doctors felt the current rota was not sustainable in the longer term and a business case to increase the number of doctors on the rota had been approved but not yet implemented.

Maternity and family planning — Requires improvement 

Mothers received care that was delivered with compassion, dignity and empathy. However, There was not enough staff to provide a safe service to women during their pregnancy. The midwife to birth ratio was up to beyond 1:33. This was above the national recommended ratio of midwives to births of 1:28.
There had been frequent closures of the midwife-led Singleton unit in recent months. This had reduced choice for women and meant that some women were transferred to other units for non-clinical reasons.
We found that leadership vacancies and interim arrangements had continued for significant periods. Clinical guidance and policies used by staff were out of date. Some essential equipment was in short supply.

Summary of findings

Services for children and young people — **Inadequate**

The children's ward, special care baby unit, and neonatal intensive care unit provided a safe and suitable environment in which to care for and treat children. Other areas in the hospital where children were seen and treated had not been risk assessed to make sure that it was a safe and suitable place to treat children.

There were suitable numbers of appropriately trained nursing staff and the skill mix reflected current guidelines in the wards. Parents told us they were happy with the care and support that was provided on these units. Children did not receive care from appropriately trained and skilled staff in other areas of the hospital. In the day surgery unit, the staff caring for children did not have any specialist training or experience. In A&E children were not always seen by a specialist children's nurse and there was no specialist input into the care and treatment for children.

Risk management and clinical governance relating to the care of children was not managed effectively. Areas identified as serious concerns had not been addressed for long periods.

There was no leadership strategy in place for children's services and no clear accountability. Leaders were unaware of significant issues threatening the delivery of safe and effective care.

End of life care — **Requires improvement**

The specialist palliative care (SPC) team provides specialist advice and guidance for individual patients and family members. The staff are experts in pain management and deliver a holistic approach including emotional, spiritual, and psychological care, as well as providing up-to-date advice on symptom control.

Since the removal of the Liverpool Care Pathway, we saw little evidence of strategic trust-wide leadership and support for end of life care. The provision of end of life care was disjointed across the wards and departments. Although individual staff were committed to delivering good care, the result was an ad-hoc reactive response to people who needed care at the end of their lives.

Outpatients — **Requires improvement**

All the patients we spoke with told us they felt they had been treated with dignity, and that they had found staff in the outpatients department polite and caring. We found that some clinics were very busy

Summary of findings

and that staff routinely overbooked patients for clinics because the number of appointment slots did not always reflect patients' needs. Patients could therefore experience long waiting times, although they were kept informed about the expected length of delay.

Patients who required follow-up appointments told us that they often had these appointments cancelled, moved to a later date and often there was a significant delay in patients receiving a follow-up appointments. Staff told us that when appointments needed to be cancelled, they generally cancelled follow-up appointments as this did not affect how the trust met the two and 18-week referral to appointment time targets. We found that staff were collecting data on waiting times and overbooked clinics, however despite this felt unable to make improvements.