

Southend University Hospital NHS Foundation Trust

Southend University Hospital










Quality Report

Prittlewell Chase, Westcliff-on-Sea,
Essex SS0 0RY
Tel: 01702 435555
Website: www.southend.nhs.uk

Date of inspection visit: Announced 12-14 January
2016, unannounced 24 January 2016
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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	Requires improvement	
Urgent and emergency services	Good	
Medical care (including older people's care)	Requires improvement	
Surgery	Good	
Critical care	Good	
Maternity and gynaecology	Good	
Services for children and young people	Requires improvement	
End of life care	Requires improvement	
Outpatients and diagnostic imaging	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this inspection 12-14 January and returned unannounced 24 January 2016. The main part of the inspection was a comprehensive announced inspection. We inspected Southend Hospital and the outpatient's service for children and young people at the Lighthouse Child Development Unit.

This service was not triggering as high risk from national data sets or as an outlier.

Southend University Hospital NHS FT is part of the Success Regime. This includes Southend, Basildon and Mid Essex trusts working together to influence system change across the health economy. This process is key to improved care in the NHS.

During the first day of the inspection the junior doctor's strike was in progress. The trust was offered the option to cancel the inspection but declined. We noted that the trust had a clear plan for patient care during this period of industrial action.

During our inspection the trust was on a high state of escalation due to the increased number of patients coming in to the hospital. This had existed for some time before our inspection.

We rated the services offered by Southend University Hospital NHS Foundation Trust as 'requires improvement'.

Our key findings were as follows:

- The increase in the number of beds at the trust had put additional strain on the services, but in particular a strain on the staff.
- Staff nurse to patient ratios were too high particularly in medicine and musculoskeletal surgery.
- High numbers of elective surgery cancellations were seen in addition to clinic cancellations all relating to the alert status, capacity and congestion within the hospital.
- Good patient outcomes were evidenced in particular the stroke service.
- Staff went the extra mile for patients and demonstrated caring and compassionate attitudes.
- The trust scored above the England average for Patient-led assessments of the Care Environment (PLACE) consistently for all categories assessed. (2013-2015)
- Cleaning undertaken by nurses and technicians for November and December 2015 of high risk equipment was 95% and 97% compliance rates. There were no MRSA cases reported and lower than the England average rates of C.Diff.
- Mortality and morbidity meetings took place but they did not follow a consistent format, and actions to support learning lacked timescales.

We saw several areas of outstanding practice including:

- We rated well led for the emergency department as outstanding. The local leadership and team worked well to deliver the service. Their governance practices ensured risks were identified and managed. They engaged staff to ensure they remained motivated.
- Stroke service patient outcomes receiving the highest rating by Sentinel Stroke National Audit Programme. CT head scanning were delivering a 20 minute door to treatment time which was a significant achievement.
- The trust had implemented an Early Rehabilitation and Nursing team (ERAN). The ERAN Team supported the early discharge of primary hip surgery and knee surgery patients.

Summary of findings

- The 'Calls for Concern' service, allowing patients and relatives direct access to the CCORT (critical care outreach team) following discharge home.
- The learning tool in place within Radiology allowing learning from discrepancy in a no blame environment.
- The Mystery Shopper scheme that actively encouraged people to regularly give their feedback on clinical care and services.
- Safe at Southend was a new initiative to allow staff to share day to day clinical and operational issues with executive Directors for rapid action.

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

Importantly, the trust must:

- Ensure staffing ratios comply with NICE guidelines, to ensure both patients and staff are not at increased risk.
- Ensure duty of candour regulations are fully implemented, the trust was not able to demonstrate that they had met all parts of the requirements.
- Ensure that clinical review is part of the process for cancelling elective surgical patients.

To see the full list of actions the trust must and should take please see the areas for improvement section toward the end of this report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

Overall we have rated emergency services at Southend University Hospital NHS Foundation Trust as good, with some areas of excellent practice and some areas for improvement. . The well led domain was rated outstanding. An experienced, highly trained team of competent and professional multidisciplinary staff provided care and treatment in the ED, based on national guidance and best practice evidence.

Staff were encouraged to engage with specialist treatment pathways and nurse-led audits enabled junior members of the team to develop skills and competencies in a variety of areas, such as National Early Warning Scores and dementia care. We saw a significant and consistent approach to person-centred care but the department was not able to meet the requirements of the Royal College of Emergency Medicine (RCEM) regarding minimum hours of consultant cover and there were not always enough children's nurses on shift to provide a level of care in line with the guidance of the Royal College of Nursing (RCN). Some staff told us the process for disseminating learning from incident reporting could be more robust and we found a significant lack of security in the department, which had resulted from the removal of a security officer post based in the department.

Patients were treated by a multidisciplinary team but referral into medical specialties was problematic due to a lack of engagement from some clinical specialties and an overall lack of capacity in the trust. A new executive team had engaged the ED leadership team, who told us they were confident they were being supported to extend mitigation strategies and practices aimed at reducing patient assessment and treatment delays. Staff provided treatment based on national guidance and best practice policies from the National Institute of Health and Care Excellence, the RCEM and the RCN. Although staff had access to policies, these were not always up to date and so did not reflect the latest practice guidance. We observed compassionate, age-appropriate care

Summary of findings

throughout our inspection and saw staff had a meaningful understanding of the needs of the local population, particularly related to dementia, alcoholism and homelessness. A range of services and facilities were available to support people with challenging or complex needs and staff demonstrated a substantial commitment to providing individualised treatment to people with mental health needs.

Staff described and we saw a robust, well-respected and highly visible tripartite leadership team with a clear vision and strategy for a service under a high degree of pressure. This had resulted in a coherent and supportive working culture, in which professional development and good practice was recognised and rewarded.

Medical care (including older people's care)

Requires improvement



There were insufficient numbers of nursing staff on the majority of medical wards which compromised patient safety. Nurse recruitment within medical services was a known challenge for the trust.

Despite initiatives to attract nurses to work for the hospital and the use of agency nurses, the number of nurses remained insufficient.

Incident reporting was established and was acted upon when needed. However, ongoing staff shortfalls meant that staff did not always have the time to report required incidents. Improvement was needed in how the outcome of incidents was fed back to staff.

Patients' records were inconsistently completed.

Care was provided in accordance with evidence-based and best practice guidelines, although care pathways were not in place for endoscopy. Care was monitored to show compliance with standards and there were good outcomes for patients and particularly for renal and stroke patients. Seven-day working was established for the majority of staff and multidisciplinary working was evident to coordinate effective patient care. However staff were not always able to access both mandatory and development training and compliance with appraisals required improvement to meet trust targets.

There was evidence of innovative nutrition initiatives being implemented, such as a red tray system to identify patients who needed help with

Summary of findings

eating, volunteer 'feeding buddies' and plans to introduce a modified texture diet menu. Patients said that staff were caring and friendly and felt that their dignity and privacy were respected. We observed staff delivering kind and compassionate care.

The trust responded to the local population's needs and particularly noteworthy was the seven-day transient ischaemic attack (TIA) clinic that GPs could access electronically. However, we found that male and female patients were accommodated in the same bay on the acute stroke unit (Benfleet) which was a breach of the Department of Health's 'mixed sex accommodation' policy. There was a high rate of medical outliers (patients not accommodated on the correct ward for their treatment) due to capacity issues and medical patients were frequently moved from ward. The leadership had good level of oversight regarding the directorate's improvement plans. We saw staff were supported to give a good level of care which staff were positive about. We saw a culture of audit and improvement.

Surgery

Good



We rated surgical services as good overall. The area requiring improvement was the responsive domain.

We found that the trust was cancelling elective surgery because of capacity issues in the hospital. At the time of inspection there was a lack of clinical input in the decision making process as to which surgical cases would be cancelled. The trust was below the England average for patients being treated within 28 days of cancellation of their operation date, therefore further delaying surgery. We rated the safe, effective, caring and leadership domains of the service as good.

We saw that incidents were raised and used as a learning tool; escalation triggers were identified and followed. Infection protection and control methods were used to ensure patients safety. However, we found that there was no ward based pharmacy service. Patient's prescription charts were not reviewed or checked by a pharmacist and

Summary of findings

we saw delays in patients receiving prescribed medicines. We also saw that nursing staffing levels were below planned levels on musculoskeletal wards.

We observed good multidisciplinary working between nursing staff, medical staff and allied health professionals. The service participated in national audits to record patient outcomes with opportunities for improvements identified and action plans put in place to address issues highlighted following audits. We saw that assessments for patients were comprehensive, covering all their health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. Staff interacted with patients in a friendly, polite and professional manner. Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw staff treated patients with dignity and respect.

Surgical services were well led. Senior staff were visible on the wards and theatre areas. Staff appreciated this support.

Critical care

Good



Effective processes were in place to learn from incidents and staff used learning from incidents and complaints to improve their practice and deliver safer, more effective care. The environment was clean and staff followed infection control procedures. Medicines, including controlled drugs, were safely and securely stored.

Medical and nursing staffing numbers did not always follow guidelines laid down in the Core Standards for Intensive Care Units.

Patients received treatment and care according to national guidelines and best practice. We saw effective multi-disciplinary team working across the units, with good consultant input. Junior doctors were adequately supported to provide safe treatment and assessment. Physiotherapists, dieticians, microbiologists and pharmacists were highly spoken of by CCU staff and were available when needed.

Without exception, staff were complimentary about the leadership on the unit. Managers on CCU and

Summary of findings

ARCU demonstrated commitment to patient care, delivering a positive patient experience, developing and caring for their staff, robust governance and effective strategic planning.

Maternity and gynaecology

Good



Overall we rated the service as good but safety required improvement.

There were established local and divisional risk and governance arrangements. Staff felt the service had a profile on the trust board agenda. There were processes in place to share lessons learnt from incidents and investigations.

The trust promoted breastfeeding and women were supported in their chosen method of feeding. Women were positive about the care they had received. We observed staff interacting with women and their partners in a respectful compassionate way.

Women and their partners felt involved with their care and were happy with explanations given to them. Partners had the choice to stay to support women throughout the night.

There was an effective multidisciplinary approach to care and treatment, which involved a range of staff in order to enable services to respond to the needs of women. All staff told us that that working relationships between the professional groups was excellent.

Staff wanted to continue to develop the service and demonstrated this through implementing new ideas. For example the development of a range of specialist clinics to meet women's needs.

Women using the maternity service received evidenced based care on the maternity service's guidelines and national guidance.

However, medical staffing and the numbers of supervisors of midwives were not in line with national guidance.

There were no displays of information for people using the services about how to make a complaint if they were dissatisfied. The majority of women and their families we spoke with did not know how to make a complaint.

Services for children and young people

Requires improvement



Overall, we rated Children's and Young People's services at Southend require improvement. We rated safe as requires improvement for a number of reasons including: poor documentation

Summary of findings

of patient notes, observation of poor hand sanitisation on entering and exiting the children's ward, and poor hygiene maintenance in patient and parent's bathrooms on the Neptune ward, robustness of incident reporting, the robustness of consent discussion and recording, and awareness of the Gillick competence as these were not audited on the ward. From our review of notes and information regarding gaining of consent there was no evidence that all staff were fully aware of the trust procedure. The children's ward had no dedicated pharmacy cover including for controlled and cancer drugs. There were waiting lists for electroencephalogram (EEG) tests which record electrical activity produced by the brain and Autism Spectrum Disorder ASD appointments. There were concerns about adults staying on the children's ward and the security risk this posed. Additionally, there were concerns about children receiving surgery on adults' wards and whether staff competency levels on those wards were sufficient to deal with a paediatric medical emergency. We rated effective as requires improvement because there was low compliance with the service own audit plan, which meant opportunities to improve were lost. We saw that the diabetic audit action plan had not been completed. Also, only 53% of children had received their antibiotics within the nationally prescribed one hour.

We rated caring as 'good' because the friends and family rating for December 2015 returned a positive response rate of 83% and positive parent and family feedback had been received for both paediatric outpatients and the Neptune children's ward. There were good supportive systems in place for parents or carers dealing with the bereavement of a child, and volunteer members of staff organised provision of memory boxes in such instances which could contain objects to remind parents of positive experiences they had shared with their child.

We rated responsive as 'good' as the service had designed orientation sessions for children before attending hospitals for procedures to aid with alleviating any anxieties they may have had. Dermatology services had previously been provided off-site and had been relocated so children could be treated within a familiar environment. However,

Summary of findings

there was an issue with patient waiting lists where clinic appointment had been cancelled due to staff annual leave as this could in some cases add an additional six month wait for a follow up appointment for a child.

We rated well-led as requires improvement because local governance needed to be improved in relation to incident management. The leadership had failed to recognise the importance of this group of staff being part of any major incident response and as such ensure training was offered. There was an inconsistent approach to the cancellations of clinics, which increased the risk to those attending.

End of life care

Requires improvement



We found the safety of end of life care service (EoLC) required improvement. The mortuary facilities were not secure and installations and equipment were worn out and unreliable. Not all wards looking after end of life patients were fully staffed and there were not enough EoLC consultants working for the trust. However, we also found incidents were reported and learned from, medicines were properly managed and hygiene practices were good. The effectiveness of the EoLC service was good. Care and treatment followed national guidelines within individualised care plans for patients. This included pain relief and staff were competent. The trust monitored its own effectiveness with clinical audits and compared its performance with other trusts nationally. However, we also found the EoLC specialist service was not available seven days a week and Southend Hospital did not have seven day clinical nurse specialist cover. Specialist consultants were available only on call across the county 'out of hours'.

We found EoLC services were caring. Relatives and friends of patients spoke very highly about staff at all levels in the service. Patient's privacy and dignity was respected including after death. Staff gave relatives and friends of dying patients support and help. However, we also saw nurses and doctors were not good at finding out what patient's spiritual needs were to prepare for dying.

We found responsiveness of EoLC services required improvement. The trust was not achieving preferred place of care for many end of life patients or able to discharge most of them within 24 hours

Summary of findings

when requested. The age and condition of the mortuary facilities had a knock on effect on the flow of the service and were often full to capacity. Some beds in the specialist wards were regularly used to care for patients not needing palliative or EoLC when the hospital was under pressure and this created risks. However, we also saw there was a specialist palliative care team available to help nurses and doctors and a weekly outpatient's clinic. Most patients were contacted within 24 hours of being referred and there was a new bereavement suite in the hospital where relatives/friends could register a patient's death.

Leadership of EoLC services required improvement. The short coming in the mortuary related to security, equipment replacement and lack of space which impacted on the service. We also found the trust didn't meet all the key signs of a good quality organisation in a national 2015 audit and not all risks and necessary improvements it identified itself were dealt with quickly enough.

Outpatients and diagnostic imaging

Requires improvement



We have rated this service as requires improvement for safe. This is because incident learning at directorate level was not well embedded; there were delays in patient follow up which had resulted in patient harm. The WHO check list was not embedded within diagnostic imaging and several pieces of diagnostic imaging equipment were listed as past their replacement dates. However we also saw that departments were clean, sufficient equipment was available to the staff and patient records were well maintained.

Effective was inspected but not rated; we found that multidisciplinary working was evident throughout the departments with excellent interaction from therapies staff. Staff training and re-validation were effective, as were supervision and appraisal systems. There was a good understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards. Sonographers were becoming deskilled in anomaly scans which in turn were adversely affecting recruitment.

We have rated this service as good for caring. Feedback from patients and relatives was positive about the way staff treated people. Interactions between staff and patients were kind and friendly.

Summary of findings

Patients and their carers' were involved and informed and complimentary about their experiences with staff at all levels, they felt staff took time to explain complex information in a way they could understand.

Responsive required improvement; there were significant access and flow issues in ophthalmology and respiratory services and there were no paediatric facilities within diagnostic imaging. However we also saw that the trust had good partnership working and excellent multidisciplinary team working. Learning from complaints was evident and the trust supported individuals with learning disabilities and dementia.

Well led required improvement; there were significant delays in follow up patient appointments in two specialities, these delays due to miss management had resulted in patient harm.

Joint meetings across all outpatients department and diagnostic imaging were not held therefore shared learning was lost. Many items of diagnostic imaging equipment were significantly out of date; there was not a robust plan in place to address this. However we also saw that staff we spoke to were aware of the trusts vision statement and understood their role within the organisation.

There was good staff moral despite staff shortages in diagnostic imaging and staff felt valued and innovation was evident.

Southend University Hospital

Detailed findings

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

Detailed findings

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Background to Southend University Hospital

There were approximately 590 beds although the trust did open flex beds so this number was changing regularly.

The hospital had one main acute site Southend Hospital and the Lighthouse Child Development Unit.

Southend University NHS Foundation Trust serves a population of around 338,800 from the Prittlewell Chase site and at outlying clinics across the Southend-On-Sea, Castle Point and Rochford areas.

Currently 17.8% of the population are over 65, a figure that is set to rise to 19.7% by 2020. The over-85 population is expected to double and the birth rate in Southend is substantially higher than the national average.

Southend-On-Sea is the 75th most deprived local authority district out of 326 local authorities nationally, and lies in the 2nd most deprived quintile. About 21.7% (7,200) children live in poverty. Life expectancy for both men and women is similar to the England average.

Castle Point is 177th most deprived and lies in the 3rd most deprived quintile. About 16.8% (2,500) children live in poverty. Life expectancy for women is lower than the England average.

Rochford is joint 200th most deprived and lies in the least deprived quintile. About 10.2% (1,500) children live in poverty. Life expectancy for both men and women is higher than the England average.

In line with the commissions commitment to inspect all NHS acute services by March 2016 we undertook this scheduled inspection.

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper Monitor improvement Director and retired Director of Nursing/Deputy Chief Executive

Head of Hospital Inspections: Tim Cooper Care Quality Commission

The team included CQC inspectors and a variety of specialists: A&E Junior Doctor, A&E Matron,

Honorary Consultant Surgeon, Endovascular surgeon (Retired), Clinical leader in emergency surgery,

RGN – Surgical Ward, Consultant General Surgeon, Nurse Consultant Critical Care, Clinical Unit Manager - Neonatal, Head of Midwifery, Consultant Obstetrician and Obstetric, Paediatric Modern Matron, Paediatric Surgeon, Consultant in Clinical Oncology, community Macmillan nurse, Head of Outpatients,

Detailed findings

Consultant Radiologist, Outpatient Clinics Imaging Services Manager, Director of Nursing & Quality, Midwifery, Respiratory Consultant and previously Medical Director and a Non-Executive Director.

How we carried out this inspection

1. We analysed data available from national data sets. We received information directly from the trust as part of the provider information request. During and following the inspection we requested further documents for review. We reviewed documents on site; spoke to staff, patients, carers, relatives and visitors.
2. We visited on 12-14 January announced and 24 January 2016 unannounced.
3. Prior to the inspection received feedback from CCG's, Monitor, Health Education England and NHS E. We also conducted public listening events and a number of staff focus groups to get their opinions of the hospital.

Facts and data about Southend University Hospital

Staff: 3,714 staff – including: <ul style="list-style-type: none">• 494 Medical• 1,950 Nursing (Inc. HCAs, scientific and technical staff)• 1,270 Other 2014/15 Revenue: £ 273,656,000 Full Cost: £ 283,490,000	Deficit: £ 9,834,000 Activity summary (Acute) 2014-15 <ul style="list-style-type: none">• Inpatient admissions: 53,712.• Outpatient (total attendances): 530,750• Accident & Emergency attendances 95,217: (Oct 14 – Oct 15) Please note that the figures quoted here were reviewed for factual accuracy by the trust prior to our inspection.
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Our ratings for this hospital







Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Outstanding 	Good
Medical care (including older people's care)	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

Safe	Good	
Effective	Good	
Caring	Good	
Responsive	Good	
Well-led	Outstanding	
Overall	Good	

Information about the service

The Emergency Department (ED) at Southend University Hospital NHS Foundation Trust comprises of an adult majors unit with 16 cubicles, an adult minors unit with seven cubicles and an additional theatre, a paediatric unit with four cubicles and a resuscitation unit with three adults bays, one paediatric bay and a flexible bay. The ED has a number of additional treatment and assessment rooms, including a plaster room, examination rooms for optometry and physiotherapy, a private paediatric assessment room, a private adolescent assessment room, pastoral rooms for relatives of patients and a room suitable to care for patients under police escort. A new mental health suite has opened on a three-month trial basis staffed by a specialist team from South Essex Partnership University NHS Foundation Trust (SEPT) working in partnership with the Southend ED. This service was managed independently from the ED but offered a fully integrated referral service. Documents supplied by the trust demonstrated that April 2014 a joint operational policy was put in place.

The paediatric ED is open seven days a week between the hours of 0800 – 2100 and has a glass-fronted patient waiting area enabling staff to view the area from within the department. A clinical director leads the ED with dual training in adults and children's emergency care and six other consultants. A team of 52 registered nurses, led by an experienced matron, provide nursing care in the ED and work closely with a team of emergency nurse practitioners, emergency department assistants, an associate practitioner and a range of other professionals. A leadership team comprised of a matron, general manager

and clinical lead provide oversight, governance and service development. On a day-to-day basis a consultant, a supernumerary nurse in charge and an ED coordinator lead the ED.

The South Essex Emergency Doctor Service (SEEDS) provides triage and GP services in the ED from 0800 – midnight seven days a week. The service was offered under a service level agreement. SEEDS is a provider external to the trust and operates under a service agreement. We did not inspect this service, however we did inspect the interaction of the service with the trust own emergency department.

During 2014/15 the adult ED saw 74,579 patients and the paediatric ED saw 17,982 patients. The ED experienced exceptional demand on its services throughout 2015, which has resulted in a need for significant strategic oversight in improving performance whilst maintaining patient safety and staff skills. The leadership team have implemented a number of policies and practices to help sustain the service and ensure staff can work effectively, with a reduction in delays to assessment and treatment.

During our inspection, we spoke to 12 nurses, three emergency department assistants, an associate practitioner, the SEEDS team, five receptionists and administrators, housekeeping staff, the mental health team, five doctors and the department leadership team. We also spoke with 15 patients and relatives, reviewed information from comment cards, looked at patient records, performance data and looked at an additional 27 items of evidence to support our judgement.

Urgent and emergency services

Summary of findings

Overall we have rated emergency services at Southend University Hospital NHS Foundation Trust as good, with some areas of excellent practice and some areas for improvement. An experienced, highly trained team of competent and professional multidisciplinary staff provided care and treatment in the ED, based on national guidance and best practice evidence.

Staff were encouraged to engage with specialist treatment pathways and nurse-led audits enabled junior members of the team to develop skills and competencies in a variety of areas, such as National Early Warning Scores and dementia care. We saw a significant and consistent approach to person-centred care but the department was not able to meet the requirements of the Royal College of Emergency Medicine (RCEM) regarding minimum hours of consultant cover and there were not always enough children's nurses on shift to provide a level of care in line with the guidance of the Royal College of Nursing (RCN). Some staff told us the process for disseminating learning from incident reporting could be more robust and we found a significant lack of security in the department, which had resulted from the removal of a security officer post based in the department.

Patients were treated by a multidisciplinary team but referral into medical specialties was problematic due to a lack of engagement from some clinical specialties and an overall lack of capacity in the trust. A new executive team had engaged the ED leadership team, who told us they were confident they were being supported to extend mitigation strategies and practices aimed at reducing patient assessment and treatment delays.

Staff provided treatment based on national guidance and best practice policies from the National Institute of Health and Care Excellence, the RCEM and the RCN. Although staff had access to policies, these were not always up to date and so did not reflect the latest practice guidance. We observed compassionate, age-appropriate care throughout our inspection and saw staff had a meaningful understanding of the needs of the local population, particularly related to dementia, alcoholism and homelessness. A range of services and

facilities were available to support people with challenging or complex needs and staff demonstrated a substantial commitment to providing individualised treatment to people with mental health needs.

Staff described and we saw a robust, well-respected and highly visible tripartite leadership team with a clear vision and strategy for a service under a high degree of pressure. This had resulted in a coherent and supportive working culture, in which professional development and good practice was recognised and rewarded.

Urgent and emergency services

Are urgent and emergency services safe?

Good



The emergency department (ED) services good

Because;

- Medicines were stored according to established regulations in the Medicines Act 1968.
- Incidents were investigated appropriately. Learning from incidents was not consistently disseminated to individual staff although we found substantial evidence that changes in practice and procedures were clearly communicated to the staffing team as a whole.
- The environment was visibly clean and well-maintained for infection control purposes.
- There was a clear focus on safeguarding from a team who demonstrated an acute awareness of the risks inherent in treating vulnerable people.
- We found staff were well prepared to respond in a major incident and had undergone appropriate specialised training.

However:

- This is because of shortfalls in consultant cover and the lack of registered children's nurse, to meet the Royal College of Emergency Medicine and Royal College of Nursing standards.
- Security arrangements in the ED did not protect patients or staff from the risks associated with violence and aggression from authorised persons or those under the influence of alcohol or narcotics.
- The paediatric ED was not secure and senior staff had recognised the vulnerability of the department in a risk register rating, which indicated the department could not be locked down in a major emergency.
- Staff did not have adequate levels of safeguarding training. In addition to this the compliance rates of training undertaken was short of the trust target.
- There was room for improvement in the tracking of equipment maintenance and calibration.

- Staff did not always receive feedback following incidents they had reported.

• Incidents

- Staff reported 498 incidents in the ED from July 2015 to November 2015. The need for assistance from security staff to help with violent or aggressive patients accounted for 20% of the incidents. Other common incidents included non-hospital acquired pressure ulcers. Staff we spoke with told us a security officer used to be based in ED but this provision had been removed. This meant the department had no visible deterrent to violence and meant staff had to wait for assistance from security staff based elsewhere in the hospital. Staff told us security officers were very supportive and fast to respond but overnight there were only two staff on duty across the hospital site, reducing their response time. This was because the security staff were responsible for other areas of the hospital with open access at night.
- There had been one serious incident reported in the unit between January 2015 and January 2016. We looked at the investigation of the serious incident from January 2015 and found staff had effectively used the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation to improve practice, including a root cause analysis investigation.
- There had been no Never Events in the twelve months prior to our inspection. Never Events are serious, wholly preventable incidents involving patient safety that can be avoided through adequate safety systems.
- The matron told us the reporting culture of abuse and assault had improved amongst staff following a recent instruction to ensure both the clinical staff and security officer involved reported on their own respective system.
- Staff demonstrated a proactive approach to engaging with other services in the investigation of, and learning from, incidents. For example, where a patient who lived in a care home was treated in the ED, instances of pressure ulcers were reported back to the social care provider.
- Mortuary staff had discussed the use of paper wristbands to identify people, which often deteriorated quickly. To address their concerns, the ED introduced plastic wristbands instead.

Urgent and emergency services

- Senior staff had recognised the need for a more robust debrief process for staff involved in incidents such as inviting mental health staff to speak with nurses following an incident involving distressing or violent behaviour.
- Staff we spoke with told us they were encouraged to submit incident reports but they felt it wasn't always clear what happened after they submitted the report. For example, one nurse said they didn't get an individual reply to incidents they submitted and they didn't know if anything had happened as a result. Another individual said, "I have submitted an incident report but heard nothing back. I don't know what happens afterwards... I don't think there's a mechanism for me to chase it." However, staff demonstrated learning from previous incidents in some cases. For example, three falls in September 2015 had prompted senior staff to issue a reminder to double-check trolley sides were always up.
- **Cleanliness, infection control and hygiene**
 - We saw clinical staff routinely washed their hands between patients and used antibacterial gel when moving between different areas in the department. This complied with the World Health Organisation's guidance "Five Moments of Hand Hygiene."
 - Staff used 'I'm clean' stickers to indicate when equipment had been cleaned and disinfected. Each room or individual area of the ED had documented processes for staff to sign when a room or bed space had been cleaned. We saw from checking 16 individual rooms and areas that there was a consistent approach to cleanliness.
 - Cleaning staff were visible throughout our inspection and we saw they responded rapidly to areas that needed urgent attention and that waste was managed in line with the trust policy. Staff from this team were available 24-hours, seven days a week.
 - The matron or a senior nurse completed a daily cleaning and storage checklist to ensure the ED was compliant with trust standards of cleanliness. This included checking the availability of commodes, the condition of the sluice and the cleanliness of toys in the paediatric ED as well as staff compliance with the 'bare below the elbow' policy. We looked at the daily records for the month prior to our inspection and found high levels of daily compliance. Staff had documented the action taken where problems had been found.
- Emergency department assistants (EDAs) conducted hand hygiene audits in the department and monitored nurses in correct infection control processes when a patient was being cared for in a barrier-nursing bay. Barrier nursing is a model of care used to protect patients from cross-infection when a person is considered to be an infection risk.
- We observed staff routinely cleaning trolleys between patients and using appropriate personal protective equipment (PPE). Some disposable curtains in the ED had not been changed every six months which was not in accordance with trust policy.
- **Environment and equipment**
 - A senior sister had raised a concern that the ED did not have sufficient equipment to treat and accommodate bariatric patients. Managers had been able to secure bariatric equipment from an external contractor when needed.
 - Staff felt they did not have the necessary training to use the bariatric equipment effectively and had escalated the issue to the senior team in the unit to consider the provision of their own dedicated specialist equipment.
 - We examined 27 items of equipment for service maintenance and calibration. We found most items (25) to be serviced and had a safety test date. One blood pressure machine and one oxygen monitor had no documented maintenance safety check and staff contacted the estates department who immediately removed the equipment for checking.
 - The matron or a senior nurse checked and documented the condition of resuscitation equipment on a daily basis. This included a check of storage areas to make sure sharps bins were stored off the floor; there were no chemicals or drugs stored inappropriately.
 - The service manager had conducted a consultation with staff as part of a review of the environment for a refurbishment plan. This research had resulted in the refurbishment of the ED reception area. This included an open-plan reception desk to reduce communication barriers between staff and patients whilst maintaining enough space to ensure conversations were confidential. The next stage of the refurbishment plan included the replacement of the waiting room chairs, some of which were in poor condition.
 - Staff had provided a child-friendly environment in the paediatric ED waiting room, which included bright wall decorations and toys to play with, which staff could use

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for distraction. However, assessment bays in the paediatric ED were not decorated in a child-friendly manner and the adolescent room had no decoration or resources appropriate to this age group. We asked three nurses about this who told us the adolescent room was used for young people with mental health concerns. The room had a ligature point and oxygen suction and tubing equipment present but the nurse in charge told us a young person would never be left unattended in this room.

• Medicines

- Drugs fridges were kept locked and only the senior nurse on duty had access to them. We saw staff had recorded a daily temperature check of the fridges, which had been maintained within a safe temperature range for the storage of chilled medicines.
- We checked the anaphylactic reaction drug treatment box in the paediatric ED and found it to be sealed with a documented check of its contents and ready for use.
- The matron contributed to the trust-wide medicine utilisation safety action group to discuss serious incidents in the ED and to identify areas for learning and development. This was briefed to senior sisters at monthly meetings for dissemination to other staff.
- Senior staff used a decision tree tool as a prevention mechanism with nurses who had been involved in a medication error. This helped the individual to identify contributing factors to the error and provided them with an opportunity to reflect on their practice, to identify how the error could be avoided in future. We saw this process was followed after each drug error, regardless of whether the patient had been affected.
- All staff who had responsibilities for the administration of medicines had received up to date training and competency checks.

• Records

- Patient records and clinical notes were created and stored using an electronic system. We looked at a random sample of patient notes as well as how these were captured during three medical handovers. Notes were detailed, fit for purpose and included evidence of personalised care and multidisciplinary input. Staff noted communication with relatives as well as observations where they were concerned about a patient's behaviour.

- The electronic patient record system included a mandatory component, which ensured patients could not be discharged without a doctor issuing a letter to their GP.
- We looked at the notes of 15 patients to check for time to treatment, and to check that essential assessments had been carried out. We found in all cases staff had recorded the time of patient arrival into the ED, the time they were assessed by a clinical decision-maker and confirmation they had been triaged within 15 minutes of arrival. A doctor had signed seven of the records we looked at but had not included their grade. Doctors had fully completed the other eight sets of notes.
- Doctors had completed detailed assessment and treatment plans in the records we looked at, including the results of electrocardiograms (ECGs) and working diagnoses.
- **Safeguarding**
 - Safeguarding training was a mandatory requirement for all staff and 63% of ED staff had up to date adult safeguarding training to level one. In addition, 81% of staff had up to date child safeguarding level one training and 53% of staff had this training to level two. All staff who worked in the paediatric ED held child safeguarding level two as a minimum and senior band 7 nurses held child safeguarding level three training. The trust's minimum target for mandatory training, which included safeguarding, was 85%.
 - The electronic patient tracking system had a flagging tool, which identified children who were known to be at risk of safeguarding concerns from the local authority risk register.
 - We spoke with the trust safeguarding lead who told us they were arranging level three safeguarding training for all ED staff. This had commenced and was being offered on a rolling basis to ensure all staff in the unit would be up to date within six months.
 - Staff in the ED had access to the System 1 national database to check child protection information, including children who had been identified as at risk of domestic abuse or those who had experienced non-accidental injuries. Paediatric nurses checked the safeguarding status of each child admitted to the ED and were able to request a management review at any time. This meant staff could take appropriate steps to safeguard children at risk of abuse and neglect.

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- The paediatric ED was not secured and there was no policy or access restriction in place to prevent unauthorised people from accessing the unit.
- **Mandatory training**
 - The trust target for the number of staff with up to date mandatory training was 85%. In the ED, 68% of staff had undertaken all required mandatory training, which was below the trust target but represented a significant improvement of over 20% in the three months prior to our inspection.
 - Sixty five percent of staff had undergone training in the assessment of risk for venous thromboembolism (VTE) and 56% of staff had been trained in the management of falls risks.
 - The low numbers of staff with completed mandatory training reflected the acute pressures on the department from continually high demand. This had meant senior staff could not release nurses for training without compromising patient safety. Senior staff had taken steps to address this by increasing protected training time from two hours each month to a whole day. This had ensured staff were taken from the clinical rota so they could focus on training progression. The success from this approach was indicated by the increase in training completion since October 2015 and the specific areas in which training compliance met trust minimum requirements, such as oxygen therapy. This training required specialists to deliver it senior staff ensured all nurses were able to attend, which meant patients who needed oxygen therapy always had access to appropriately trained staff.
 - The matron and administrator used a learning management system to keep track of nurse training needs such as the administration of intravenous medication and the management of deteriorating patients.
- **Assessing and responding to patient risk**
 - ED staff used a clear and robust process and flow chart for the streaming and triage of patients into minors and majors and the South Essex Emergency Doctors Service (SEEDS) provided an on-site urgent care and triage service. We saw reception staff were provided by the trust and by SEEDS and worked well together to ensure the timely and safe registration of patients.
 - SEEDS doctors undertook triage and streaming for the trust, which staff told us was working well with the recent introduction of new SEEDS managers. We did not identify any concerns regarding the flow and streaming of patients through the service. During our inspection no consideration had been given to diverting some ambulances with patients to SEEDS staff where the patient could be effectively seen by a GP. After our inspection the trust told us the nurse in charge would normally divert ambulances to the SEEDS service as necessary. The SEEDS service was in operation seven days a week from 0800 - 0000. After midnight another doctor service was available in the hospital, which operated as an urgent care facility and patients could be referred in to this from the ED.
- When the department was at capacity and ambulances were waiting there was a process instigated which enabled patients to be brought in to have initial tests done such as blood test. The patients would then continue to wait in the ambulance until a cubicle became available.
- The local ambulance service provided two hospital-ambulance liaison officers (HALO), to support the patients whilst they waited to be handed over to the care of the staff in the ED.
- We reviewed 50 pathways using the electronic patient monitoring system and observed that 100% of patients had received an initial assessment within 15 minutes and 100% had received initial treatment within 60 minutes.
- Staff in the department had set internal targets for treatment decisions to be made within two hours and worked to this. In the 50 patient records we looked at, staff had achieved the target in 100% of cases. This meant the process being followed by the department to assess and treat patients was working effectively.
- Between December 2014 and December 2015 the trust consistently met the requirement to triage patients within 15 minutes and provide treatment within 60 minutes this is in line with the NHS England average. Audit data showed the reasons where 60-minute treatment times were not met, which was linked to high capacity and demand issues where the volume of patients was too high for the number of doctors present. The department's performance was close to the England average standard for similar units.
- The department had a doctor-led rapid assessment and treatment (RAT) process, with a registrar, which was operational for 12 hours each day. The RAT team

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reviewed all patients who came into the department by ambulance and fed back to the receiving coordinator what the plan of care would be what was required and also commenced the treatment plan.

- Staff used the National Early Warning Scores (NEWS) system during triage to identify sick patients who needed a review from a critical care nurse or doctor. We saw staff used a robust escalation process to send a 'call for concern' to the critical care outreach team, who were able to attend and rapidly review deteriorating patients. Children's nurses monitored sick paediatric patients using the paediatric early warning scores (PEWS) system as well as the SBAR tool.
- Staff tracked the amount of time each patient was in the ED and initiated a care round where this exceeded four hours. This triggered the use of the Anderson scores tool to assess pressure area risks.
- Reception staff and were trained in conflict resolution to help them respond appropriately in situations involving aggressive or upset people. The general manager was part of a violent crime oversight group with local police and fire services and ensured learning from this was shared with the ED staff.
- A nurse we spoke with told us they had called security to help them with an incident in the paediatric waiting area and said security staff responded very well and diffused the situation.
- We found the paediatric ED to be unsecured and access was not monitored routinely. This meant staff could not be aware of who was entering or leaving the department. We asked three nurses about this. They told us they did not always feel safe in the department, particularly as there was no longer dedicated security cover in the unit. There were no panic alarms in the ED and staff had to rely on being able to contact security staff by telephone. One nurse told us they had tried to call security during a previous violent incident and had been told to call the police instead. This meant we could not be sure staff and patients were always appropriately protected from the risks associated with violent patients or unauthorised persons on the premises.
- **Nursing staffing**
- At the time of our inspection 52 registered staff nurses staffed the ED with one unfilled vacancy. The matron told us although the recruitment of one additional nurse would mean the unit met the staffing levels established by the RCN as needed for an optimal safe service, an

additional three children's nurses were needed to open the paediatric ED 24-hours. A business case had been submitted for the nurses and was awaiting approval so recruitment could begin.

- Two emergency nurse practitioners (ENPs) were available 18 hours a day, seven days a week to provide clinical treatment and support to nurses and GPs and an advanced nurse practitioner had just been appointed.
- Nurse to patient ratios in the ED were maintained at a minimum level of 1:4, with additional support from EDAs, ENPs and an Associate Practitioner (AP).
- Two band seven children's nurses and five band five children's nurses staffed the paediatric ED between 0800 - 2200. Outside of these hours, there was not always a registered children's nurse on shift. This meant the unit did not always meet the requirements of the RCN 2013 Safe Staffing Levels in Children's Services that two registered children's nurses be available at all times. The matron had tried to mitigate the risks associated with this until more children's nurses were recruited by ensuring there was always an adult ED nurse with emergency paediatric life support (EPLS) training on shift. ENPs and band seven nurses with dual paediatric training were able to treat children with minor injuries. Children who arrived when the paediatric ED was closed were treated in the adult's minors area.
- The matron deployed nursing staff based on their level of training and experience, which meant each area of the ED was staffed by the most appropriately trained and skilled nurses. Training taken into account for staffing each area included skills in cannulation, phlebotomy, competency in plastering and splints, wound closure, major incident planning and life support skills.
- ENPs had access to the same training as nurses as well as leadership training. ENPs told us they had been offered collaborative learning with the medical team, which had helped to improve specialist practice.
- A team of band two and band three emergency department assistants (EDAs) supported nurses and the SEEDS triage function and were able to take blood samples, cannulate patients, apply wet dressings and apply Steristrips. This helped to alleviate pressure on nurses in the minors area.
- Senior staff supported EDAs to develop their competencies and skills and one individual had been supported to become a band four associate practitioner.

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- Nurse handovers took place three times daily, at 0800, 1300 and 2030. The 0800 handover was combined with the medical team.
- Nurse uniforms had been modified with colour-coding to assist patients and visitors to identify different roles and grades. For example, the supernumerary nurse in charge wore a red tabard to make them highly visible and ENPs wore a black uniform to indicate they were working as clinicians. The entrances to the ED and each bed space had a large colourful poster displayed, which included a colour picture of each type of uniform.
- Nurses were organised into teams, in each case led by a band seven nurse. This helped to ensure staff received consistent support and guidance.
- Nurse staffing levels in the resuscitation unit were sufficient for one person to two patients. A nurse we spoke with said staffing levels in resuscitation were a problem and told us, "There aren't enough nurses for the resuscitation unit but the nurse in charge is really good at finding us an extra nurse when we need it."
- **Medical staffing**
 - A clinical director who was also the lead consultant led medical care in the department.
 - The department had seven consultant grade staff, including one with a dual registration for adults and children's emergency care. Clinical staff and managers had secured funding for an eighth consultant to join the team. Of the seven consultants on the rota, six were permanently employed by the trust and the seventh consultant was a locum doctor on a long-term contract.
 - Consultant cover was provided in the department from 0800 – 2100 on weekdays and from 1000 – 1900 at the weekend, with an on-call consultant available outside of these times. Overnight an ST4 or ST5 grade doctor led the ED medical team.
 - The College of Emergency Medicine requirement was that 16 hours of consultant cover be provided per day. There were not enough consultants in the ED to consistently fulfil this requirement although this was sometimes met through an on-call system and consultants working additional hours.
 - We viewed the training records of the locum consultant and found they had been given an appropriate induction.
 - 15.6 whole time equivalent (WTE) ST4 grade doctors, 11 WTE ST3 grade doctors and 11 other trainee doctors staffed the ED in addition to the consultants.
- A consultant led a medical handover and board round four times daily. We observed four medical handovers and found them to be comprehensive and detailed and engaged junior doctors appropriately. We saw staff understood what their role was for the remainder of the shift and a good awareness of how to obtain escalation support.
- A dedicated registrar was available in the paediatric ED from 1000 – 2100hrs seven days a week. All consultants were trained in advanced paediatric life support.
- **Major incident awareness and training**
 - A full, simulated evacuation exercise had taken place in the twelve months prior to our inspection, which had tested the unit's call-out cascade processes and established responsibilities if a real situation was ever to occur. Staff had also taken part in a table-top major incident exercise to help them strategise how they would respond in the event of a major incident at Southend airport.
 - Senior staff had identified the security of the department as a risk and had included this on the unit's risk register. A security review had taken place as part of the unit's five-year plan. This was focused on business continuity and the inability to lock down the ED during an emergency situation. We saw senior staff had escalated this issue as far as possible and were awaiting support from the executive team, who were considering options.
 - Staff had implemented the major incident plan during an emergency in the year prior to our inspection. This had involved closing the department to new patients and ensuring those inside the ED were protected from harm, cared for and treated appropriately. The general manager had used the outcomes of this incident to identify areas for improvement in how the unit trained staff to respond in major incidents.
 - Staff had completed hazardous materials (HAZMAT) and decontamination training in December 2015, which had included the use of equipment and emergency procedures. HAZMAT response equipment was stored in locked cupboards to which only senior staff had access. A major incident folder was readily available in the ED, which included action cards to prompt staff during an emergency. Senior staff had reduced the number of action cards from 64 to 23 following a recent review, which enabled staff to provide a more focused, timely response during an emergency.

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- We found emergency procedures and policies to be up to date. This included a July 2015 major incident recording policy review and a June 2015 update of the chemical, biological, radiological, nuclear and explosives (CBRNE) procedures. 24 decontamination suits were available, all of which had up to date documented checks. Hand-held Geiger counters, handset radios and a battery-operated pop-up tent control centre were available and we saw that all staff had either undertaken training in their use or were booked onto a training course.
- The paediatric ED had no controlled access points and we found people could freely move into the unit without the need for an interaction with a member of staff.
- We checked all of the resuscitation equipment in the ED. We found staff had documented daily checks of the equipment and where items were found to be missing or defective, immediate remedial action had been taken.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



The emergency services were good in the effective domain.

Because;

- Staff contributed to a range of local and national audits, including those led by the Royal College of Emergency Medicine (RCEM). Performance in some audits was above the national standard for England and significantly below RCEM standards in others. We saw clinical staff had implemented re-audits to improve.
- Staff demonstrated a consistent awareness of patient needs in areas such as pain relief and nutrition and hydration, which was evidenced in the high standard of patient records.
- There was clear multidisciplinary working in the emergency department, including numerous specialty consultation services available on a 24-hour, seven-day basis.
- The whole emergency department team had access to on-going professional and clinical training.
- Awareness of, and adherence to, the requirements of the Mental Capacity Act (2005) was evident from our discussions with staff and our observations of care and treatment.
- Staff were well trained, highly competent and based their care and treatment on evidence-based practice.

Evidence-based care and treatment

- There was a clear protocol for staff to follow with regards to the management of stroke and sepsis. The department had introduced the 'Sepsis 7' interventions to treat patients. Sepsis 7 is a bundle of medical therapies designed to reduce the mortality of patients with sepsis. Staff also had access to care bundles for neutropenic sepsis. Children's nurses used a paediatric variation of the Sepsis 6 pathway after undergoing training by a specialist sepsis nurse. Staff conducted a monthly audit of consultant-sign off in neutropenic sepsis cases, which we saw had resulted in improved results.
- There were signs for the management of sepsis displayed throughout the department, including signs near hand washing stations and staff areas, which read 'Keep calm and think Sepsis 7'. Staff told us the signs were an effective reminder for them, which ensured they always followed best practice.
- We examined the records of four patients with suspected sepsis and found staff had followed the pathways appropriately, evidenced by a very high standard of sepsis care records. This showed us staff ensured a consistent standard of care in line with sepsis guidelines.
- Staff used the latest 2015 Resuscitation Council review of resuscitation practice and had electronic access to this when needed. A January 2016 pathway for patients with threatened miscarriages was in place and a new surgical pathway for appendicitis had been introduced.
- Staff highlighted orthopaedic and back pain pathways as an area of concern and the clinical lead had tried to resolve this with a new treatment protocol. This was overruled this, which resulted in on-going delays for referring patients to this medical specialty. Senior staff had escalated the problem to the executive team and at the time of our inspection were awaiting a decision about the next steps to take.
- We looked at the treatment guidelines available to staff on the intranet and in the department. We found up to date policies for the treatment of head injuries and

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upper limb fractures but the pathway for bronchiolitis was out of date. In addition, the integrated care pathway for diabetic keto acidosis was based on 2004 guidance from the National Institute for Health and Care Excellence (NICE), not the latest 2015 NICE diabetes guidelines review. However, we did not find evidence of an impact on care as a result.

- There were established protocols for the assessment and treatment of children arriving in the department. A streaming GP would see children within 15 minutes of arrival and send them to the paediatric ED, which improved the department's ability to respond quickly to individual needs.
- Staff in the paediatric ED provided care using the ED Paediatric Pathway 0-16 years.

Pain relief

- We looked at the records of 13 patients and found in each case a doctor had assessed pain and prescribed analgesia where appropriate.
- We saw staff assessed levels of pain and offered pain relief to all patients arriving by ambulance.
- ED nurses led audits in pain relief and the use of paediatric early warning scores (PEWS). Band seven nurses presented audit findings and learning to new doctors to shape teaching and development plans.
- All majors and resuscitation bays had a sign used by staff to indicate the patient's current pain score and analgesia given.
- Staff used the Abbey Pain Scale to assess patients who were not able to verbalise how they felt.

Nutrition and hydration

- Staff had identified and recorded risks of malnutrition and dehydration in patient records and completed nutrition tracking charts were appropriate. A dietician was available on-call to provide additional support for patients with complex needs.
- Sandwiches and juices were delivered to the ED at two-hourly intervals during the day and 20 sandwiches were delivered in preparation for night shift. Staff were able to order hot meals for patients and their relatives if needed and they offered snacks and drinks during regular comfort rounds.
- We saw patients were offered food and drink at frequent intervals during our inspection where clinically safe to do so.

Patient outcomes

- Staff had contributed to the 2014/15 Mental Health in the emergency department Royal College of Emergency Medicine (RCEM) audit, in which the department presented positive results. This was demonstrable of a broad approach to caring for and treating patients with mental health needs.
- The department had performed poorly in some other RCEM audits, such as the Assessing Cognitive Impairment in Older People, Management of the Fitting Child and consultant sign-off audits. In a 2014/15 audit sample, none of the parents of the children treated had received written safety information on discharge. The RCEM requires 100% compliance with this standard.
- The RCEM requires all older people presenting in an ED to have a NEWS score documented. In the 2014/15 audit sample at this trust, no patients meeting this criteria had a NEWS score recorded. We saw doctors recorded NEWS scores appropriately in patient notes and the department would be in a position to contribute data to the next audit cycle.
- In the latest available data, a consultant had seen or discussed a patient in 4% of cases, which was significantly lower than the England and RCEM standard. In the same sample group, a doctor of ST4 grade or higher had seen the patient in 73% of cases, which was in the upper region of England ED units.
- In the management of active seizures where the child was actively fitting on arrival audit, 100% of children had been managed using established life support algorithms.
- We saw the clinical lead had established targets for re-audits and doctors were responsible for identifying areas for improvement and presenting evidence of this.
- In the 2014/15 year, a mental health practitioner had assessed 5% of audited patients within one hour of arrival. The RCEM standard for this is 100% of patients to be seen within one hour.
- The general manager tracked unplanned re-attendance rates and we saw these were discussed during quarterly directorate meetings. Minutes from the October 2015 meeting indicated a 0.6% reduction in unplanned re-attendances, which staff were reviewing to achieve a further reduction by improving community treatment pathways. The national standard for unplanned re-attendance is 5%, which the trust had not met in the twelve months prior to our inspection. However, rates

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were consistently better than the national average. For example, between January 2015 and July 2015, the England average for unplanned re-attendances was at or above 7.2%. In the same period, the trust's rate was between 5.8% and 7%.

- An advanced paediatric life support algorithm was available in the department although this was dated 2010. This meant it was not clear if staff were using the most up to date guidance available.
- The paediatric ED had a resuscitation bay and the main resuscitation unit had a paediatric bay and a flexible bay for a child or adult. If a child needed to be cared for in a resuscitation bay, they would most often be brought to the main resuscitation unit where staffing levels were higher. A paediatric nurse would accompany them from the paediatric ED and an ED nurse with EPLS training would temporarily swap places with them in the paediatric ED.

Competent staff

- The General Medical Council had revalidated all medical staff within the department and all doctors had received an appraisal in the last 12 months. The service manager ensured staff maintained up to date professional registration.
- Junior doctors were allocated education days and were required to begin their continuing professional development (CPD) programme immediately on commencing their role. We saw consultants supported junior doctors to maintain their CPD as part of the appraisal process and had provided regular reviews.
- Junior medical staff who were allocated a rotation in the ED often arrived without having undertaken dedicated skills training or CPD prior to joining the department. This meant senior staff had to allocate additional development time to them, usually every six to eight months.
- Medical students in the ED were supported by the ENPs, who we observed offering tuition and supervision.
- Nurses with an appropriate level of experience and competence were able to take an advanced trauma nursing course (ATNC), which the matron used as part of a development programme they said was designed "to keep nurses excited about working here."
- Trainee paediatric nurses completed a six month rotation on a children's medical ward as well as a six month rotation in the paediatric ED to help develop their competencies.

- 86% of nurses had received an appraisal in the 12 months prior to our inspection. Nurses we spoke with were positive about the appraisal process. One individual said, "[Managers] are quite hot on appraisals, I always get mine on time. There's always time to keep them up to date and we get to set goals that we are supported to meet."
- Band five nurses were supported by band six or band seven nurses to take their preceptorship, which we received unanimous positive feedback about.
- The trust had recruited nurses internationally to address shortfalls. We found ED nurses recruited from outside the UK had undergone an enhanced four week trust wide induction programme followed by a further four weeks of induction in the ED.
- A practice development nurse had recently been appointed and was available five days per week to support staff in the development of basic ED skills, including suturing and plastering as well as professional development.
- EDAs and nurses underwent a two week supernumerary period as part of their induction and received a one-to-one introduction to the whole ED team at the start of their appointment.
- Senior staff told us they were concerned about the turnover of middle-grade doctors. As a result they had implanted a 'step-up' programme, which enabled junior doctors to receive structured training to take on additional responsibilities. The senior team supported middle grade doctors to achieve Fellowship status of the CEM within two years of commencing their training.

Multidisciplinary working

- The clinical team in the ED, made up of doctors, nurses, emergency nurse practitioners, emergency department assistants and an associate practitioner formed a specialist, cohesive multidisciplinary team. GPs, administrators and clerks were very much part of the ED team and demonstrated consistent, well-developed collaborative working.
- The hospital's stroke team worked with ED nurses to develop thrombolysis competencies, which included the support of stroke link nurses. This demonstrated an on-going development of stroke pathways, including the attendance of an anaesthetist with the stroke team when they attended resuscitation. We found staff used an established stroke pathway, which was understood by all of the nurses and doctors we spoke with.

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- The streaming GP from the SEEDS service worked closely with the ED consultants and ENPs. For example, the GP was able to initiate analgesia and provide prescriptions for minor complaints and refer patients with chest pain or respiratory distress to the majors section.
- Mental health staff from SEPT operated the mental health suite with the assistance of a healthcare assistant trained in emergency care. This was a 24 hours, seven days a week service to which streaming and triage staff referred patients using established treatment criteria. A crisis coordinator, a registered mental health nurse and a registered nurse staffed this team. There was a doctor on-call 24-hours, seven days a week and there was a clear referral pathway to community crisis services. Staff could contact a crisis resilience home treatment team to help them support patients who had entered the ED from a community setting with needs relating to alcohol dependency.
- Mental health facilities in the department met the standards set out by the Psychiatric Liaison Accreditation Network.
- Staff had access to an associate practitioner for dementia services as well as the hospital to home team to ensure patients with social care needs received an appropriate discharge into respite care or home with a care package. This relationship ensured patients with dementia or mental capacity concerns received holistic care. For example, if a patient who lived in the community with dementia had experienced a fall, staff in the ED would treat their injuries and then refer them to the dementia service who would look at why they had fallen.
- A physiotherapist was based in the ED from 0800 to 2000, seven days per week. Physiotherapy facilities were available in the ED, which meant patients could be seen quickly and without the need for an immediate referral to another department or site.
- Following an increase in ED attendances by people under the influence of alcohol, an alcohol liaison nurses visited the department on a daily basis to identify patients who might benefit from their intervention.
- Psychiatric liaison nurses were available to attend the department for patients who needed a specialist assessment and who were not under the influence of alcohol.

- A fortnightly multidisciplinary team meeting took place in the unit and acted as a learning session to share good practice and identify areas of concern.
- We observed a consistent level of communication between ED staff and paramedics. This included staff offering reassurance to patients and relatives and explaining what would happen in the ED.

Seven-day services

- A pharmacist visited the ED seven days a week to check and rotate drug stock.
- A physiotherapist was available to attend the department between the hours of 0800 – 2000, seven days a week. Occupational therapists, the hospital to home team, a diabetic nurse and a range of community rapid response teams were also available seven days a week.
- The alcohol liaison team and psychiatric liaison nurses were available on-call 24-hours, seven days a week.
- An X-ray and CT scanner were located adjacent to the ED and were available 24-hours, seven days a week.

Access to information

- The associate practitioner for dementia services had access to patient notes and could look for an historic diagnosis of dementia if ED staff were concerned about a patient's mental condition. This meant staff could more rapidly differentiate between dementia and delirium in a patient not previously known to them.
- From looking at the records of 15 patients, we saw doctors had access to medical histories and past test results. For example, we found a patient was referred to the outpatients cardiac clinic after a clinician reviewed their past medical notes with their presenting symptoms in the ED.
- We saw discharge plans were detailed and included information relating to specialist follow-up clinics.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a good understanding of the Mental Capacity Act (2005) and their responsibilities with regards to this. We saw staff used an enhanced observation sheet for patients with reduced mental capacity, which they used to determine the frequency of observations needed.

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- 47% of staff had up to date Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) training. This was below the trust target of 85%.
- An appropriate member of staff had recorded a mental capacity check and documented consent in all of the patient records we looked at. We observed a discussion between a patient, their doctor and nurses about their degree of mental capacity because they wanted to leave the ED against medical advice. We saw staff spoke to the patient with respect and conducted an appropriate mental capacity assessment to ensure they were able to make their own decisions.

Are urgent and emergency services caring?

Good



The emergency services are good in the caring domain.

Because

- Staff demonstrated a consistently compassionate, empathetic and caring approach to communicating with patients, their relatives and friends.
- We saw staff were able to adapt their communication to be able to speak meaningfully with patients who were vulnerable or had mental health needs.
- Nurses we observed demonstrated an exemplary approach to speaking with young children and adolescents and this was echoed by a reception team that demonstrated unwavering awareness of patient anxiety and attention to detail in making people feel welcome.
- We saw staff involved patients and their relatives in decisions relating to their care where appropriate and doctors offered private spaces when discussing bad or unexpected news.
- Staff had access to counselling and community mental health services on a 24-hour, seven-day service, including a bereavement service.

Compassionate care

- We saw staff offer compassionate and sensitive care to a family who had accompanied a critically ill patient.
- In October 2015 the latest available results from the Friends and Family Survey indicated 86% of patients would recommend the department, which was below

the England average by 1%. In the previous 12 months, this measure of satisfaction had remained consistently above 84% in each month, with a high score of 87.4% in January 2015. The matron had started to use the help of hospital volunteers to increase response rates by handing out surveys to patients and their relatives. We saw this in practice and found volunteers approached people sensitively and with consideration of their situation.

- The department had a process which enabled them to gain feedback of the service from sample patients following discharge.
- During one observation we saw a healthcare assistant who was assisting the SEEDS triage team did not offer an appropriate level of care to a patient who was waiting to be seen. For example, the patient did not understand the triage process or how patients were prioritised and asked why a patient who had arrived after them was being assessed first. The healthcare assistant said, "Well you'll see another doctor. I don't know what they'll do." We saw the patient was left in an anxious state after this. We asked the general manager about this who promised to follow it up immediately.
- This was not representative of our other observations in the waiting area, during which time we observed reception staff give patients and their relatives a very high level of friendly interaction. In one case a patient was visibly delighted when the whole reception team said, "Bless you!" when they sneezed. This attention to detail ensured patients were treated as individuals and showed us reception staff understood how to calm their nerves and make them feel welcome.
- We saw a young patient arrive in the department on foot but who was struggling to walk. A receptionist noticed this before the patient had entered the building and proactively retrieved a wheelchair and took it to help them.
- We asked 13 patients about their experiences in the ED. In all cases people were positive above the level of care they had received. One patient said, "Everyone here in the A&E is very nice." We observed a personal, caring approach from all staff in the ED. For example, we observed a porter get a blanket for a patient who was waiting to be moved and who appeared to be cold. The patient was very happy with this and told us everyone they had encountered was "lovely."

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Understanding and involvement of patients and those close to them

- We saw staff communicated with patients clearly and professionally. For example, an ENP nurse explained a patient's condition to them as well as the investigations they would receive and the treatment plan. In the paediatric ED we saw nurses explained treatment plans to parents and explained to children what their symptoms meant using age-appropriate language. Staff distracted younger siblings as needed.
- We asked five patients about their experience in the ED. In all cases people told us they had had been treated well and with respect. One person said they appreciated staff keeping them up to date with what was happening and another person said they appreciated how staff had helped to keep their two young children calm and distracted. All of the patients we spoke with said a doctor had explained their condition and treatment to them within one hour of arrival. One patient said, "Staff are very polite, very lovely. They have all introduced themselves and explained themselves fully. I couldn't be in a better place."
- One patient we spoke with told us they were pleased staff had kept them informed about their assessment and treatment at regular intervals. All of the patients we spoke with said they had received pleasant and friendly service from receptionists although this had not included an estimated waiting time.

Emotional support

- We saw staff treated the parents of a child with a learning disability with respect and dignity, including an acknowledgement that they were exhausted from a sleepless night. Staff demonstrated a naturally caring attitude and reassured the child's parents with an informative and simple explanation as to their condition and treatment plan.
- Staff could refer patients and their relatives to a 24-hour, seven days counselling service where needed. There were also established links with community counselling services, which we saw staff were able to signpost patients to.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good



The emergency services are good in the responsive domain

Because;

- Staff demonstrated an exceptional level of understanding and attention to detail in meeting the individual needs of patients and their relatives. This included ensuring there was provision for people with dementia, learning disabilities or who were experiencing homelessness.
- A wide range of clinical specialties was available on a 24-hours, seven days basis for staff to refer patients to and we saw the emergency department (ED) team demonstrated excellent awareness of these.
- The leadership team had implemented a number of mitigating strategies to address delays in access and flow, including the innovative introduction of multidisciplinary roles at peak times to help assess patients and the efficient use of the on-site GP triage service.
- Senior staff took complaints seriously and we found evidence of learning and subsequent changes in practice as a result.

However;

- The department had experienced several months of prolonged, exceptional demand on its services. As such, national standards of times to treatment or discharge had not always been met.

Service planning and delivery to meet the needs of local people

- Staff worked with the hospital to home team to ensure the needs of the local elderly population were met. For example, staff could request assistance with discharge processes from social workers, a physiotherapist and occupational therapist to help them ensure a patient would receive appropriate care at home or in their community facility.
- A policy was in place to help staff care for people who arrived under a police escort. This included the removal of suction or oxygen equipment from an assessment bay to reduce the number of items that could be used as weapons.

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- Additional capacity in the alcohol liaison team had been provided to address the needs of patients with alcohol-related conditions.
- A significant expansion in on-site mental health services had been completed to ensure patients with complex or challenging psychological needs could be cared for and assessed in an environment that did not trigger or escalate anxiety-related behaviours.
- Local service users who attended our 'listening event' ahead of the inspection told us they were concerned about the impact the closure of a local urgent care centre would have on the Southend ED. We asked the clinical services manager, general manager and matron about this and found they had established plans to mitigate the impact this would have on waiting times as well as sustain the needs of the local community. This included implementing a 'navigator' at the entrance to the ED to redirect patients to pharmacies or GPs if they could be treated more appropriately there. Staff were also working with local GP services to secure protected slots that could be used for patients with minor complaints.

Meeting people's individual needs

- Paediatric staff worked with local children and young people's mental health services (CAMHS) to ensure that services could be accessed in a timely way. We looked at the CAMHS crisis assessment protocol staff used in the department and found it to be undated. This meant it was not clear if staff were working to the latest available guidance.
- Mental health liaison services were available in the trust 24-hours, seven days a week. A new mental health assessment suite had recently opened following a period of consultation between ED staff and the mental health team provided by SEPT. This enabled the team to provide a calm and quiet area for patients who required a mental health assessment away from the main ED, which could be busy and noisy. There was also a further waiting area in the department, which met the needs of those with mental health concerns who needed to be supervised by police or cared for in a private room.
- The development of the suite had resulted from learning from complaints and incidents and the need to improve services and facilities for people attending the department with mental health needs. We found ED staff had a good understanding of the referral processes to ensure the mental health team could assess patients and this facility reflected an innovative approach to ensuring the service met the needs of the local population. Patients had to be fit for discharge or assessment before they were able to use this service.
- A private adolescent room was available in the paediatric ED but staff told us mental health referrals for adolescents could be a slow process, although an on-site liaison nurse often assisted this.
- Staff had access to a telephone translation service, 24-hours, and seven days a week.
- A link nurse champion for learning disabilities had received training in understanding learning disabilities and complex needs and provided support and instruction to other ED nurses. The learning disability nurse was available Monday to Friday and we saw outside of these hours staff had access to policies and guidance on the intranet.
- Leaflets on a variety of conditions including back pain, flu, choosing pathways of care and when to access emergency care were available to patients in the reception area. The leaflets available were in English and Polish; other languages were available on request. Information was also provided for patients with regards to the College of Emergency Medicine (CEM) Fitting Child Audit 2014/15 and how ED staff would care for children who experienced febrile fits.
- Information was available to patients on support processes to help living with long term or chronic conditions such as diabetes and pain and how to avoid admissions.
- Staff used a 'bumblebee pin', attached to the outside of bed-space curtains, to indicate when they were having difficult conversations with people. The pin was an indication staff should not be disturbed and the patient was to be given a high level of privacy. We observed the pins in use during our inspection and saw they were an effective tool to ensure privacy and dignity was observed.
- Staff had access to a dementia-friendly newspaper for patients who remained in the ED for longer periods of time, which helped to reduce anxiety and confusion.
- A learning development nurse worked with ED staff to convert a majors cubicle into a space suitable for patients with autism and dementia. This represented the embedded approach to meeting the needs of patients with learning disabilities shown by ED staff. This approach included adaptations of hospital leaflets into

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a more accessible format, using pictures in place of words. Staff had also produced a video for patients to explain basic ED processes and what patients could expect in the department.

- A former ED nurse had moved into an associate practitioner for dementia services role and provided dedicated support and guidance to ED staff to help them care for patients with dementia. The practitioner had worked with matrons around the hospital to establish a new dementia strategy, which was of particular relevance to ED staff. Although dementia training was not mandatory in the hospital, ED staff had been given dementia training by the associate practitioner and had resources to help them obtain specialist guidance when needed. A blue flower on the ED whiteboard provided a visual cue to staff that a patient had been diagnosed with dementia.
- The associate practitioner for dementia services was a member of the Dementia Action Alliance Group and had provided staff with training on communicating with people living with dementia as well as specialist training for paramedics in treating patients with dementia.
- Staff could book an admission to a day unit in the hospital for patients with dementia who expressed a wish to leave the department but who were too unwell to go home. In this case a doctor would visit the patient in the ED and liaise with the hospital to home team to make sure they were medically fit to leave the department.
- Reception staff had undertaken dementia training to help them provide support to patients on arrival.
- Staff used the electronic patient tracking system to flag people with a learning disability. This process was followed to trigger a learning disability checklist for staff to follow to ensure assessments and treatments were provided appropriately.
- The lead consultant for medicine was also the lead for HIV services and staff could contact them for additional support, alongside an HIV link nurse when they needed help to provide care for an HIV-positive patient or following a needle stick injury.
- Staff had established a relationship with a local homeless shelter, which had provided printed signposting cards to help staff communicate with people. ED nurses were also able to work with the on-site mental health team to support patients who were homeless and ensure they were discharged appropriately.
- Patients who attended the ED frequently were discussed during CCG meetings and senior nurse meetings. Staff could arrange for a mental health assessment where appropriate and had also liaised with local GP practices to provide alternative arrangements if a person's treatment in the ED was clinically inappropriate.
- Clinical staff led the triage process supported by EDAs, who were able to identify patients who would benefit from a mental health assessment at this stage. This meant they could trigger a consultation with the on-site mental health team and provide rapid access to the mental health suite.
- Nurses were encouraged to take on a specialist link champion role to develop audits, practice and education in specialist areas. Nurse champions included sepsis, safeguarding, major incident planning, oncology, organ donation, stroke, student nurse support, mental health, substance misuse and domestic violence. The hospital's trauma lead had worked with an ED nurse to establish a trauma champion role and a new link role had been created in the paediatric ED for child female genital mutilation (FGM).
- Two relatives rooms were available in the department, including facilities to prepare drinks and a chapel was situated in the main ED.
- A water machine was available in the waiting area.

Access and flow

- The England national standard for patients to be admitted, transferred or discharged within four hours of arrival is 95%. This department met or exceeded this standard on six occasions between August 2014 and October 2015. The department's worst performing date was in September 2015 when 89% of patients were seen within the four hour target. The department performed best in August 2014 and September 2015 when 96.8% and 97.6% of patients were seen within four hours, respectively. The trust was typically within 3% of the national England average during this period.
- We monitored 40 patients during our inspection to check their triage, assessment and treatment times. We found the national four-hour target for a patient to be seen was not being met but this was due to a lack of available beds elsewhere in the hospital. Staff successfully achieved the 15-minute time to initial assessment in all cases and treatment decisions were

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made within an appropriate time frame. Where a decision to admit was made, this was within two to three hours of arrival. The delays and breaches came due to a lack of bed availability in the hospital.

- Staff used a surge capacity protocol to alert other departments in the trust when the ED was experiencing extremely busy periods. We observed the department activate this protocol, which involved the use of a 'red alert' system to respond to increased demand. This included the use of an additional triage and assessment area and deployment of the rapid assessment team (RAT) to the ambulance bay.
- The department performed consistently better than the England average for patients waiting between four and 12 hours to be admitted and had reduced the number of patients leaving without being seen since March 2014. Between September 2014 and August 2015, two patients waited over 12 hours to be admitted.
- Patients waited an average of 53 minutes for a clinical assessment following triage in the year October 2014 to October 2015. This had been impacted by lengthy ambulance delays due to a lack of capacity elsewhere in the hospital to which to transfer or admit patients.
- The average time patients spent in the ED waiting to be admitted increased from 5 hours 52 minutes in August 2015 to 6 hours 13 minutes in September 2015. Senior staff discussed this as part of a quarterly governance meeting and had identified the introduction of a medical model in the exit flow from the ED as a contributing factor.
- The department had not met the trust's target of a turning around 85% of ambulances within 15 minutes but the percentage of arrivals achieving this had increased from 48.9% in August 2015 to 51.7% in September 2015.
- Senior sisters used monthly meetings with multidisciplinary colleagues to discuss strategies to improve patient flow through the ED. For example, in September 2015 ED sisters had discussed the issue of the stroke service not accepting some stroke patients and instead referring them to other services. This had resulted in delayed patient flow from the ED.
- Between October 2014 and October 2015, there was a consistent rise in the number of ambulances waiting over 30 minutes on arrival. In October 2014, 232 patients who attended the ED in an ambulance had a delayed admission over 30 minutes and in October 2015 this

figure was 409 patients. This figure had decreased to 375 in December 2015 and early January 2016, which was due to improved capacity in medical wards and specialties elsewhere in the hospital.

- Between June 2014 and May 2015 there were 560 black breaches, where handovers from ambulance arrival to the patient being moved into the ED took longer than 60 minutes. The largest number of black breaches (127) occurred in December 2014. Staff in the department had continually worked to decrease the breach rate, with a reduction to 62 recorded in November 2015.
- Staff described the main reason for the breaches as the prolonged three-month black alert status of the trust. A black alert is declared when an exceptionally high number of patients result in increased pressure on staff and services. We reviewed this situation as part of our inspection and found the number of black breaches was often due to a lack of available space within the department. Staff had implemented escalation plans for when the department reached capacity and ambulance arrivals breached the process for patient assessments. One plan to address this was the introduction of a (HALO) role. There were two HALOs during peak hours in the department for up to 12 hours. HALOs were supplied by a local ambulance service and would be experienced paramedics with knowledge of control and command structures. We saw this had reduced ambulance waiting and turnaround times and staff in the ED told us how this role provided a high degree of access and flow support to them. In addition, when staffing levels allowed, the matron would assign a second RAT team to assist in the ambulance bay. The clinical director and consultants informed us it was their aim to achieve a second RAT team on a consistent, responsive basis within the next year when more staff were due to arrive.
- The matron, clinical lead, general manager and clinical service manager attended a weekly meeting to discuss breaches in the department. This included analysis of how staff used the escalation plan and data from the electronic patients record system that listed reasons for each breach.
- Senior staff reviewed a daily report of black breaches to identify areas where processes could be improved or streamlined. This included a review of mitigation strategies such as the RAT team and HALO and how well the SEEDS streaming service had worked. A new emergency department assistant (EDA) role had been introduced in an initial assessment function. The EDA

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would assist incoming paramedics, take initial observations and conduct an initial assessment. This helped to reduce waiting times for patients arriving by ambulance.

- During times of exceptional demand on the service, patients were brought from waiting ambulances into the unit to have an initial assessment and blood tests and were then sent back to the ambulance until space was available in the department. Staff recognised this was not an ideal solution to capacity problems but it was used as a temporary mitigation strategy to reduce patient delays.
- The paediatric ED closed at 21:00 daily. If a child was still in the unit at this time, staff would assess them for transfer to a children's ward or treat them in a separate minors bay away from adult patients.
- Senior staff had introduced a strategy to improve the overall flow rates of the ED, using a well-defined and robust 10-step process. This strategy included definitions of time to treatment and assessments targets for staff as well as processes for the onward referral of patients to medical, surgical, oncology and paediatric services. The process ensured patients who presented at the ED having been discharged from another specialty service would be referred back to that service within 30 minutes of assessment. In addition, specialties elsewhere in the hospital were not able to insist ED staff conducted investigations that did not contribute to the immediate management of the patient. This revised approach to how the ED operated was intended to streamline assessment and referral processes and ultimately reduce delays and backlogs in the department.
- We spoke with 13 patients about their experience of the ED and the time they had spent there. In all cases we were told the pace of the service had been appropriate. One patient said, "It's a busy department but it seems to be working well. I saw a doctor much quicker than I thought."

Learning from complaints and concerns

- The matron and ED consultant responded to all complaints in the first instance and implemented an investigation plan. It was planned that the senior nurse in charge of the shift referred to in the complaint would lead the investigation and resolution in the future.
- We saw the introduction of a new reception supervisor and provision of additional support and supervision for

this team had addressed previous complaints regarding the attitude of some reception staff. Reception staff had also undertaken a customer care course to help them meet the needs of patients and visitors. Complaints received about the SEEDS service had not previously been dealt with in a manner that adhered to ED or trust standards. Although the trust was not responsible for complaints made to SEEDS, patient experience had been impacted and senior staff were keen to ensure everyone visiting the department had a positive experience. The general manager had established a working relationship with a new SEEDS management team and was assisting in their response to previous complaints.

Are urgent and emergency services well-led?

Outstanding



The emergency department services are outstanding in the well-led domain

Because;

- This reflected the robust, well-respected and clearly defined leadership structure we found in the department.
- Committed professionals who recognised the need for a stable and well-supported team of staff who were proud of their contribution to the running of the service led the department.
- Staff we spoke with had a clear definition of the vision and strategy for future service development and told us they understood how managers were trying to ensure the department was sustainable.
- We found a strong positive attitude amongst staff when we asked about their morale and the culture of the service.
- We found senior staff had implemented a number of strategies to ensure the department's team was stable and committed to future success in service provision, including a significant financial loyalty bonus and support for student nurses and middle-grade doctors.
- The leadership team had clearly identified the challenges the department faced and we found extensive evidence of their work to overcome these.

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- Senior staff had a clear and sustained approach to developing staff and supporting them to progress professionally, with a focus on improving patient care.

Vision and strategy for this service

- Senior staff in the unit told us they felt “genuinely listened to” by the executive team and were confident their plans for the service, as well as their concerns about capacity and flow were being addressed. This relationship had resulted in business plans being successfully presented by unit staff to the executive team to secure funding for a learning disabilities specialist bay in majors and the provision of a sensory room for the paediatric ED.
- Staff we spoke with were clear about the vision and strategy for the department in relation to service development and continuation, particularly with regards to the expansion of hours for the paediatric ED.

Governance, risk management and quality measurement

- Senior staff were focused on the stabilisation and development of the workforce to ensure the service was able to provide care and treatment for the consistently high number of patients it saw. To address this, they had introduced a recruitment and retention bonus for nursing staff, a more robust training programme for junior doctors and significant opportunities in professional development for all staff. Staffing levels in the paediatric ED were also a priority of the senior team, who hoped to recruit an additional three full time paediatric nurses to enable a 24-hours, seven-day service.
- The general manager, matron, clinical director and clinical service manager used a six weekly governance meeting to review unplanned re-attendance rates, the average total time patients spent in the department and other issues relating to patient flow. We saw effective progress had been made in the year prior to our inspection, such as the introduction of a hospital-ambulance liaison officer (HALO) to reduce ambulance turnaround time.
- Staff used regular meetings to discuss risks that concerned them in the ED. For instance, senior sisters had rearranged equipment and staffing plans in the resuscitation unit to ensure paediatric patients would be treated safely and quickly in an emergency.
- Senior staff were proactive in exploring solutions to staffing problems, such as the need for more paediatric nurses. We saw the leadership team were timely and proportionate in their presentation of business cases to address the key departmental risks to the senior trust executive team.
- We asked senior staff about delays in admitting patients to specialist services. They told us although clinical staff used the surge protocol to request acute medical, geriatrics or surgical doctors to come to the ED to ‘see and treat’, because the trust does not hold medical staff to account when the emergency department requires specialist service support, this process does not always work effectively.
- The trust declares a high number of black alerts and the focus of the executive team to support the emergency department was observed by us to be seen as a priority.
- Senior staff maintained a risk register, which demonstrated allocation of risk management processes to an appropriately qualified and experienced individual. We saw this was monitored effectively and action had been taken to reduce the impact of identified risks. For example, following an incident of the mislabelling of blood, senior staff had met with pathology colleagues and introduced a competency check for each member of ED staff. A bloods record sheet had also been placed in each cubicle and staff had been trained to label bloods in the cubicle rather than outside at the nurse’s station. This had resulted in a resolution of the risk. Staff we spoke with were aware of the risk register and understood the nature of the most significant risks to the service. We saw these risks and they were present on the risk register.
- The introduction of the mental health suite had resulted from an on-going collaboration between ED staff and mental health specialists from South Essex Partnership University NHS Foundation Trust (SEPT) to address risk concerns about facilities to appropriately treat patients with mental health needs. Funding for the suite had been obtained after staff had successfully presented the need for such a facility at a funding summit.
- The CSM was positive about the department’s relationship with the Director of Nursing and said they were working together to improve the department’s relationship with medical heads of service to improve patient pathway referrals.
- An ED consultant was also the unit’s governance lead and delivered fortnightly audit and educational

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meetings with a consultant colleague who acted as an audit lead. The meetings were used to engage staff with learning from complaints and to facilitate robust team-working practice. The service manager and matron continued the focus on audits and learning from them by encouraging staff to engage in re-audits and service improvement, such as in the sepsis audits.

- We saw that where other providers delivered on-site services, a standard operating procedure (SOP) governed the relationship and six-weekly meetings between senior staff from both providers ensured staffing levels were appropriate and incidents were responded to.

Leadership of service

- We saw robust and consistent leadership from the clinical director, matron, general manager and clinical service manager (CSM). Care and attention had been given to the experience and skill mix of the senior team so they could influence the development of the department. For example, the CSM had used their MSc Leadership and Healthcare to support the operation of the department and the significant experience of the senior team contributed to a unit in which passionate staff were rewarded.
- The consultant body demonstrated clear leadership and support to junior staff and three junior doctors we spoke with said they felt well led and supported by consultants.
- The senior nursing leadership team worked well together with a supernumerary nurse in charge of each shift. This role worked closely with the department coordinator to manage the efficient triage, assessment and flow of patients.
- The nurse in charge, clinical director and coordinator demonstrated their good working relationship was embedded into the leadership of the department.
- Where leadership development needs had been identified by nurses for doctors, or doctors for nurses, these were shared openly amongst the leadership team and enabled staff to obtain the leadership development support they required.
- The divisional managers of the service were present, visible, worked well as part of the team and were fully engaged in the running of the service with clear lines of accountability. This included corroborating the messages to give at each operational bed meeting regarding the status of the service.

- Support from the divisional management team to the ED management team was not consistently evident regarding the culture and procedures of other services that resulted in poor working relationships. For instance, ED staff had a perception that it was difficult to admit patients to some specialities. Members of the divisional management team we spoke with acknowledged this, however no action had been formally taken to help resolve the disconnect between medical specialties and the ED. The senior ED team told us they felt support from the divisional management team had improved recently. One senior member of staff said there was now “real support” from the divisional team to help improve this and said they felt this was reflective of isolated attitudes from specific wards rather than from clinical directors as a whole.
- Senior nurses were able to take a local leadership course to support their management development. This was through the study of a specialist module, which including topics such as managing difficult conversations, conflict management, performance management, communication skills and motivating others.

Culture within the service

- The senior team used a process of empowerment to support band seven nurses to exercise more proactive and robust influence in the use of medical referral pathways. It was hoped this process would enable a more efficient relationship to be established with medical specialities and enable senior nurses to contribute to the achievement of more frequent four-hour referral times.
- All of the staff we spoke with told us how proud they were to work for the service and they felt opportunities for development were a highlight of the support provided to them. One nurse said, “It feels vibrant here. I’m really thrilled to be a part of it.”
- The trust had provided training in the Duty of Candour for staff, who were able to confidently explain their role in this.
- Several staff in the department had worked in the ED on a long-term basis; in some cases over 20 years. Staff who had worked there for a shorter time told us they intended to stay. One individual who had worked there

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for seven years said, “This is the best team I’ve ever worked in. The managers and the matron are superb. It feels like a family, it never feels that I’m being looked down upon.”

Public engagement

- The ED contributed to the national Friends and Family Test. This was prominently advertised in several areas of the department. The department also engaged people through the A & E survey, which staff used to improve patient experience. For example, 2014 A & E survey results indicated patients were not always told what their medication was for and did not always feel reassured when they were anxious. Staff addressed both of these areas.
- Staff had engaged with the family of a patient who had presented in the ED with dementia. The family had highlighted a number of areas for improvement in dementia care and staff had produced a video with them, to indicate the specific needs of patients with dementia.







Staff engagement

- Senior staff prepared a monthly newsletter to ED staff to provide updates on the learning and outcomes of complaints and incidents. We looked at the newsletter and saw it included details of items on the risk register, performance indicators and feedback from compliments and complaints.
- Staff at all levels described an engaging and collaborative culture in which their views and skills were recognised. A nurse told us there was a positive working relationship between doctors and nurses, with respect shown both ways.

Innovation, improvement and sustainability

- We saw there was improvement of the service since the last inspection (7 August 2014). For instance the provision of a dedicated paediatric emergency department.
- Senior staff had introduced a number of new policies and practices to help stabilise the workforce. This included a 5% recruitment and retention pay bonus to new nurses as a strategy to attract new talent and ensure the service was sustainable during a prolonged period of exceptionally high demand. Bank nurses were moved from monthly to weekly pay and nurses were organised into structured teams to provide them with clearer lines of support and accountability. Middle grade doctors were offered enhanced pay to work to a specialty contract and the service paid for their life support training and trauma course. As a combined approach this had resulted in fewer vacancies and higher staff morale.
- Student nurses were welcomed in the unit as a strategy for future recruitment and nurse sustainability. Students were able to shadow EDAs and watch processes such as cannulation as part of their learning.
- The role of the navigator in response to the closing of a nearby minor injuries service was innovative to meet the needs of the public and manage the flow in to the ED
- The response to the black breaches by undertaking initial tests before a cubicle was available was a good escalation process and response. In addition to this the use of the two HALO’s to further support patients at times of high demand.

Medical care (including older people's care)

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

Information about the service

Southend Hospital between July 2014 and June 2015 had 43,785 medical admissions.

Medicine specialities included elderly care, diabetes, respiratory medicine, renal medicine, cardiology, stroke and neurology, gastroenterology, haematology and oncology. The trust had an acute medical unit (AMU) which incorporated a short stay ward. There was a stroke unit with 14 acute stroke beds on Benfleet ward and 26 stroke/ neuro rehabilitation beds on Paglesham ward. The stroke unit provided a 24-hour seven days a week thrombolysing service (to break down the clots which cause some types of strokes), a renal unit with 28 haemodialysis stations and a cardiac care unit.

During our inspection, we visited Benfleet (the acute stroke unit), Blenheim ward (renal and general medicine), Eleanor Hobbs (gastroenterology, diabetes and endocrine, general medical), Bedwell (the acute medical unit), the endoscopy unit, Elizabeth Lorry ward (oncology and haematology), the chemotherapy day unit, the discharge lounge, Sita Lumsden (the coronary care unit), Gordon Hopkins (the cardiac rehabilitation ward), Windsor (elderly care), Rochford and Westcliffe wards (respiratory medicine) Princess Anne ward (elderly care) and the renal unit.

The CQC inspection of medical services was undertaken announced between 13 and 14 January 2016. We also visited unannounced on 24 January 2016. We spoke with 78 members of staff, including nurses, doctors, therapists, managers, healthcare assistants and housekeepers. We

spoke with 35 patients and seven relatives. We reviewed 38 care records and observed interactions between staff and patients. We attended a medical handover and multidisciplinary team meetings. We held focus groups which were also attended by staff working within medicine.

Medical care (including older people's care)

Summary of findings

There were insufficient numbers of nursing staff on the majority of medical wards which compromised patient safety. Nurse recruitment within medical services was a known challenge for the trust. Despite initiatives to attract nurses to work for the hospital and the use of agency nurses, the number of nurses remained insufficient.

Incident reporting was established and was acted upon when needed. However, ongoing staff shortfalls meant that staff did not always have the time to report required incidents. Improvement was needed in how the outcome of incidents was fed back to staff.

Patients' records were inconsistently completed.

Care was provided in accordance with evidence-based and best practice guidelines, although care pathways were not in place for endoscopy. Care was monitored to show compliance with standards and there were good outcomes for patients and particularly for renal and stroke patients. Seven-day working was established for the majority of staff and multidisciplinary working was evident to coordinate effective patient care. However staff were not always able to access both mandatory and development training and compliance with appraisals required improvement to meet trust targets.

There was evidence of innovative nutrition initiatives being implemented, such as a red tray system to identify patients who needed help with eating, volunteer 'feeding buddies' and plans to introduce a modified texture diet menu. Patients said that staff were caring and friendly and felt that their dignity and privacy were respected. We observed staff delivering kind and compassionate care.

The trust responded to the local population's needs and particularly noteworthy was the seven-day transient ischaemic attack (TIA) clinic that GPs could access electronically. However, we found that male and female patients were accommodated in the same bay on the acute stroke unit (Benfleet) which was a breach of the Department of Health's 'mixed sex accommodation'

policy. There was a high rate of medical outliers (patients not accommodated on the correct ward for their treatment) due to capacity issues and medical patients were frequently moved from ward.

The leadership had good level of oversight regarding the directorate's improvement plans. We saw staff were supported to give a good level of care which staff were positive about. We saw a culture of audit and improvement.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



We have rated this service as Requires Improvement for the safe domain.

Because:

- There were insufficient numbers of nursing staff on all medical wards which put patients at risk. This was a known challenge for the trust.
- Staff did not always report incidents, mainly because they did not have time due to staffing shortages.
- There was limited feedback and learning from incidents, particularly on the acute stroke unit (Benfleet).
- The environment required improvement for patient safety on the acute medical ward.
- Lack of clarity of the level of safeguarding training required for all staff
- Mandatory training was below compliance targets because of staffing shortages.
- On the elderly care ward (Princess Anne) medicines were not always stored securely and we saw some medicines, which should have been locked away, out on the countertop.
- Inconsistent systems of recording patient medicines across the trust caused medicine errors and could delay patient discharge.

However we also saw that;

- There were sufficient doctors. This was supported by nursing staff who confirmed there was good medical cover across all medical wards.
- Sufficient equipment was available to the staff to meet patients' needs.
- Staff were confident with raising safeguarding concerns to protect patients from abuse and felt well-supported by the safeguarding lead.
- Wards and equipment were clean and staff adhered to the uniform policy to minimise risk of infection.

Incidents

- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were zero never events registered for medical care services from 1 November 2014 to 31 October 2015.

- The trust had an established electronic system for reporting incidents and near misses. From 1 November 2014 to 31 October 2015 there were 15 serious incidents which required investigation, and included five grade three pressure ulcers, five slips, trips and falls, two incidents of sub optimal care of a deteriorating patient, an inpatient (not in receipt of care) and one security threat. Each incident submitted was reviewed and graded by a senior nurse and the investigation was proportionate to the grading and any harm to the patient involved.
- Staff we spoke with were aware of how to report accidents and had access to, the incident reporting system. This allowed them to report incidents, including 'near misses', where patient safety may have been compromised. However staff on Windsor ward told us that due to regular understaffing they did not have the time to complete incident reports. In addition, the ward sister confirmed that the ward had been short staffed by one registered nurse for the previous shift but they had not reported this as it was usual.
- Staff reported inconsistent feedback from incidents. Staff working on Elizabeth Loury ward told us they received feedback from incidents and learning from incidents was shared during team meetings. However, other staff said they did not always receive feedback about incidents. One matron acknowledged that they needed to improve staff feedback on incidents and they were looking at how this could be achieved.
- The ward manager on Eleanor Hobbs ward told us that some feedback was given to staff who reported the incident but learning was fed back to the ward team during their ward meetings which were held every three months.
- Junior doctors told us that consultants may sometimes ask them to complete an incident report, such as an inappropriate transfer out. They told us they did not always receive feedback on the incidents reports that had been made
- The trust investigated every serious incident through a root cause analysis (RCA) process. We looked at a selection of RCAs, which included sub optimal care, falls with harm and pressure ulcers. We saw that investigators identified actions required. We saw examples when these actions had been addressed, for example sharing learning during ward and sister meetings. However they did not always follow the same format.

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- The morbidity and mortality meetings were held quarterly and were chaired by the medical director. Minutes of these meetings sent to us by the trust showed the meetings were mainly attended by doctors although occasionally a matron was also present. The records of mortality and morbidity meeting showed variable levels of discussion especially around patient mortality cases. Although we saw some discussion around learning from practice, we did not see allocated responsibility or time scales to ensure the actions were completed.
- There was variable understanding amongst staff about 'duty of candour'. Ward sisters generally understood the principle and told us that it was about telling patients when mistakes had been made. Two matrons told us they had excellent support from senior managers when they investigated a serious incident that required an appropriate 'duty of candour response'. Both matrons told us that the meetings had been held with the patient / or their representative and a letter of apology had been sent. Other staff did not understand or recognise the term 'duty of candour' but when we asked what they would do if they made a mistake they told us that they would give an apology when needed.

Safety thermometer

- The NHS safety thermometer provided a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections (C.UTIs), venous thromboembolism (VTE) and falls. The safety thermometer information was displayed at the entrance to each ward so that staff and visitors to the ward were aware of the performance in the ward or department.
- Staff identified patients at high risk of pressure ulcers, falls or VTE and when necessary actions were taken to reduce this risk. We saw on several wards patients who were identified as at high risk of falling had one-to-one care or a staff member remained in that bay/ area at all times.
- The overall number of C.UTIs was 57, although we have no benchmark information this figure appeared high.
- The trust target for patient VTE assessment was 95%; medical services had achieved 94.3%.
- Ward managers we spoke with were aware of the performance of their ward against agreed targets such

as staff sickness, vacancy rates, compliance with mandatory training and appraisal and incidence of pressure ulcers, slips, trips and falls and patient feedback.

Cleanliness, infection control and hygiene

- We saw that care environments were clean and well maintained. All wards we visited were clean and cleaning schedules were in place. Equipment was cleaned and marked as ready for use.
- Staff followed the trust's infection control policy. We observed that staff were 'bare below the elbow'. Staff had access to personal protective equipment that included aprons and gloves.
- Hand sanitising gel was available at the entrance to each ward/ unit and throughout the unit. Signs to remind both staff and visitors about hand hygiene were visible on the floor and the walls throughout the medical wards/ units we visited. We observed that most staff washed their hands appropriately. However on Blenheim ward, we observed two healthcare assistants taking observations who did not wash their hands when moving between patients in separate side rooms.
- Information provided by the trust showed that medical services had met the trust target of 85% of staff had infection control training.
- Staff compliance with infection control practices which included hand hygiene, management of sharps and knowledge and practice to reduce MRSA and clostridium difficile (C.Diff) was checked monthly by a senior nurse. We saw that findings (percentage of compliance or questions answered correctly) for each ward were identified and this was shared with ward managers to improve staff practice.
- There was one case of MRSA bacteraemia recorded across medical wards/units between January 2015 and January 2016. MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. There were 20 patients who had C.Diff within medical services between January 2015 and January 2016.
- An audit in June 2015 of the knowledge and practice of staff working in relation to MRSA had identified 95.1% compliance across medical wards. The action point

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from this audit was to, “feedback to individual ward managers and matrons regarding the excellent level of ward compliance from audit undertaken and the need to maintain this”.

- We saw, and staff confirmed, that side rooms were used, where possible, as isolation rooms for patients identified as having an increased infection control risk (for example patients with MRSA).

Environment and equipment

- Generally we found the majority of wards were tidy and well maintained. However, in AMU the area around the reception desk was cluttered and it made access to the unit difficult particularly for patients on trolleys and beds. The ward manager also raised concerns about the cramped facilities. Staff told us that in addition to the availability of equipment within this area patients referred by the GP to the hospital would also be ‘queuing’ in chairs to receive assessment / treatment on the ward.
- Staff working within AMU told us that the unit had moved recently. Staff raised their concerns about the suitability of the location of the unit which was on the other side of the hospital to the accident and emergency and x-ray departments. One staff member said, “we need to be closer to ambulances”. They told us that the unit was too small and we found space on the unit to be limited.
- Problems had been identified with the quality of the water system within the renal unit. The matron told us this was being addressed and other information we received from the trust confirmed this.
- Pressure-relieving mattresses and cushions for people at risk of pressure damage were in place.
- The renal unit used an alarm for high-risk patients who may not be aware of or were unable to alert staff to blood loss during dialysis. The alarm alerted staff quickly to the presence of any moisture (which may be blood loss).
- The trust required that all resuscitation equipment was checked and ready for use. Resuscitation equipment on the wards we visited had been recorded as checked regularly; appropriately packaged and ready for use. However, we found that on Eleanor Hobbs ward although the resuscitation trolley had been recorded as checked daily, there was out of date equipment. The

pharmacy box was not sealed as it should be for patient safety. We highlighted this to the ward manager who confirmed before we left the ward that it had been addressed.

- On Sita Lumsden ward (the coronary care unit) spare equipment such as cardiac monitor leads were kept on the unit. Staff told us when they reported faulty equipment to medical engineering they replaced and repaired their equipment quickly. This meant that they had appropriate equipment to safely meet patients’ needs.

Medicines

- We found the medical wards we visited generally had appropriate storage facilities for medicines.
- On Princess Anne ward a medicine alert dated April 2015 was displayed in the medicine storage room reminding staff about the importance of medicine security. However, we found that medicines were not always stored securely. Although the medication storage room had a secure keypad access we found the door was not secured or locked at the time of our visit. We saw that medicines that should have been locked away were out on the countertop.
- Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. However, temperature records for the medicine storage room and for the medicine refrigerator were not always documented daily to ensure that medicines were stored within safe temperature ranges. This meant that the trust was not able to guarantee the effectiveness of the medication it was administering to patients.
- The medication storage room on Princess Anne ward was very small for the safe storage, handling and preparation of medicines. We were shown a new purpose-built room for medicine storage. However due to final checks on the water supply it was not in use at the time of our inspection.
- We found on medical wards patients’ medicines were prescribed and the administration of the medicine (or the reason for non-administration) was recorded.
- The trust had introduced Electronic Prescribing (EP) but it was not available on all wards. However patients moves occurred which meant that they could be moved from wards with and without EP. This resulted in some challenges for wards. In particular when patients were transferred from a ward using the paper-based system to a ward using the new Electronic Prescribing (EP)

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system and vice versa. Staff working in AMU told us their concerns about these arrangements. They told us that there had been a recent incident when a medicine had been administered twice which had put the patient at risk of harm.

- On Princess Anne ward although arrangements were in place for recording the administration of medicines using the new electronic prescribing system, an error had occurred. An incorrect code had been recorded on the system which resulted in one patient missing a dose of a pain relief medicine for three days. This had resulted in the doctor prescribing a higher dose to help control the patient's pain. On informing the doctor of the error they changed the prescription. This was reported as a medicine incident.
- Staff wore red aprons when they were administering medicines which identified they should not be disturbed. This was good practice because reducing staff disruption reduced the risk of medicine errors.
- Controlled drugs which require special storage and recording were stored in line with good guidance procedures including daily checks by two nurses. However we found on Princess Anne ward a counting discrepancy had been identified during a routine check and a controlled drug was missing. This was reported as a medicine incident.
- Allergies to medicines were clearly recorded on patient's medicine records. On Princess Anne ward we saw reminder stickers to check patients allergy status displayed in the medicine storage room which was good practice.
- Timely discharge of patients from hospital was helped by the EP system although this was not the case for patients with paper prescriptions. This was because ward-based staff had to leave the ward with the paper prescription and wait in pharmacy to obtain the medicines. This increased the waiting time for discharge of patients as well as the number of ward-based staff leaving the ward.
- Staff on Blenheim ward told us that the use of EP had improved discharge arrangements and had ensured that patients had the correct medicines when they went home.

Records

- Medical wards mostly used paper records, although patients' prescriptions and medicine records were electronic.
- Patients had one set of patient records in which doctors, nurses and other professionals recorded information including: the treatment plan, the patient's condition and results of any tests or investigations the patient had. We found that medical records were mostly legible, dated and with the name of the health professional who had completed the record. However the time of the entry was not consistently recorded.
- Patients' daily care charts were at the bottom of their beds. These included information such as records of observations and which included an early warning score to identify any deterioration in their health, 'comfort' checks (regular checks if the patients needed to be moved, go to the toilet or wanted a drink), and food and drinks provided.
- We looked at three sets of patient records in the endoscopy unit. We saw that the patient's assessment was fully completed, however the nursing evaluation on the care provided was not recorded. This meant we were unable to see if the patient's treatment and care plan had been completed as expected.
- We looked at three sets of patient records on AMU and found none of the records we looked at were fully completed. The "admission assessment" document was not completed for two patients. On the third record some information was missed such as the early warning score, the nutritional screening tool, pressure ulcer risk, bedrail risk assessment and continence and personal care needs. We also found that the 'comfort round checks' were only recorded as completed for one of the three patients whose records we looked at. We found that records we looked at during our unannounced inspection however were complete.

Safeguarding

- Staff were able to describe situations in which they would raise a safeguarding concern, and how they would escalate any concerns. We saw and staff told us about examples where appropriate actions were taken to protect patients from abuse.
- Staff we spoke with were aware who the adult safeguarding lead was and their contact details. Staff in AMU and the stroke unit told us that they had excellent advice and support from the adult safeguarding lead when they had reported safeguarding concerns.

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- Staff told us they had received adult and children's safeguarding training but were uncertain about what level.
- The ward manager of Eleanor Hobbs ward told us that the trust were currently reviewing safeguarding and confirmed all staff should have safeguarding adults training at level two.
- The trust target for all mandatory training including safeguarding was 85% of staff. Staff working within medical services had not met this. Information provided by the trust showed that:

- 72.9% of staff working with the medical directorate had undertaken safeguarding level one training,

- No information was provided to confirm that staff had or were required to have level two safeguarding adults training,

- 73% of staff had received level one child safeguarding training,

- 56.5% of staff had received level two child safeguarding training.

The safeguarding adults policy was on the trust intranet. The policy did not specify what level safeguarding training and nurses/doctors should have.

Mandatory training

- The trust's mandatory staff training covered many subjects e.g. conflict resolution, cardio pulmonary resuscitation (CPR): equality and diversity, fire safety, infection control and information governance. Also, moving and handling, Mental Capacity Act (MCA) and deprivation of liberty safeguards (DOLS) Level 1.
- Information provided by the trust showed that average compliance with mandatory training within medical services was 70%, which did not meet the trust target of 85%. The January Clinical Directorate Performance report identified that overall the directorate performance was being impacted by medical staff compliance (including junior doctors).
- Ward managers and matrons told us that although mandatory training compliance was not meeting the

trust's target compliance, this was due mostly to insufficient staffing. However they told us that compliance was improving and records we looked at confirmed this.

- Managers told us that, to enable staff to access mandatory training more easily, some of it (around 50%) was available electronically. The matron of the stroke unit said there were also plans to have a computer so that staff could access and undertake mandatory training when the ward was quiet.

Assessing and responding to patient risk

- Medical services within the hospital used an early warning score to identify acutely ill adult patients.
- The service offered cerebral embolectomies (the emergency surgical removal of a clot which is blocking blood circulation in the brain) to patients requiring this intervention. Documents supplied by the trust demonstrated that appropriate healthcare professionals worked together to reduce risk to patients. These were a stroke consultant, consultant interventional radiologist and consultant anaesthetists. The trust had a flowchart to help identify suitable patients and to ensure all the back-up services were in place before commencing the procedure.
- A patient's early warning score was calculated from each observation recorded on the patient's records. The score then identified deteriorating patients who required input from the critical care outreach team/ or a doctor. The team/ doctor then assessed the patient and a decision was made in relation to their on-going management.
- Nursing staff told us that, should a medical assessment be required for a deteriorating patient, doctors mostly attended quickly to review the patient.
- We saw on Paglesham ward a graph which identified early warning score, level of risk and actions staff should undertake in response to identified scores.
- We observed 'board rounds' which took place when staff (doctors and nurses) were updated on patients and their treatment needs. We saw evidence of multi-disciplinary 'board rounds' with physiotherapists and other allied health professionals also attending. It is important that this information is shared but this should

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be undertaken in a private room where information cannot be overheard by visitors or patients. The sharing of information in a public place breached patient's confidentiality.

Nursing staffing

- The trust provided information for planned compared to actual nurse staffing from 1 November to 31 December 2015. Information provided showed that there were 1,788 occasions where the number of qualified staff on duty was less than planned on medical wards.
- The safer nursing care staffing tool was completed daily by the senior nursing staff for medical wards.
- We observed during our announced inspection that planned and actual staffing levels were displayed on all wards.
- We spoke with the medical directorate senior management team. They told us that there was a large number of nursing vacancies throughout the directorate. They told us the area with the most nurse vacancies was the stroke unit which had 18 nurse vacancies at the time of our visit.
- We found that on the acute coronary care ward (Sita Lumsden) and the renal unit that there was the required number of staff were on duty.
- However generally other ward managers told us they had difficulties ensuring that their wards were fully staffed.
- When we visited the acute stroke unit there were three registered nurses on duty although the 'planned' qualified nurse number for the ward was six nurses. For hyper acute (high dependency) stroke patients there should be one nurse to care for two patients. We observed that one qualified nurse provided care for eight patients. Nurses told us that they were providing support to patients both within the bay and in the side ward. We observed on several occasions there was no nurse available in each acute bay and high dependency patients were not being directly observed by staff.
- On Paglesham ward we looked at records that showed that a patient should be checked every 30 minutes due to identified risks. We saw that records showed that staff had checked the patient infrequently. We showed the records to the ward sister who agreed that the patient had not been checked at the required intervals.
- Staff on the stroke unit all told us they were concerned about staffing levels on the stroke unit. One band six nurse told us they were worried about staffing levels and safety of the ward. They told us that due to staffing levels they struggled when they held the bleep alerting them to potential stroke patients in accident and emergency at night who required emergency care.
- We observed on the stroke unit on several occasions there was no nursing presence in the high dependency bay. Nurses were expected to cover both the high dependency bay and the side wards which also had patients with high dependency needs.
- When we visited Windsor ward there were two registered nurses on duty with caring for 30 patients. We visited later the same day and found that the ward had been sent an additional trained nurse from another ward. This still meant that there was one trained nurse to care for 10 patients, which was higher than the Royal College of Nursing (RCN) recommended ratio of one nurse providing care for no more than eight patients. We found from duty rotas we looked at during the inspection (for the previous 3 months) that usual staffing levels were three registered nurses on duty (day and night).
- The ward manager of Windsor confirmed that nurse staffing was difficult and there were five registered nurse vacancies with an additional two registered nurses on long term sick and two on maternity leave. The ward manager of Windsor told us they did not feel that the ward was unsafe because of the increased number of health care assistants who were also available to supplement nursing care.
- The ward manager on Princess Anne told us their main concern was staffing. At the time of our visit there were three nurses (they did have four but one nurse was moved to another ward) leaving one nurse to eight patients. In addition there were 10 health care assistants because several were providing on- to-one support for patients with complex and challenging needs.
- The ward manager of Eleanor Hobbs said they had five vacant band five posts. They told us they had particular concerns about the sufficiency of qualified nurses on night duty and reliance on agency staff.
- The ward manager of Elizabeth Loury told us that they were struggling to achieve the full staff establishment on night duty and they were not always able to have a band six nurse on night duty as planned.
- Following our visit we asked the trust for the actual numbers of planned and actual nurses on each shift in the last month for medical wards. The trust provided information for planned compared to actual nurse

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staffing from 1 November to 31 December 2015.

Information provided showed that there were 1,788 occasions where the number of qualified staff on duty was less than planned on medical wards.

- The majority of wards used agency staff. On the wards we visited we saw that agency staff received a local recorded induction to show them equipment and discuss emergency procedures. Staff on Sita Lumsden ward (coronary care) told us they never used agency staff.

Medical staffing

- The proportion of consultants, middle career and junior doctors across medical services division was lower than the national average. There were 9% consultants working within the trust compared to 34% in England; 2% middle career doctors within the trust compared to 6% in England and 7% junior doctors compared to 22% in England. There was a significantly higher proportion (82%) of registrars compared to the England average (39%).
- The acute medical unit had at least two consultants on duty between 8am and 5pm and one consultant between 5pm and 10pm. A consultant was on call from home overnight.
- There was sufficient medical cover out of hours. There were two middle grade doctors between 5pm and 9.30pm. Between 9.30pm and 8am there was one middle grade doctor covering the medical wards.
- There were four junior doctors between 5pm and 9.30pm covering the acute medical unit and the medical wards. There were two junior doctors between 9.30pm and 8am covering both AMU and the medical wards which was also sufficient to meet the needs of patients.
- The clinical lead for medicine told us that they found recruiting consultants to work within elderly care difficult. They told us they had to rely on locum consultants and registrars to support the four permanent consultants. They told us that two additional posts for stroke consultants had been created but they had also been difficult to recruit to.
- Cardiology had six consultants of which four undertook 'pacing' procedures. There was consultant on call every day of the week to ensure that patients were seen by a consultant.

- Doctors told us that all cardiology outlier patients were seen in the morning and when possible arrangements were made to move them to a cardiology ward. (An outlier a patient who is not located on the correct ward for their care such as a medical patient on a surgical ward).
- The ward manager on Blenheim told us that they had good access to doctors and any patient concerns would be escalated in a timely way to a senior doctor.
- We attended the medical handover for the hospital. It included two consultants, a middle grade doctors and several junior doctors, a patient safety officer, associate director of nursing and medical staffing representative. The handover was structured and gave key events from the previous shift such as patient deaths, cardiac arrests, number of patient transfers to the intensive care unit and surgery. Then followed a doctors shift handover which gave doctors more information about patients and gave concerns about identified patients overnight, and the number and location of medical outliers.
- Nursing staff reported excellent medical cover across all wards, with minimal delays when they requested assessment of patients whose condition had deteriorated.
- Junior doctors covered weekends and told us they had access to and support from consultants and medical registrars as required. Consultants were rostered to work the weekend, but were not present on site for all hours of the weekend. Junior doctors confirmed that consultants would come into the hospital when on-call.
- The hospital used locum doctors if shifts could not be covered by permanent doctors. Senior doctors told us that the majority of locums had worked at the hospital on a regular basis and were familiar with the wards, staff and procedures. This aided continuity of patient care.

Major incident awareness and training

- The trust had a major incident policy. This policy provided an agreed framework to prepare for all emergencies and ensure business continuity plans were in place. The policy which described emergencies and disruptions to services such as: a period of severe bed pressure, extreme weather conditions, an outbreak of an infectious disease, industrial action or a major transport accident.

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- When we visited the hospital they were on 'black alert' due to increased numbers of patient admissions and ongoing pressure on bed capacity. All staff were aware of this and most were aware of additional meetings to review bed capacity. Staff were also aware that the policy was in place.
- Staff on some wards were aware of the trust's plan to put additional beds on established ward with experienced managers in response to 'winter pressures'. We saw these additional beds during our visit.
- Emergency plans and evacuation procedures were in place and on display on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.
- Staff told us that there was a bed management system that aimed to ensure that patients' needs were met when there was an increased demand for beds. The lead consultant told us that medical services had used winter pressures wards previously.

Incidents

- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were zero never events registered for medical care services from 1 November 2014 to 31 October 2015.
- The trust had an established electronic system for reporting incidents and near misses. From 1 November 2014 to 31 October 2015 there were 15 serious incidents which required investigation, and included five grade three pressure ulcers, five slips, trips and falls, two incidents of sub optimal care of a deteriorating patient, an inpatient (not in receipt of care) and one security threat. Each incident submitted was reviewed and graded by a senior nurse and the investigation was proportionate to the grading and any harm to the patient involved.
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- Staff reported inconsistent feedback from incidents. Staff working on Elizabeth Lorry ward told us they

received feedback from incidents and learning from incidents was shared during team meetings. However, other staff said they did not always receive feedback about incidents. One matron acknowledged that they needed to improve staff feedback on incidents and they were looking at how this could be achieved.

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- Ward managers we spoke with were aware of the performance of their ward against agreed targets such as staff sickness, vacancy rates, compliance with mandatory training and appraisal and incidence of pressure ulcers, slips, trips and falls and patient feedback.

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- Hand sanitising gel was available at the entrance to each ward/ unit and throughout the unit. Signs to remind both staff and visitors about hand hygiene were visible on the floor and the walls throughout the medical wards/ units we visited. We observed that most

staff washed their hands appropriately. However on Blenheim ward, we observed two healthcare assistants taking observations who did not wash their hands when moving between patients in separate side rooms.

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suitability of the location of the unit which was on the other side of the hospital to the accident and emergency and x-ray departments. One staff member said, “we need to be closer to ambulances”. They told us that the unit was too small and we found space on the unit to be limited.

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- Pressure-relieving mattresses and cushions for people at risk of pressure damage were in place.
- The renal unit used an alarm for high-risk patients who may not be aware of or were unable to alert staff to blood loss during dialysis. The alarm alerted staff quickly to the presence of any moisture (which may be blood loss).
- The trust required that all resuscitation equipment was checked and ready for use. Resuscitation equipment on the wards we visited had been recorded as checked regularly; appropriately packaged and ready for use. However, we found that on Eleanor Hobbs ward although the resuscitation trolley had been recorded as checked daily, there was out of date equipment. The pharmacy box was not sealed as it should be for patient safety. We highlighted this to the ward manager who confirmed before we left the ward that it had been addressed.
- On Sita Lumsden ward (the coronary care unit) spare equipment such as cardiac monitor leads were kept on the unit. Staff told us when they reported faulty equipment to medical engineering they replaced and repaired their equipment quickly. This meant that they had appropriate equipment to safely meet patients' needs.

Medicines

- We found the medical wards we visited generally had appropriate storage facilities for medicines.
- On Princess Anne ward a medicine alert dated April 2015 was displayed in the medicine storage room reminding staff about the importance of medicine security. However, we found that medicines were not always stored securely. Although the medication storage room had a secure keypad access we found the door was not secured or locked at the time of our visit. We saw that medicines that should have been locked away were out on the countertop.
- Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. However, temperature records for the medicine storage room and for the medicine refrigerator were not always documented daily to ensure that medicines were stored within safe temperature ranges. This meant that the trust was not able to guarantee the effectiveness of the medication it was administering to patients.
- The medication storage room on Princess Anne ward was very small for the safe storage, handling and preparation of medicines. We were shown a new purpose-built room for medicine storage. However due to final checks on the water supply it was not in use at the time of our inspection.
- We found on medical wards patients' medicines were prescribed and the administration of the medicine (or the reason for non-administration) was recorded.
- The trust had introduced Electronic Prescribing (EP) but it was not available on all wards. However patients moves occurred which meant that they could be moved from wards with and without EP. This resulted in some challenges for wards. In particular when patients were transferred from a ward using the paper-based system to a ward using the new Electronic Prescribing (EP) system and vice versa. Staff working in AMU told us their concerns about these arrangements. They told us that there had been a recent incident when a medicine had been administered twice which had put the patient at risk of harm.
- On Princess Anne ward although arrangements were in place for recording the administration of medicines using the new electronic prescribing system, an error had occurred. An incorrect code had been recorded on the system which resulted in one patient missing a dose of a pain relief medicine for three days. This had resulted in the doctor prescribing a higher dose to help control the patient's pain. On informing the doctor of the error they changed the prescription. This was reported as a medicine incident.
- Staff wore red aprons when they were administering medicines which identified they should not be disturbed. This was good practice because reducing staff disruption reduced the risk of medicine errors.
- Controlled drugs which require special storage and recording were stored in line with good guidance procedures including daily checks by two nurses.

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However we found on Princess Anne ward a counting discrepancy had been identified during a routine check and a controlled drug was missing. This was reported as a medicine incident.

- Allergies to medicines were clearly recorded on patient's medicine records. On Princess Anne ward we saw reminder stickers to check patients allergy status displayed in the medicine storage room which was good practice.
- Timely discharge of patients from hospital was helped by the EP system although this was not the case for patients with paper prescriptions. This was because ward-based staff had to leave the ward with the paper prescription and wait in pharmacy to obtain the medicines. This increased the waiting time for discharge of patients as well as the number of ward-based staff leaving the ward.
- Staff on Blenheim ward told us that the use of EP had improved discharge arrangements and had ensured that patients had the correct medicines when they went home.

Records

- Medical wards mostly used paper records, although patients' prescriptions and medicine records were electronic.
- Patients had one set of patient records in which doctors, nurses and other professionals recorded information including: the treatment plan, the patient's condition and results of any tests or investigations the patient had. We found that medical records were mostly legible, dated and with the name of the health professional who had completed the record. However the time of the entry was not consistently recorded.
- Patients' daily care charts were at the bottom of their beds. These included information such as records of observations and which included an early warning score to identify any deterioration in their health, 'comfort' checks (regular checks if the patients needed to be moved, go to the toilet or wanted a drink), and food and drinks provided.
- We looked at three sets of patient records in the endoscopy unit. We saw that the patient's assessment

was fully completed, however the nursing evaluation on the care provided was not recorded. This meant we were unable to see if the patient's treatment and care plan had been completed as expected.

- We looked at three sets of patient records on AMU and found none of the records we looked at were fully completed. The "admission assessment" document was not completed for two patients. On the third record some information was missed such as the early warning score, the nutritional screening tool, pressure ulcer risk, bedrail risk assessment and continence and personal care needs. We also found that the 'comfort round checks' were only recorded as completed for one of the three patients whose records we looked at. We found that records we looked at during our unannounced inspection however were complete.

Safeguarding

- Staff were able to describe situations in which they would raise a safeguarding concern, and how they would escalate any concerns. We saw and staff told us about examples where appropriate actions were taken to protect patients from abuse.
- Staff we spoke with were aware who the adult safeguarding lead was and their contact details. Staff in AMU and the stroke unit told us that they had excellent advice and support from the adult safeguarding lead when they had reported safeguarding concerns.
- Staff told us they had received adult and children's safeguarding training but were uncertain about what level.
- The ward manager of Eleanor Hobbs ward told us that the trust were currently reviewing safeguarding and confirmed all staff should have safeguarding adults training at level two.
- The trust target for all mandatory training including safeguarding was 85% of staff. Staff working within medical services had not met this. Information provided by the trust showed that:
 - 72.9% of staff working with the medical directorate had undertaken safeguarding level one training,
 - No information was provided to confirm that staff had or were required to have level two safeguarding adults training,
 - 73% of staff had received level one child safeguarding training,

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- 56.5% of staff had received level two child safeguarding training.

The safeguarding adults policy was on the trust intranet. The policy did not specify what level safeguarding training and nurses/doctors should have.

- Mandatory staff training covered many subjects e.g. conflict resolution, cardio pulmonary resuscitation (CPR): equality and diversity, fire safety, infection control and information governance. Also, moving and handling, Mental Capacity Act (MCA) and deprivation of liberty safeguards (DOLS) Level 1.
- Information provided by the trust showed that average compliance with mandatory training within medical services was 70%, which did not meet the trust target of 85%. The January Clinical Directorate Performance report identified that overall the directorate performance was being impacted by medical staff compliance (including junior doctors).
- Ward managers and matrons told us that although mandatory training compliance was not meeting the trust's target compliance, this was due mostly to insufficient staffing. However they told us that compliance was improving and records we looked at confirmed this.
- Managers told us that, to enable staff to access mandatory training more easily, some of it (around 50%) was available electronically. The matron of the stroke unit said there were also plans to have a computer so that staff could access and undertake mandatory training when the ward was quiet.
- In the hospital used an early warning score to identify acutely ill adult patients.
- A patient's early warning score was calculated from each observation recorded on the patient's records. The score then identified deteriorating patients who required input from the critical care outreach team/ or a doctor. The team/ doctor then assessed the patient and a decision was made in relation to their on-going management.
- Nursing staff told us that, should a medical assessment be required for a deteriorating patient, doctors mostly attended quickly to review the patient.
- We saw on Paglesham ward a graph which identified early warning score, level of risk and actions staff should undertake in response to identified scores.
- We observed 'board rounds' which took place when staff (doctors and nurses) were updated on patients and their treatment needs. We saw evidence of multi-disciplinary 'board rounds' with physiotherapists and other allied health professionals also attending. It is important that this information is shared but this should be undertaken in a private room where information cannot be overheard by visitors or patients. The sharing of information in a public place breached patient's confidentiality.
- Information for planned compared to actual nurse staffing from 1 November to 31 December 2015. Information provided showed that there were 1,788 occasions where the number of qualified staff on duty was less than planned on medical wards.
- The safer nursing care staffing tool was completed daily by the senior nursing staff for medical wards.
- We observed during our announced inspection that planned and actual staffing levels were displayed on all wards.
- We spoke with the medical directorate senior management team. They told us that there was a large number of nursing vacancies throughout the directorate. They told us the area with the most nurse vacancies was the stroke unit which had 18 nurse vacancies at the time of our visit.
- We found that on the acute coronary care ward (Sita Lumsden) and the renal unit that there was the required number of staff were on duty.
- However generally other ward managers told us they had difficulties ensuring that their wards were fully staffed.
- When we visited the acute stroke unit there were three registered nurses on duty although the 'planned' qualified nurse number for the ward was six nurses. For hyper acute (high dependency) stroke patients there should be one nurse to care for two patients. We observed that one qualified nurse provided care for eight patients. Nurses told us that they were providing

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support to patients both within the bay and in the side ward. We observed on several occasions there was no nurse available in each acute bay and high dependency patients were not being directly observed by staff.

- On Paglesham ward we looked at records that showed that a patient should be checked every 30 minutes due to identified risks. We saw that records showed that staff had checked the patient infrequently. We showed the records to the ward sister who agreed that the patient had not been checked at the required intervals.
- Staff on the stroke unit all told us they were concerned about staffing levels on the stroke unit. One band six nurse told us they were worried about staffing levels and safety of the ward. They told us that due to staffing levels they struggled when they held the bleep alerting them to potential stroke patients in accident and emergency at night who required emergency care.
- When we visited Windsor ward there were two registered nurses on duty with caring for 30 patients. We visited later the same day and found that the ward had been sent an additional trained nurse from another ward. This still meant that there was one trained nurse to care for 10 patients, which was higher than the Royal College of Nursing (RCN) recommended ratio of one nurse providing care for no more than eight patients. We found from duty rotas we looked at during the inspection (for the previous 3 months) that usual staffing levels were three registered nurses on duty (day and night).
- The ward manager of Windsor confirmed that nurse staffing was difficult and there were five registered nurse vacancies with an additional two registered nurses on long term sick and two on maternity leave. The ward manager of Windsor told us they did not feel that the ward was unsafe because of the increased number of health care assistants who were also available to supplement nursing care.
- The ward manager on Princess Anne told us their main concern was staffing. At the time of our visit there were three nurses (they did have four but one nurse was moved to another ward) leaving one nurse to eight patients. In addition there were 10 health care assistants because several were providing on- to-one support for patients with complex and challenging needs.
- The ward manager of Eleanor Hobbs said they had five vacant band five posts. They told us they had particular concerns about the sufficiency of qualified nurses on night duty and reliance on agency staff.
- The ward manager of Elizabeth Loury told us that they were struggling to achieve the full staff establishment on night duty and they were not always able to have a band six nurse on night duty as planned.
- Following our visit we asked the trust for the actual numbers of planned and actual nurses on each shift in the last month for medical wards. The trust provided information for planned compared to actual nurse staffing from 1 November to 31 December 2015. Information provided showed that there were 1,788 occasions where the number of qualified staff on duty was less than planned on medical wards.
- The majority of wards used agency staff. On the wards we visited we saw that agency staff received a local recorded induction to show them equipment and discuss emergency procedures. Staff on Sita Lumsden ward (coronary care) told us they never used agency staff.
- consultants, middle career and junior doctors across medical services division was lower than the national average. There were 9% consultants working within the trust compared to 34% in England; 2% middle career doctors within the trust compared to 6% in England and 7% junior doctors compared to 22% in England. There was a significantly higher proportion (82%) of registrars compared to the England average (39%).
- The acute medical unit had at least two consultants on duty between 8am and 5pm and one consultant between 5pm and 10pm. A consultant was on call from home overnight.
- There was sufficient medical cover out of hours. There were two middle grade doctors between 5pm and 9.30pm. Between 9.30pm and 8am there was one middle grade doctor covering the medical wards.
- There were four junior doctors between 5pm and 9.30pm covering the acute medical unit and the medical wards. There were two junior doctors between 9.30pm and 8am covering both AMU and the medical wards which was also sufficient to meet the needs of patients.
- The clinical lead for medicine told us that they found recruiting consultants to work within elderly care difficult. They told us they had to rely on locum consultants and registrars to support the four permanent consultants. They told us that two additional posts for stroke consultants had been created but they had also been difficult to recruit to.

Medical care (including older people's care)

- Cardiology had six consultants of which four undertook 'pacing' procedures. There was consultant on call every day of the week to ensure that patients were seen by a consultant.
- Doctors told us that all cardiology outlier patients were seen in the morning and when possible arrangements were made to move them to a cardiology ward. (An outlier a patient who is not located on the correct ward for their care such as a medical patient on a surgical ward).
- The ward manager on Blenheim told us that they had good access to doctors and any patient concerns would be escalated in a timely way to a senior doctor.
- We attended the medical handover for the hospital. It included two consultants, a middle grade doctors and several junior doctors, a patient safety officer, associate director of nursing and medical staffing representative. The handover was structured and gave key events from the previous shift such as patient deaths, cardiac arrests, number of patient transfers to the intensive care unit and surgery. Then followed a doctors shift handover which gave doctors more information about patients and gave concerns about identified patients overnight, and the number and location of medical outliers.
- Nursing staff reported excellent medical cover across all wards, with minimal delays when they requested assessment of patients whose condition had deteriorated.
- Junior doctors covered weekends and told us they had access to and support from consultants and medical registrars as required. Consultants were rostered to work the weekend, but were not present on site for all hours of the weekend. Junior doctors confirmed that consultants would come into the hospital when on-call.
- The hospital used locum doctors if shifts could not be covered by permanent doctors. Senior doctors told us that the majority of locums had worked at the hospital on a regular basis and were familiar with the wards, staff and procedures. This aided continuity of patient care.

Major incident awareness and training

- The trust had a major incident policy. This policy provided an agreed framework to prepare for all emergencies and ensure business continuity plans were in place. The policy which described emergencies and

disruptions to services such as: a period of severe bed pressure, extreme weather conditions, an outbreak of an infectious disease, industrial action or a major transport accident.

- When we visited the hospital they were on 'black alert' due to increased numbers of patient admissions and ongoing pressure on bed capacity. All staff were aware of this and most were aware of additional meetings to review bed capacity. Staff were also aware that the policy was in place.
- Staff on some wards were aware of the trust's plan to put additional beds on established ward with experienced managers in response to 'winter pressures'. We saw these additional beds during our visit.
- Emergency plans and evacuation procedures were in place and on display on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.
- Staff told us that there was a bed management system that aimed to ensure that patients' needs were met when there was an increased demand for beds. The lead consultant told us that medical services had used winter pressures wards previously.

Are medical care services effective?

Good



Overall we rated the medical care services as good for the effective domain.

Because:

- All medical wards we inspected delivered evidence-based practice and used national guidance and action plans to improve performance.
- All patients we spoke with were happy with their level of pain relief and nurses monitored patients' pain levels.
- Dietary and fluid charts were completed fully which meant that staff were aware of patients' food and drink intake and could respond effectively to any changes or concerns.
- There was evidence of innovative nutrition initiatives being implemented, such as a red tray system to identify patients who needed help with eating, volunteer 'feeding buddies' and plans to introduce a modified texture diet menu.

Medical care (including older people's care)

- Patient outcomes for the stroke and renal units in particular were good; survival rates for renal haemodialysis patients were the fourth-best in England.
- The renal unit used a new standardised taping technique for dialysis needles to reduce the risk of needle dislodgement and blood loss. In the last three months there had been no incidences of needle dislodgement.
- On the renal unit, a blood loss alarm was in use to alert staff to needle displacement.
- The stroke unit had a seven-day transient ischaemic attack (TIA) clinic.
- From our observations of clinical practice, staff handovers and multidisciplinary team (MDT) meetings, staff working across medical services were found to be competent and knowledgeable.
- Multidisciplinary working was evident to coordinate patient care and provide different types of support to the patient, for example dietary, social and psychological.

However:

- There were no clear care pathways in place for endoscopy.
- The endoscopy unit did not take part in Joint Advisory Group on Gastro Intestinal Endoscopy (JAG) accreditation. There was no other accreditation or benchmarking assessment; this gave limited assurance that the unit was meeting set endoscopy standards.
- There was inconsistent understanding among ward staff about how information was stored and reviewed relating to medical outliers (patients who are not located on the correct ward for their condition). Staff on the oncology ward (Kitty Hubbard) told us outliers were not always reviewed quickly.
- Outliers occurred which meant that patients were cared for in area which did not relate to their symptoms. This ran the risk of patients not receiving timely review.

Evidence-based care and treatment

- All medical wards delivered evidence-based practice and followed recognised and approved national guidance across the medical directorate. When speaking with nursing staff we found they had a good knowledge of guidelines, best practice and where to find

guidance. For example staff on the stroke unit were able to tell us about the pathways for both newly admitted stroke patients and patients who had a transient ischaemic attack which met best practice.

- The trust performed better than the England average in the MINAP Audit for nSTEMI patients admitted to a Cardiac Unit and receiving Angiography (April 2013-March 2014). There were care pathways based on the National Institute of Health and Care Excellence (NICE) guidance for stroke patients, heart failure, diabetes and respiratory conditions. The hospital contributed to national audits such as the renal registry. This meant that performance could be compared against other hospitals and when needed improvements made. We saw that action plans were in place to improve performance.
- In the endoscopy unit written care pathways were not all in place. The matron for endoscopy told us that care pathways for bronchoscopy and endoscopy had been written but were not in place at the time of our visit. Care pathways for a new procedure, endobronchoscopic ultrasound (EBUS) were not in place. EBUS is an ultrasound procedure whereby a bronchoscope with a scanner is used to locate and biopsy enlarged lymph nodes. The matron confirmed that at the time of the inspection there had been no audits undertaken that confirmed required care pathways were being met.

Pain relief

- Medical services used a pain scoring tool that enabled staff to assess pain and the effectiveness of any pain relief administered. We saw nurses ask patients if they were in pain and when needed ensure that pain relief was administered.
- All patients told us they received the pain relief they needed. We looked at two patients' records and found both had their pain relief regularly reviewed by medical staff.
- Patients were mostly administered pain relief according to their individual prescriptions and nursing staff were vigilant when monitoring patients' pain levels. However we did see that two patients did not have their prescribed pain relief which may mean they were in pain or increased pain.

Nutrition and hydration

Medical care (including older people's care)

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patients' nutrition and hydration when applicable.
- We observed that fluid balance and food charts were completed appropriately. This ensured that staff were aware and had taken appropriate actions when there were any concerns about patients' dietary and fluid intake.
- We observed that patients had access to a cold drink by their bedside.
- Patients said they were given choices of food and snacks. Patients generally told us that the food was of excellent quality.
- The nutritional specialist showed us new menus being developed to ensure that patients' needs were fully met. The new menus included choices for patients who were vegan, or required a halal diet or renal diet.
- The wards had introduced protected meal times this was a period of time over lunch and supper where all unnecessary activities on the ward stopped.
- There were red trays and red topped jugs to identify patients who needed support with eating and drinking which is good practice. We observed one patient with a red tray being helped by staff. When we asked two members of staff on the ward what the red tray system meant, they were able to tell us. They also told us that the trays would not be removed until ward staff had confirmed the patient had finished their meal.
- The nutritional specialist told us and we saw that they were introducing a modified texture menu to assist patients who had difficulty in eating solid foods. This menu was to be launched the week after our visit. Staff on this ward also told us they wanted to introduce twice-daily menu choices, rather all meals being ordered the day before.
- The hospital had 'feeding buddies' to assist patients who struggled to feed themselves. The feeding buddies were volunteers and were trained to assist with patient feeding. Staff on the stroke wards and elderly care wards confirmed that they had regular 'feeding buddies' to help them at mealtimes. This meant that patients' needs were being met whilst enabling staff to undertake other care.
- The Standard Hospital Mortality Indicator (SHMI) produced by the Health and Social Care Information Centre (HSCIC) for April 2014 to March 2015 was banded "as expected" for the trust. SHMI reports mortality at trust level across the NHS in England. SHMI compares the number of deaths in each hospital with an expected number of deaths and takes into account the types of patients the hospital cares for. A SHMI figure of 1 is equal to the national average, below 1 is better than the national average and above 1 is worse than average. Information displayed on the trust website (20/01/2016) identified the trust's target SHMI was not to exceed 1.07 and the actual SHMI was 1.03.
- The trust had demonstrated excellent performance in stroke care resulting in a score level A (level A is the highest achievement and level E is the lowest) in the Sentinel Stroke National Audit Programme (SSNAP) in the report dated November 2014.
- The trust's renal unit had positive patient outcomes highlighted by the renal register which assessed patients between 2009 and 2012. The renal registry report (2015) showed that patient survival rates and measurements of blood pressure for transplant patients' phosphate results were better than expected. The report highlighted that the trust's haemodialysis patients had the fourth best survival rates in England.
- Staff working on the renal unit told us they knew their patients and what was normal for them such as blood pressure as they came so regularly. Staff told us that this enabled to seek timely medical advice when needed and this helped improve patient outcomes.
- The renal unit was using a new standardised taping technique (chevron) to secure needles used during dialysis to prevent dislodgement of the needle. Dislodgement of the needle can result in considerable blood loss. Audit results have shown that in three months there have been no incidents of needle dislodgement since the new procedure was implemented.
- The trust performance in the National Diabetes Inpatient Audit (NaDIA) 2015 had shown some overall performance was mixed (18 better , 1 the same as and 11 worse than the England average) The trust had lower diabetes nurse specialist, consultant, dietician, podiatrist (0 hours), pharmacist (0 hours) hours per patient per week, higher percentage of emergency admissions for diabetes patients (90.7% compared to England average of 86.2%) and average number of

Patient outcomes

Medical care (including older people's care)

consultant hours, dietician per patient per week patients and foot risk assessments within 24 hours of admission and also a foot risk assessment during their stay, where improvement was needed included visits by a specialist diabetes team, Better than the England average included, medication errors including insulin and management errors, timing and suitability of meals for diabetic patients, staff knowledge of diabetes and patient overall satisfaction with diabetes care. Improvement made since the last NaDIA included the timing and suitability of meals.

- The trust performed similar to the England average in the National Heart Failure 2013/2014. Six of the 11 indicators were better and five were worse than the England average. An example of identified good practice was the percentage of patients prescribed medicines that have been found to benefit patients with heart failure on their discharge from hospital.
- The trust's endoscopy unit did not participate in the Joint Advisory Group on GI Endoscopy (JAG) which reviews set standards in endoscopy. The ward manager told us they had previously attended a study day about JAG accreditation and there had been plans to expand the unit. The matron told us that there were no plans at the time of the inspection to apply for JAG accreditation of the unit as it was too small. We were unable to see any other process that the service was using to provide assurance that the unit was meeting set endoscopy standards.
- Ward staff gave us inconsistent information about patients who were outliers. Outliers are patients who are not on their correct ward such as medical patients on a surgical ward. Some staff told us that a list of outlier patients was held centrally and clinicians confirmed when they had reviewed these patients each day. If for some reason their review was not confirmed bed managers would follow this up to ensure the patient had been seen by a doctor and their care reviewed. However staff on Kitty Hubbard ward said that medical (outlier) patients were not always reviewed in a timely fashion. This meant that there was a lack of common understanding of procedures by staff.
- The risk of readmission to medical services within the trust was similar to the England average for elective and non- elective procedures.

Competent staff

- We observed clinical practice, attended staff handovers and multidisciplinary team (MDT) meetings and saw that staff working across medical services were competent and knowledgeable within their chosen wards.
- Staff competency assessments were in place to show that staff had been assessed and were proficient within their respective specialist wards. For instance, the plans we saw for the delivery of staff induction and competency training on the renal and chemotherapy units were excellent.
- The ward manager of the AMU told us that that staff competencies were confirmed electronically but said that most were now "quite out of date". They also told us that there was a need for specific competencies for AMU so that staff had required skills to work effectively in AMU.
- New nursing staff received induction training and were supernumerary for at least one week. Staff we spoke to were positive about the induction they had received. However nurses working within specialist areas such as the renal unit were supernumerary for at least three months. The renal unit manager told us that the induction period may be extended if staff were not confident in their role and procedures on the unit.
- A newly qualified nurse on Elizabeth Loury ward told us they had been well supported received a good induction and were being supported to achieve required competencies within six months.
- However several nurses told us that staff training and development had been difficult due to staffing levels. One nurse on Princess Anne ward told us "I can't make time for training". A nurse working on the stroke unit told us that training was "on hold" due to current staffing levels.
- Doctors we spoke with said they received good support from consultants and registrars.
- We saw in ward and team meeting records that managers encouraged staff to seek practice support from senior colleagues to improve care and record keeping.
- Medical services had not met the trust target of 85% of staff had undertaken mandatory training with actual achievement of 70% of staff had achieved this (identified within the December 2015 medicine board performance report). Information we looked at on the wards confirmed that the majority of wards had struggled to achieve this target.

Medical care (including older people's care)

- The trust for annual appraisal was 85% information provided by the trust identified that compliance with appraisal for medical services was 67.3 % YTD. Staff we spoke with confirmed they had an annual appraisal or had one scheduled. Staff told us that as part of their appraisal they discussed their development and any training needed for their revalidation.
- Ward managers and matrons received monthly information about staff who required an appraisal. This enabled them to plan appraisals with those staff who were due to have appraisals.

Multidisciplinary working

- Physiotherapists, occupational therapists, speech and language therapists and dieticians attended the medical wards as required.
- Staff working on Windsor ward told us that they had a nutritional specialist who attended the monthly multidisciplinary meeting to provide advice and support. In addition catering staff would visit the ward weekly to discuss the ongoing dietary needs of their patients.
- Staff working on Windsor ward told us that voluntary services would come and talk to patients to identify their needs and preferences such as food preferences.
- We observed a multidisciplinary team (MDT) meeting on Benfleet ward and the stroke unit. On the stroke unit we observed that the patient's consultant, nurses, physiotherapists, speech and language therapist psychologists and social worker attended.
- Staff working on the stroke wards told us there were good multidisciplinary working and they were fortunate to have a psychologist who worked with them to provide psychological support for their patients. One ward sister told us that due to the increased acuity of patients one symptom was an increase of incontinence for stroke patients they needed a continence nurse to promote continence and help patients manage their incontinence.
- There was a daily MDT board round which included social care, doctors (consultants, registrars and junior doctors), physiotherapists, nurses and occupational therapists.

Seven-day services

- The medical lead for medicine told us there was seven-day consultant cover within medical services. Information we looked at during the inspection confirmed this.
- The stroke team had a seven day transient ischaemic attack (TIA) clinic that general practitioners could access electronically.
- Doctors told us that there were daily doctor's rounds. However the trust identified that there were fewer discharges at the weekend and they were looking to ensure that all patients were consistently reviewed by a consultant seven days a week.
- Consultants told us that over the weekend all new patients and patient's whose condition was of concern would be seen by a consultant. This meant that patients whose condition was stable were not seen, which had impacted on timely patient discharges over the weekend.
- Therapy services, such as respiratory and musculoskeletal and stroke physiotherapists and occupational therapists were available from 8.30am to 4.30pm seven days a week and on an on-call basis overnight.
- Speech and language therapists and dieticians were available five days a week.
- The hospital pharmacy was open seven days a week, although for reduced hours at the weekend. Urgent medicines could also be accessed by senior on-call staff.
- Doctors confirmed that they were able to arrange x-rays over the weekend and during the night when a need was identified.

Equipment

- Renal unit patients told us that they frequently found the unit to be very cold, although staff did offer them blankets. Staff also confirmed this and the manager said although the air conditioning had been turned off it continued to blow out cold air and this had been reported that morning to the estates department. One staff member said: "the unit is a bungalow in the carpark and is always cold". We also found the unit to be cold on the day of our visit. We reported this to the trusts management who took action on this.

Medical care (including older people's care)

- On the renal unit, information had been sent out to haemodialysis patients to explain the risks and prevention of needle displacement during treatment. If the needle was dislodged an alarm system was in place to alert staff to any moisture around the dialysis site protecting patients from blood loss.

Access to information

- On most of the wards nursing observation charts were kept close to patients and were accessible at all times. Patients' notes were kept on the wards securely within notes trolleys.
- Medical wards used a large white board detailing patient details, admission and estimated discharge date, listed healthcare professionals involved in the patients care and some identified if tests were awaited. This provided staff with information as to the location and condition of each patient.
- Nursing staff told us that, when patients were transferred between wards, staff teams received a handover about their medical condition. This facilitated the continuity of patient care from ward to ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust target for mental capacity and deprivation of liberty safeguards staff training was 85%. Information provided by the trust showed that 65% of staff working within medical services had received this training.
- Patients' consent for endoscopy was gained at the time of the procedure but there were plans in place to send out the consent forms prior to the patient's procedure to enable them to improve the consent process so patients had more information.
- Staff on AMU told us mental capacity assessments were done by doctors. Mental capacity assessments we looked at confirmed this, however we found on Benfleet ward one patient record showed that the doctor had not ticked whether or not the patient had capacity.

Are medical care services caring?

Good



Overall we rated the medical wards as good for the caring domain.

Because:

- We observed patients receiving compassionate care from staff and the patients with whom we spoke felt they were treated with dignity and respect.
- Patients felt involved in their own care and treatment and this was supported by our observations of staff explaining things clearly and asking whether patients and their families had questions.
- We saw evidence of emotional support for patients and families, both directly from staff and from other pathways to which they could be referred.
- The medical wards scored overall similar or slightly better than the national average in the most recent Friends and Family Test (FFT).
- Feedback from the 2014 CQC inpatient survey was overall in line with the England average in all 12 measures.
- There were mixed responses in the Cancer Patient Experience Survey.

Compassionate care

- The medical wards scored on average similar or slightly better than the England average on the Friends and Family Test (FFT) for the period August 2014 to July 2015. The 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. The overall response rate for this period was 21.4%, lower than the England average of 35.5%.
- The FFT results for November 2015 showed variation between the medical wards. For example, 68% would recommend the Bedwell acute medical unit (a response rate of 9.7%). However, results had been much higher in previous months; for example, 95.5% in September 2015. The survey found that 96% would recommend the Elizabeth Louri specialist cancer ward (a response rate of 25%).
- We spoke with 35 patients and seven relatives across the medical wards. Most of these patients felt they were receiving a good level of care. On the acute stroke unit (Benfleet ward), patients described the nurses as "helpful" and "attentive". However, one patient told us that night staff "sometimes don't have the time to ask how you are" because of low staffing levels. We spoke with four patients on Paglesham ward, which is the rehabilitation section of the stroke unit, all of whom

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were positive about the care they were receiving. For example, one patient stated they felt “well cared for” by health care assistants (HCAs) and nurses and that staff did “an excellent job considering the stretching of resources”. However, one patient on Paglesham ward told us that the wait time for a nurse at night was “sometimes unacceptable”, but that generally the care was good. In the discharge lounge we spoke with six patients, all of whom were positive about the standard of care. They described staff as “friendly”, “kind” and “considerate”. On Princess Anne ward, a specialist unit for elderly patients, we spoke with six patients, all of whom reported that they received compassionate care. For instance, a patient told us nurses “try very hard” despite being “well and truly overworked”. On Windsor ward, a specialist unit for patients over 65, patients and relatives also spoke highly of the care they received.

- A patient on Benfleet ward raised concerns about night staff treating her in an unfriendly and inconsiderate way. She told us they “seemed to have a chip on their shoulders”. We discussed this with the lead nurse who assured us they would investigate these concerns.
- On all wards we observed staff taking the time to explain things clearly to patients. On Princess Anne ward a doctor demonstrated their respect for patient dignity by ensuring the patient was behind a screen during the examination, and checking that the patient was comfortable at each stage.
- During our inspection staff were observed to be polite and courteous to patients and responded compassionately to patients’ needs. For example, on Princess Anne ward we observed HCAs carefully giving small amounts of water from a spoon to one patient who had difficulty swallowing. The patient’s daughter and the staff told us that she was showing gradual improvement and attributed this to the perseverance and compassionate care from staff. On Benfleet ward, both HCAs and nurses were observed showing care and attention to patients at lunch time, asking what they would like, offering options and providing positive encouragement to patients with small appetites.
- The trust took part in the 2014 National Cancer Patient Experience Survey. Out of 1,065 eligible patients, 637 questionnaires were completed (a response rate of 66%, slightly higher than the national average). The questions in this survey are summarised as the percentage of patients who reported a positive experience. Responses were mixed, with three indicators in the top 20%

nationally, including nurses ‘not talking in front of the patient as if they were not there’. Eleven indicators, including patients’ confidence that their views were definitely taken into account when discussing treatment with doctors and nurses, fell within the bottom 20%. 49 indicators were in the middle 60% of trusts.

- The trust took part in the 2014 CQC inpatient survey and performed about the same as other trusts in all 12 reported measures. The survey was sent to 850 recent inpatients and 372 were completed (a response rate of 44%, slightly lower than the overall national rate of 47%). It asks about aspects of care such as involvement in own care, emotional support and interactions with staff.

Understanding and involvement of patients and those close to them

- On Benfleet and Paglesham wards, patients spoke positively about involvement in their own care. One patient told us “the doctor explains everything fully and asks if I have any questions”. Another said “doctors have explained exactly what is happening and have not missed out telling my children, [who are also invited to] ask questions”. On Princess Anne ward patients also reported being kept well-informed about their treatment and care plans.
- There was a weekly relatives’ forum on Benfleet ward which aimed to give the patient’s family an opportunity to discuss the patient’s progress.

Emotional support

- Staff on Benfleet ward explained that a psychologist worked with them to provide psychological support to patients.
- An oncology counsellor was available to support the emotional needs of patients with cancer and their families.
- On the cardiac medical ward there was a support group which provided support to people with implanted cardioverter defibrillators (ICDs). This was led by two cardiac physiologists and met every four months. There was also a support group called PACERS which supported patients with pacemakers and met every three months.
- In the Department of Medicine for the Elderly (DME) patients could be referred to the community mental

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health team. There was a nurse-led follow up memory clinic once a week and a telephone helpline for patients and carers where people could gain information or discuss problems.

Are medical care services responsive?

Requires improvement



We have rated the medical care services requires improvement for the responsive domain.

Because:

- There was a high rate of medical outliers (patients not accommodated on the correct ward for their treatment) due to capacity issues. Over the six months prior to our inspection, there had been 1,359 medical patients who had been moved between wards three or more times.
- The trust was not consistently meeting referral to treatment time waiting time standards for cancer patients.
- Male and female patients were accommodated in the same bay on the acute stroke unit (Benfleet) which was a breach of the Department of Health's 'mixed sex accommodation' policy.
- The acute medical unit (AMU) was located on the other side of the hospital from A&E and x-ray wards. This meant that transferring patients from those wards was difficult and time consuming, and staff were sometimes away from the unit for extended periods.
- The renal unit was very cold.

However, we also found:

- A TIA clinic was available giving GPs access to book patients into it electronically.
- Referral times for starting consultant-led treatment were better than the national average for medical services. In particular, 100% of patients treated in the geriatric medicine and neurology units had begun treatment within the target 18 weeks.
- Patients' individual needs were carefully assessed prior to discharge and staff made appropriate discharge arrangements with care agencies or families based on this assessment.
- Patients living with dementia, learning disabilities and mental health problems could be provided with one-to-one support where needed on wards.

- The stroke unit was particularly responsive to patient needs. For example, it provided embolectomy (emergency removal of blood clots that block normal blood circulation) when it was likely to improve a patient's condition, and had stopped using anti-embolism stockings because they found they were of no benefit to stroke patients.
- The renal unit had recently begun to offer home dialysis which was popular with patients.

Service planning and delivery to meet the needs of local people

- The trust provided emergency treatment (thrombolysing or clot-busting and thrombolectomy or clot retrieval), 24 hours a day, and seven days a week for stroke patients.
- The stroke team had a transient ischaemic attack (TIA) clinic. The GP could use the electronic system to assess and identify patient risk and priority of appointment. Timely access for patients who have a TIA is imperative as patients may go on to have a stroke without timely medical intervention. This clinic has been awarded an innovation award.
- The renal unit was open Monday to Saturday and provided sessions from 7.30am until 12 midnight (Monday, Wednesday and Friday) and from 7.30am to 7pm (Tuesday, Thursday and Saturday).
- A stroke support worker on Paglesham ward told us about a stroke support pack for patients with "appropriate information for their individual risks and needs". The pack included relevant contact numbers for support after discharge.

Access and flow

- National standards state that 90% of referred patients should start consultant-led treatment within 18 weeks of referral. Between September 2014 and August 2015 the trust achieved better than the England average with all specialisms achieving 97.5% or higher for this standard for medical services with the exception of December 2014. Geriatric medicine and neurology had achieved 100% figures for patients who were admitted. This was also above the England average for those specialities.

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- The most recent information for the two-week cancer wait shows that since March 2014 the target had been met. However the 62-day wait for first treatment was not met from March 2014, although there had been some improvement from December 2014.
- All patients who had an acute ST-segment-elevation myocardial infarction (STEMI) were sent to a local cardiology centre.
- There was a two-week wait for non-urgent referrals to a local cardiology centre however if waits were identified as longer patients were sent to an alternative hospital.
- The endoscopy unit was open six days a week to meet patients' needs. The endoscopy unit had undertaken 3,611 endoscopy procedures between 1 June and 31 December 2015.
- There were occasions when there were insufficient beds for medical patients due to capacity issues. This meant medical patients sometimes had to be accommodated on a non-medical ward (medical outliers). During the inspection we found that several patients had moved wards on three or more occasions. Information provided by the trust identified that the number of medical patients who have had three or more ward moves during the last 6 months was 1,359.
- Patients were admitted under a named consultant and outlier patients were seen by the consultant's team or the consultant team on call.
- The average length of stay for non-elective patients was better than the England average (5.9 days compared to 6.8 days). However, average length of stay for elective patients was similar or slightly worse than the England average (4.2 days compared to 3.8 days).
- Patients' discharge dates were discussed at daily ward rounds and MDT meetings. This was to ensure those patients who were medically fit could be prioritised to leave the hospital.
- Prior to discharge, patients' needs were assessed so that the correct level of care could be put in place at home or in a care setting. On the stroke ward an occupational therapist discussed the outcome of a home visit during the MDT meeting. This was to assess the patient's ability to undertake tasks within their home. Staff then made appropriate discharge arrangements with care agencies or families.
- The hospital had an "Assess to admit" strategy in acute medical unit. To maximise this there was an Older Persons Assessment Service which was co-located with the AMU and the Elderly Day Assessment Units.

Meeting people's individual needs

- There was an interpretation service available for patients and their families who did not have English as their first language. Staff told us that although they had used this service the hospital had a multi-cultural staff and they were usually able to get a member of staff to translate. This was not good practice as the trust did provide a translation service.
- We saw a wide range of information available to patients and their families on large notice boards and leaflet racks on the wards and visitor waiting areas. The notice boards were clearly visible and accessible for patients and families.
- A notice board on Benfleet ward clearly displayed dementia support information for patients and carers.
- Staff told us that patients living with dementia, learning disabilities and mental health problems were provided with one-to-one support where needed on wards. Some wards also operated supervised bays where patients who needed it could have continual support and supervision which we observed during our inspection. Staff told us that when people living with dementia were confused or agitated they could request one to one care for this person. Staff said mostly this would be arranged although there were times that agency staff/ bank staff were not available to provide this additional support.
- On the non-acute coronary unit time was identified to enable trained nurses to provide 45 minutes health education advice to reduce the risk of a further heart attack.
- The risks and prevention of needle displacement during haemodialysis were explained in a new information leaflet which had been sent out to patients. The leaflet identified a need for patients to wash their arms where haemodialysis would take place when they attended the renal unit and to keep the area exposed so both patients and staff could observe for any blood loss.
- For patients who were living with dementia or lacked awareness if the needle was dislodged, three alarms had been purchased. The alarms alerted staff to any moisture around the dialysis site protecting patients from blood loss which if extreme could result in death. We found this to be good practice.
- Staff working on AMU told us about their frustrations about changes to the location of the ward. They told us that the move away from A&E and x-ray units meant that

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staff may be away from the unit for up to 40 minutes. Due to the location of stairs between AMU and accident and emergency and x-ray, patients would have to be moved in two separate lifts and from one end of the hospital to the other.

- There were plans on Windsor ward for a lounge and sensory room for people living with dementia.
- The Department of Health required all providers of NHS-funded care to confirm by 1 April 2011 that they were compliant with mixed sex accommodation except where it was in the patient's best interests or reflected their choice. A breach of 'mixed sex accommodation' refers not only to sleeping arrangements but also bathrooms and toilets and the need for patients to pass through areas for the opposite sex to reach their own facilities. We observed on Benfleet (the acute stroke unit) that male and female patients were accommodated within the same bay. Staff said that they had been told that in a hyper-acute stroke unit (HASU), male and female patients could be accommodated within the same bay. However, as the unit was not categorised as a HASU, male and female patients should not have been accommodated within the same area.
- Staff told us that, should they have a patient admitted to the ward with learning disability, they could contact the learning disabilities nurse specialist for advice and support.
- The endoscopy unit had tea and coffee making facilities and a private room for breaking bad news.
- Patients we spoke with within the endoscopy unit told us that they had not had to wait long for their endoscopy appointment. Information provided by the trust confirmed that more than 79% of patients were seen within four weeks and 99.8% of patients were seen within seven weeks.
- The stroke unit demonstrated they could deliver high quality care and effective teamwork even though there were severe staffing issues. The stroke unit was providing embolectomy (emergency removal of blood clots that block normal blood circulation). This was not funded, but provided because of the positive impact of this treatment upon patient outcomes. The stroke unit had also stopped using anti-embolism stockings because they found they were of no benefit to stroke patients. This demonstrated how a well-led service changed practice based on patient needs and was open to innovation.

- The renal unit had recently begun to offer home dialysis which, the matron told us; the unit was proud of and was very popular with patients.

Learning from complaints and concerns

- Information available to patients and visitors about how to raise concerns or complaints was displayed on notice boards and leaflets available throughout the medical wards.
- Nursing staff told us they knew how to deal with concerns and complaints. Staff we spoke with said whenever possible they would address concerns quickly and immediately. If this could not be resolved patients would be signposted to patient advice and liaison service (PALS).
- Nursing staff told us that feedback from patients was shared in a variety of ways including staff noticeboards, emails, team /ward meetings and in person.
- The endoscopy unit had received several complaints about telephone access. The matron told us as a result of these concerns there was a business case to recruit an additional receptionist to answer the phone between 9am and 5pm. However until such time this was in place to provide adequate administrative cover bank staff were employed.
- The matron for endoscopy told us and we saw that following complaints about their experience of endoscopy procedures and sedation, new patient information was available. The patient leaflets more fully described the procedure, sedation and any problems the patient may experience.

Are medical care services well-led?

Good



Overall, we rated this service as good for well led.

Because:

- The leadership at all levels had a good oversight of the directorates' plan and the areas that required improvement.
- We saw staff demonstrating the core trust values in the care they provided.
- Staff were positive about the standard of care they provided.
- Staff told us they felt well supported by management.

Medical care (including older people's care)

- There was a culture of audit and improvement within the medical services. Some governance systems were in place to highlight risks with evidence of action planning.
- We saw good examples of leadership and communication in the senior sisters' monthly meetings with a multi-disciplinary approach.
- The stroke unit had positive patient outcomes and could become a hyper-acute stroke unit (HASU) because of strong leadership however, chronic staffing shortages held the service back.

However:

- There were insufficient strategies and mitigation to manage sufficient staffing levels across all wards and units. This was causing concerns for patient care quality and affecting staff morale.
- Staff felt they were too busy to submit incident forms because of regular under staffing.
- There was recognition and actions were in place from senior management that governance processes needed to be clearer with a centralised performance report and greater communication of learning across all directorates.
- Evidence of good innovation but recognition and celebration of staff was variable.
- Mortality and morbidity meetings were lacking in consistency and attendance of nursing management was limited.
- There were gaps in safety assurance with patient bed movements due to a lack of formal risk assessment.

Vision and strategy for this service

- The trust overall had a clear statement of vision and values. Within the medical directorate, senior management outlined a five-year plan for medicine including improved directorate collaboration and plans to improve the diabetes service.
- The trust had a vision for the stroke unit to become a hyper-acute stroke unit (HASU) however; this was dependent on the sufficiency of staff to patient ratios. Staffing levels were well below the required level. The unit strived to achieve this status with an ongoing recruitment advertisement to attract experienced stroke

nurses. Although this service was experiencing chronic staffing shortages, we saw managers were aware of this and actively using agency staff to support permanent nursing staff.

- Endoscopy unit staff told us that there were no plans to attain Joint Advisory Group (JAG) or similar accreditation due to the size of the unit. To achieve accreditation, an endoscopy unit must evidence demonstration of agreed levels of clinical quality, quality of patient experience, workforce and training. JAG accreditation would provide increased assurance of the service provided.
- The trust launched their new values in November 2015 following consultation with staff and patients. We saw high quality care being given and received very positive feedback from both patients and carers about the care staff provided. This demonstrated the fundamental trust value of 'Care with compassion'. Staff frequently said their aim was to deliver high quality care. This was despite the hospital being on 'black' alert and staff shortages.

Governance, risk management and quality measurement

- Directorate management recognised that governance meetings within sub speciality teams were variable but were positive about the renal unit; highlighting their positive patient outcomes. We noted from meeting records that in the most recent clinical directorate performance meeting (January 2016) that there was recognition that the clinical governance process needed to be clearer. The directorate had started to produce a monthly central governance report.
- Records of mortality and morbidity meeting records showed variable levels of discussion especially around patient mortality cases. Medical doctors mainly attended these quarterly meetings and occasionally a matron was also present. Although we saw discussion around learning from practice, we did not see allocated responsibility or time scales to ensure the actions were completed.
- Ward managers told us about the monthly senior sisters/clinical nurse specialists (CNS) meetings with the purpose of discussing ward issues and governance. We looked at the meeting minute records and they showed evidence of good team working and communication between four levels of management (ward managers, matrons, the lead nurse and the associate director of

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nursing. Others present included various medical clinical nurse specialists (including learning disability, stroke, discharge, falls, and governance) and other multi-disciplinary teams such as dietetics, human resources, X-ray and patient involvement representatives. These records demonstrated that varied discussion took place including infection control, practice updates, workforce updates, safeguarding, training, patient feedback, discharge, governance. We saw this as good practice.

- Directorate management told us that the trust established a duty of candour pathway in April 2015 with training sessions given to managers. Ward managers were aware of duty of candour and reported having had training however said they had not been involved in any actual cases because matrons dealt with these. Junior staff knew about a duty to be open and honest.
- We found that medical ward managers held monthly team meetings however, they did tell us that sometimes it was not always possible due to clinical demands. Meeting minute records showed that managers shared incidents, complaints and compliments with staff.
- Matrons were responsible for conducting monthly 'dashboards', which were nursing assessment audits, which were fed back to managers in the senior sisters' meetings. Ward managers conducted ward level 'spot check' audits and fed back all audit results in team meetings.
- The trust told us they risk assessed patients who moved wards on three or more occasions however, we could not find any formal evidence to support this. Staff told us a verbal risk assessed occurred but there was no written/formal assessment undertaken. We came across patients who had been moved wards (on three or more occasions) on Elizabeth Lorry, the stroke Unit and Princess Anne ward but no risk assessment was evident. Patient safety assurance was therefore lacking. This was a cause of patient complaints.
- The senior management team recognised that medical services had an ongoing concern with the highest number of nursing vacancies. Current recruitment initiatives involved working with a nursing agency to source registered nurses for the stroke unit from Europe. This included the use of Skype interviews and vacancies

advertised at conferences to promote recruitment. The directorate had also been exploring the advanced nurse practitioner role, which was also good for staff development.

- The trust was on 'black' alert; experiencing unprecedented numbers of admissions immediately before and during our visit. The trust conducted a risk assessment and decided to add beds to existing wards to deal with the higher bed demand. They told us that this would ensure that an already established team and ward manager would support the use of agency staff. Based upon this risk assessment, management went with this option instead of opening an additional ward, which would require more nurses with an already understaffed service.

Leadership of service

- We found the medicine directorate generally well led at ward level up to matron level. Staff told us there was effective communication between ward staff teams and higher management. Managers said they felt able to raise concerns to higher management. A ward manager said the Director of Nursing was "inspiring and approachable". This was in contrast to what a staff nurse on Princess Anne ward who told us they said they had not seen the Director of Nursing or the senior team.
- The leadership drove continuous improvement and staff were accountable for delivering change.
- Staff reported positive and supportive leadership, particularly from the stroke unit (Benfleet), Elizabeth Lorry ward, the renal unit, the cardiac care unit and Gordon Hopkins ward. We spoke with the manager of the chemotherapy day unit who also demonstrated passion for high quality care and motivation to improve services for patients.
- Staff told us that the ward managers and matrons for the areas we visited were visible and supportive. However, we received inconsistent information from staff about the visibility of management above matron level. One manager told us that the matron was supportive but was often very busy supporting other medical wards.
- Wards had display boards showing performance and patient safety information, including actual and planned staffing levels, results of recent audits and patient feedback. This was positive for patients, carers and visitors to see and for the ward to demonstrate accountability for care.

Medical care (including older people's care)

- We observed a good example of effective leadership on the Princess Anne ward. There was a peaceful atmosphere despite several ill patients who were at the end of their life being on the ward. This was whilst the newly appointed manager was on duty, which was in contrast to when we visited previously, and this manager was off-duty. Therefore it appeared they were an effective manager.
- Generally, managers across the directorate had a good understanding of governance processes. However, one newly appointment ward manager required support in this area from the matron who they described as “wonderful”. The matron confirmed she was providing ongoing support for this manager.
- The ward manager of Eleanor Hobbs told us that there was good communication within the medical directorate. Another ward manager (Windsor) told us that quarterly manager away days (Trust-wide) was useful for communication.

Culture within the service

- Staff in several areas (Blenheim, the renal unit, the stroke unit, Elizabeth Loury) we visited commented that they were “a good team”. They told us that they would recommend the hospital. We also saw evidence of managers promoting teamwork during Bedwell/AMU ward meetings in meeting records.
- Staff on the renal unit told us they enjoyed working on the unit and that they developed good relationships with patients whom they saw on a regular basis. We spoke with several staff that had worked on the unit for over 10 years they told us they stayed because they enjoyed working there.
- All the managers told us that they were proud of their team and their commitment to providing high quality patient care.
- Staff on Elizabeth Loury told us they had a good supportive culture. However, one staff nurse on Princess Anne ward said they did not feel supported or confident as a qualified nurse on the ward. A healthcare assistant on the same ward told us it was a friendly ward, although communication could be bad between the nurses and the health care assistants.
- Staff were hard working and committed to providing the best possible care they could however, managers said

that staff were “tired” and there was “low morale” because of staffing shortages. In the NHS staff survey (2015, 69% of staff at this trust said they worked extra hours.

- The directorate managers told us that change had occurred quickly (over three to six months) and the staff had handled these changes well.
- Staff said they were proud of the strong team work ethic and the quality of care given despite daily staffing constraints.
- A medical consultant lead told us sharing learning from incidents needed to improve across all directorates to improve outcomes for patients however; they did say this was slowly changing.

Public engagement

- The FFT response rates were generally low across all medical wards however; we saw evidence of managers encouraging staff to promote this in ward meeting minute records. These results were on display boards on entry to the wards we visited.
- The trust has a patient experience team and support groups, for example, a three monthly support group meeting for patients with pacemakers known as PACERS. The trust advertised their patient support groups on their website.

Staff engagement

- The trust used a combination of email, intranet messages and newsletters to engage with staff.
- We saw in manager meeting records that they encouraged staff to complete the NHS staff survey. Management addressed the previous staff survey results by identifying two key areas to focus on, staff motivation and equal opportunities. In board meeting records, we saw an action plan was in place to address these areas of improvement and for managers to share this with staff at ward meetings.
- Records of team meeting we saw showed that managers thanked staff for their hard work in team meetings.
- We also saw in these records that managers encouraged staff to seek practice support from senior colleagues/ themselves to improve care and record keeping.
- Most staff told us they felt valued and listened to and felt able to raise concerns to their managers and matrons.







Medical care (including older people's care)

- The trust set up daily safety meetings in September, known as 'Safe @ Southend' and this was an opportunity for staff to attend and voice any concerns about patient safety with executives in attendance. Ward managers told us they had been and found the meeting helpful to share good practice and learning. The action log from this meeting was available to staff on the trust intranet. The monthly staff newsletter 'The Look' advertised this meeting which was an opportunity for staff engagement.

Innovation, improvement and sustainability

- Appropriate systems were in place to review service delivery and appropriate actions taken to address issues. Staff said managers informed them of recent clinical incidents and complaints in team meetings. We saw evidence of this communication in meeting minutes with encouragement from managers to report incidents.
- Managers encouraged staff to share compliments and positive feedback at team meetings and to the Patient Advice and Liaison service (PALs). This example of positive leadership was required for a service where staff morale is low.
- Senior managers of the renal unit told us about the use of alternative medicines that had improved patient outcomes and had achieved a cost saving (e.g. the use of Dalteparin as opposed to Heparin).
- Staff on the renal unit told us that innovation and research based improvements were encouraged and when possible implemented. The renal unit introduced a new way of taping cannulas, known as 'chevron' this kept the needle more secure and reduced the risk of displacement and blood loss. The renal unit were also using an alarm for high-risk patients that alerted staff quickly to the presence of any moisture (which may be blood loss).
- The stroke unit demonstrated they could deliver high quality care and effective teamwork even though there were severe staffing issues. The stroke unit was also providing at times embolectomy (emergency removal of blood clots that block normal blood circulation) because of the positive impact of this treatment upon patient outcomes. The stroke unit had also stopped using anti-embolism stockings because they found they were of no benefit to stroke patients. This demonstrated how a well-led service changed practice based upon their patient needs and was open to innovation.
- The renal unit has recently begun to offer home dialysis which, the matron told us, was very popular with patients and was something the unit was proud of.
- Senior directorate managers said, "innovation was constrained by resources and patient flow". Managers were aware of their challenges such as staffing and finances but were seeking ways to improve.

Surgery

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

Information about the service

Southend University Hospital NHS Foundation Trust provides a comprehensive range of services to a local population of some 338,000 in and around Southend and nearby towns.

Between July 2014 and June 2015 the trust completed a total of 30,800 surgical procedures. Of these 16,016 (52%) were day case procedures, 5,852 (19%) elective and 8,932 (29%) emergency procedures.

Southend hospital was the trusts main site for surgical procedures and 29,200 of the 30,800 cases were conducted at Southend, this included all emergency procedures. This report focuses on services provided at Southend University hospital although some national statistics quoted in the report will have been compiled using data at trust level.

The trust provided surgical services from four sites. Southend University hospital completed 29,200 procedures, and Orsett Community hospital 800, and a small number of procedures were carried out by the trusts consultants at private hospitals; BMI Southend 600 procedures and Spire Wellesley Hospital 200.

The hospital had ten main theatres, one minor operating theatre, three day case theatres and two dedicated ophthalmology theatres. Southend hospital had approximately 590 beds; the bed base can change due to demand. There were seven surgical wards; Castle Point, Chalkwell, Shopland, Balmoral, Stambridge, Hockley and Southbourne.

The trust provided a diverse range of surgical interventions; The trust is the South Essex surgical centre for uro-oncology and gynae-oncology surgery.

Management of surgical services at the trust fell within three different directorates; the Surgery Division, the Theatres, Critical Care and Anaesthetics Division and the Musculoskeletal (MSK) Division.

Services provided included: Audiology, Breast Unit, ENT, Oral and Maxillofacial Surgery, Orthodontics, General Surgery, Urology, Ophthalmology and Trauma and Orthopaedics.

During the inspection and in order to make our judgements we visited a number of wards and treatment areas. We observed practice on wards, theatres and recovery areas. We spoke with 26 patients and 8 relatives or carers about their experiences at the hospital. We spoke with 44 staff regarding their work and the hospital in general. We reviewed documentation in relation to the general running of the services, maintenance of equipment and buildings; we also reviewed 16 patient records and reviewed information provided to us prior to and during inspection.

Surgery

Summary of findings

We rated surgical services as good overall.

The area requiring improvement was the responsive domain.

We found that the trust was cancelling elective surgery because of capacity issues in the hospital. At the time of inspection there was a lack of clinical input in the decision making process as to which surgical cases would be cancelled. The trust was below the England average for patients being treated within 28 days of cancellation of their operation date, therefore further delaying surgery.

We rated the safe, effective, caring and leadership domains of the service as good.

We saw that incidents were raised and used as a learning tool; escalation triggers were identified and followed. Infection protection and control methods were used to ensure patients safety.

However, we found that there was no ward based pharmacy service. Patient's prescription charts were not reviewed or checked by a pharmacist and we saw delays in patients receiving prescribed medicines. We also saw that nursing staffing levels were below planned levels on musculoskeletal wards.

We observed good multidisciplinary working between nursing staff, medical staff and allied health professionals. The service participated in national audits to record patient outcomes with opportunities for improvements identified and action plans put in place to address issues highlighted following audits. We saw that assessments for patients were comprehensive, covering all their health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs.

Staff interacted with patients in a friendly, polite and professional manner. Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw staff treated patients with dignity and respect.

Surgical services were well led. Senior staff were visible on the wards and theatre areas. Staff appreciated this support.

Surgery

Are surgery services safe?

Good



We rated this service as good for safe.

Because:

- Staff were encouraged to report incidents using the electronic incident reporting system. Staff were made aware of trust wide incidents in various formats, for example, through team meetings, governance meetings and emails from line managers to share lessons learned.
- National Institute for Health and Care Excellence (NICE) guidelines for the prevention and treatment of surgical site infections were followed by theatre staff.
- Infection control practices were effective; when infection did occur it was below the England average.
- National Early Warning Score tool was used to ensure patients safety.

However:

- There was no ward-based pharmacist for musculoskeletal (MSK) or surgical wards therefore patients' prescription charts were not reviewed or checked by a pharmacist.
- The hospital had not implemented Electronic Prescribing (EP) system in the wards we visited. This led to delays in patients receiving prescribed medicines. Staff had to leave the ward to go to pharmacy to collect medicines. This reduced the amount of staff available on the ward to care for patients
- Nursing staffing levels were below agreed establishment for MSK wards.
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Incidents

- The trust had an electronic incident reporting system. Policies were available to staff to enable them to identify when they needed to report incidents, and how to do so. Incidents were graded according to their severity and impact on individuals or services.
- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures had been implemented. There had been two never events reported in the surgery core services between November 2014 and January 2016. One incident related to a retained swab following

surgery in the main operating theatre and the second was a medication error which took place in the anaesthetic room of the main theatre. We saw that immediate actions had been put in place following the incidents. A full root cause analysis investigations had taken place to identify the causes of the incidents. The trust had developed and carried out action plans based on the learning from the never event to prevent future occurrences.

- Between 1 November 2014 and 31 October 2015 there were 21 serious incidents reported by the surgical directorate via the National Reporting and Learning System.
- During this period there were 2,552 incidents reported by staff across surgical services. Of these, 2,484 were classified as low harm incidents, of which 342 were slips, trips and falls and 362 were pressure ulcer related.
- We spoke with staff who told us that they were encouraged to report incidents and were aware of the need to do so. Staff had access to the electronic incident reporting system, which was available through the trust's intranet site.
- Staff told us that they were made aware of trust wide incidents in various formats, for example, through team meetings, governance meetings and emails from line managers to share lessons learned. We saw posters displayed in staff rooms detailing the top five risks for the service and the controls which had been put in place to address them.
- Duty of Candour is regulatory duty that is related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person.
- During interviews, staff were able to describe their obligations under Duty of Candour and were aware of when this would come into effect. We saw that the trust had distributed information leaflets to staff explaining the expectations of them under the Duty of Candour.

Safety thermometer

- The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care. The system is designed to monitor the number of instances where

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patients who had been admitted to hospital experience hospital acquired: pressure ulcers, falls, catheter acquired urinary tract infections (UTI's) and venous thromboembolism (VTE).

- The trust participated in the NHS Safety Thermometer scheme and we saw that information about harm free care was displayed on boards at the entry to wards and departments.
- Between September 2014 and September 2015 trust figures showed that there had been 13 grade 2, 3 or 4 hospital acquired pressure ulcers. Analysis of these showed that there was no common trend. We saw that the number of pressure ulcers had fallen to zero since September 2015.
- Falls with harm had affected 12 patients during the period although none had occurred since July 2015.
- Eight patients suffered catheter acquired UTI's.

Cleanliness, infection control and hygiene

- From August 2014 to August 2015 there were no occurrences of Methicillin-resistant Staphylococcus Aureus (MRSA). There were 30 incidents of C. difficile which was below the England average.
- The trust had a robust infection control policy in place. Staff that we spoke to were aware of the policy and were able to access it via the trust intranet.
- Hand washing facilities, including hand gel were readily available in prominent positions on entry to each clinical area. We observed staff using appropriate hand washing techniques and personal protective equipment, such as gloves and aprons whilst delivering care.
- The trust's infection control dashboard was updated on a monthly basis. The dashboard included results for cleaning and decontamination audits, hand hygiene audits and invasive device audits for all surgical wards. The audit results were fed back and discussed at team meetings in order that action plans could be put in place to address any outliers. We saw copies of the team meetings which confirmed this.
- The trust provided data from September 2015 that showed the surgical and MSK wards achieved 100% in the cleaning and decontamination audit. All wards audited achieved 100% in the hand hygiene audit with the exception of Stambridge Ward where the bare below the elbows standard was not adhered to leading to a score of 75% for that aspect of the audit. This had been

fed back to staff with a reminder to check that they were bare below the elbow and to challenge any colleagues if they saw any breaches. During inspection we observed staff working bare below the elbows.

- Trust data showed that the majority of surgical and MSK wards achieved 100% in all aspects of the invasive device audit in September 2015. An invasive device is an object that requires the puncture or incision of the skin before it is inserted into the body.
- We saw that there were outliers in relation to the completion of peripheral assessment details with Balmoral Ward, Shopland Ward and Castlepoint Ward scoring 25%, 83% and 80% respectively. A peripheral assessment is completed to ascertain the health of the skin and surrounding area for the planned insertion and identifies sites which may be at risk of infection. The trust target for completion of peripheral assessment details is 100%.
- We observed that the National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008) was followed by staff in the theatres. This included skin preparation and management of the post-operative wound.

Environment and equipment

- Emergency resuscitation equipment, for use in operating theatres and ward areas, was regularly checked, and documented as complete and ready for use. Resuscitation trolleys were secured with tags which were removed daily to check the trolley and contents were in date.
- There were systems to maintain and service equipment as required. Equipment had safety tested stickers which identified they had been tested.
- We saw equipment history reports for anaesthetic gas analysers, syringe pumps and insufflator units were completed in both day stay and main theatres.
- The surgical equipment maintenance record showed maintenance intervals and service status for 89 pieces of surgical equipment. Servicing for 11 pieces of equipment was overdue; this included five infusion pumps on Balmoral Ward, one infusion pump on Eastwood Ward, one infusion pump on Southbourne Ward and one anaesthetic gas analyser in day stay theatres. There were three pieces of equipment with overdue servicing in main theatres, which included an anaesthetic gas analyser, and two additional pieces of

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equipment used in anaesthesia. The overdue servicing ranged from 4 days to 159 days overdue with an average of 51 days overdue. We saw that there were sufficient pieces of serviced equipment in all locations to ensure the safe delivery of care. A service schedule had been put in place to address the maintenance of the overdue equipment.

- There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed. Bins were emptied regularly and we observed portering staff collecting waste from the wards.
- Monthly cleaning audits took place. Between January 2015 and October 2015, the average cleaning audit score was 95.8%, which was above the national standard of 95%.

Medicines

- The pharmacy department had developed a Medicines Optimisation (MO) strategy (July 2015) to ensure medicines were managed safely and effectively with emphasis on a patient centred approach. This included gradually moving from a paper-based prescribing system to an Electronic Prescribing (EP) system to support the MO strategy.
- We found that although medicines were stored securely there were concerns with storage on both the Shopland and Castlepoint MSK Wards in that the medication room was not of suitable size for the safe handling and preparation of medicines. There were no medication room temperature records available for Shopland Ward. Medication room temperature records for Castlepoint Ward documented that the temperature was above the recommended safe temperature storage range for medicines. At the time of inspection staff had taken no action to address this.
- On Stambridge Ward (Surgical High Dependency Unit) we found that although medicines were stored securely in medicine cupboards there was no door to the medication storage room. Staff told us that a door was going to be fitted to ensure extra security of medicines.
- We were told by the Acting Chief Pharmacist that a planned roll out of new medication storage rooms was being undertaken; however at the time of inspection time scales for completion were not available.
- There was no ward-based pharmacist for MSK or surgical wards therefore patients' prescription charts

were not reviewed or checked by a pharmacist; however, the wards could telephone the pharmacy department for advice if required. The lack of a ward based pharmacist service meant that staff had to leave the ward to go to pharmacy to collect medicines. This reduced the amount of staff available on the ward to care for patients.

- The EP system had not been implemented in the wards we visited. Paper prescriptions were required to be sent to Pharmacy Department for any new medicines not kept routinely as ward stock; this was seen to lead to delays in patients receiving prescribed medicines.
- Medicine incidents were seen to be reported by staff, with learning from incidents shared locally at ward level; however, learning from medicine incidents was not shared across the trust. The most recent trust wide, "Medicine Safety Focus Bulletin," was produced in March 2015.
- Following our inspection the trust shared with us an action plan outlining how it was going to increase the number of pharmacists within the hospital.

Records

- In surgical wards and theatres, we examined 16 patients' medical and nursing records, which included assessments for patients treated in operating theatres. There were detailed and comprehensive pre-assessments made on patients prior to admission.
- Records included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. We looked at preoperative records, including completed preoperative assessment forms. Records were legible, accurate and up to date.
- Medical records were seen to be stored in secure cabinets in ward areas.
- The World Health Organisation 'WHO Five steps to safer surgery' surgical safety checklist was launched in June 2008. The checklist should be used for every patient undergoing a surgical procedure. During our inspection we saw that the WHO checklist was inconsistently used in the Interventional Radiology service. We raised this with the trust who completed an audit on 15 January 2016 this showed that the WHO checklist was completed for only 48% of procedures. A repeat audit was undertaken on 27 January 2016 and compliance was

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found to have improved to 98%. The trust advised us that compliance with WHO checklist completion would in future be reported monthly to the executive team at the Directorate Performance Review meeting.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details.
- The trust target for completion of mandatory adult safeguarding level one training was 85%. The average completion rate for all staff was 67%. Two staff groups; Allied Health Professionals and Healthcare Scientists in the MSK and Surgery directorates respectively were above the target completion rate. No staff had been trained to level 2 adult safeguarding.
- The trust target for completion of mandatory child safeguarding level one training was 85% the average completion rate for all staff was 76%. Medical staff across the MSK and Surgery directorates had an average completion rate of 49%.
- The trust target for completion of mandatory child safeguarding level two training was 85% the average completion rate for all staff was 60%. At the time of inspection there were no staff within the Surgery or MSK directorate who had completed level three child safeguarding training, although we saw that two staff within the resuscitation team had been identified to complete the training.

Mandatory training

- Mandatory and statutory training was provided by a combination of e-learning and face to face training sessions. Staff were able to access e-learning through the trust intranet site.
- Mandatory and statutory training was made up of 21 modules including adult and child safeguarding, equality and diversity, falls prevention, manual handling, infection control and information governance.
- Information governance training had a trust target completion rate of 95%. The average completion rate for staff was 83%.
- There was a target completion rate of 85% for all other mandatory and statutory training. The average completion rate across all modules was 66%.

- Staff told us that they found it difficult to find time to complete their mandatory training due to workload. Some teams such as resuscitation staff had all completed 100% of their training.

Assessing and responding to patient risk

- The National Early Warning Score tool (NEWS) which demonstrated whether a patient's condition was deteriorating was used in all surgical wards. The NEWS tool records whether observations were recorded upon patient admission to the ward, the frequency of observations post admission and any actions taken by staff for patients identified as a risk following observations. In October 2015, the majority of completion scores were 100% for surgical wards; however, Castlepoint Ward, Shopland Ward and Balmoral Ward scored 90% for documenting the frequency of observations on the patient's medical chart.
- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- We saw that the World Health Organisation 'WHO Five steps to safer surgery' surgical safety checklist was being completed across surgical services. Changes to practice and documentation were completed as required. In relation to the WHO checklist, a standardised handover was developed between main theatres, post-operative recovery and surgical wards.
- Staff in surgery were empowered to identify, mitigate and escalate risk identified through completion of the WHO checklist.
- Due to bed capacity issues elective surgical procedures were cancelled. However, the decision was not being made by a clinical member of staff. Following the inspection the trust shared an action plan with us which confirmed this practice would cease. All cancellations will have clinical review and input.

Nursing staffing

- The Safer Nursing Care Tool (SNCT) is designed to make a recommendation for the total combined Registered Nurse (RN) & Healthcare Assistant (HCA) staffing establishment for each ward. The trust used the SNCT to determine nursing staff levels.

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- The trust told us that there was a mix of 60 percent qualified to 40 percent unqualified nursing staff on general wards and 70/30 qualified to unqualified nursing staff in acute areas. The Royal College of Nursing recommends a 65/35 qualified to unqualified staffing ratio on acute general and surgical wards in England.
- The trust provided data on staffing levels. This showed that almost all ward areas had a number of vacancies. Data for December 2015 showed the Elective Admissions Lounge met establishment figures for nursing staff. However, the MSK wards, Castle Point Ward and Shopland Ward and the Stambridge surgical ward had 11% vacancies. J Alfred Lee post operation ward had 8% of its posts vacant.
- Following our inspection, we were advised by the trust that from the 22 January 2016, 12 beds on MSK wards had been closed to ensure that safe staffing levels could be maintained. The trust advised that there is an on-going nurse recruitment programme in place to recruit additional nursing staff over the next 12 months.

Surgical staffing

- Surgical doctor staffing shift patterns were dependent upon the speciality.
- Orthopaedics had a consultant on site between 08:00 and 18:00 Monday to Friday and between 08:00 and 15:00 at weekends, a consultant was available on call at all other times. There was medical cover provided by trust grade doctors and junior doctors at all times on a three shift basis.
- Ophthalmology had a consultant on site between 09:00 and 18:00 Monday to Friday, with on call cover provided at all other times.
- Urology had a consultant on site between 08:00 and 18:00 Monday to Friday and consultant cover on call at all other times. Trust grade and junior doctors provided on site cover at all times on a two shift basis.
- Vascular surgery had consultant cover onsite between 08:00 and 18:00 Monday to Friday with on call cover shared with partner hospitals at all other times.
- Maxillofacial and Oral surgery had either a maxillofacial consultant or an oral surgery consultant on site between 09:00 and 18:00 Monday to Friday. A Maxillofacial consultant was available on call at all other times. Trust grade doctors provided on site cover and on call cover at all other times.

- Junior doctors reported that they were well supported by consultants in surgery, and felt that they were always able to discuss issues with them.
- There was a dedicated ortho-geriatrician to support patients with a fractured neck of femur to assist with care planning.

Major incident awareness and training

- The trust had a major incident plan in place dated September 2015, which included information on how to deal with incidents such as transport incidents, terrorism and outbreaks of disease.
- Staff knowledge regarding major incidents was limited within the surgical areas with some staff uncertain as to what constituted a major incident. Staff were aware there was a policy and would access this via the trust intranet and call senior staff if this occurred.

Are surgery services effective?

Good



We have rated this service as good for effective.

Because:

- Assessments for patients were comprehensive, covering all health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. Patients' care and treatment was planned and delivered in line with evidence based guidelines.
- The trust participated in national audits to record patient outcomes, including the National Bowel Cancer Audit (NBOCAP), National Emergency Laparotomy Audit (NELA), Surgical HDU Audit, Peripheral Vascular Surgery Audit and Lower GI Bleed Audit. Key areas of improvement were identified following audit and action plans were put in place to address issues identified.
- We observed good multi-disciplinary working between nursing staff, medical staff and allied health professionals.

However:

- There were two prescribing systems in place. The use of the paper based system was seen to cause a delay in the dispensing of pain relief medicine. We saw an example of a patient missing a dose of pain relief medicine as a result of the delays in the paper based system.

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- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training rate was 50% against the target of 85%.

Evidence-based care and treatment

- Assessments for patients were comprehensive and holistic. Patients' care and treatment was planned and delivered in line with evidence based guidelines. For example, we saw that the trust was following National Institute for Health and Care Excellence (NICE) guideline CG124: Hip fractures – The management of hip fractures in adults. The guidance included a fast track flow process for staff to follow in order to ensure the patient was operated on the day of or day after admission and having relevant assessment and interventions. In addition, the trust's fractured neck of femur pathway included an, "Abbreviated Mental Test (AMT)". The AMT covered consent and ability to consent, and was used to identify when a more thorough Mental Capacity Act assessment would be required.
- Policies and guidelines were readily available for staff on the trust's intranet. These were seen to be up to date. Policies followed guidance with National Institute for Health and Care Excellence (NICE) and other professional associations for example, Association for Perioperative Practice (AfPP).
- Staff recorded venous thromboembolism (VTE) assessments on the drug charts. These were clear and evidence-based, ensuring best practice in assessment and prevention.
- The preoperative assessment clinic assessed and tested patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. Examples included MRSA testing.

Pain relief

- Patients' pain was assessed and managed effectively in most cases. The NEWS chart was used to record patient pain score and medication was given as prescribed. However, we saw an example on Shopland Ward where one patient missed a dose of pain relief medicine due to the patient's paper prescription chart being held in the pharmacy department, which led to a delay in the dispensing of the new medicine.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration. The MUST tool is a five step screening tool to help identify patients who were underweight and at risk of malnutrition.
- We saw that there were red trays used to identify patients who needed help with eating and drinking. Nursing and health care assistants that we spoke to were aware of the meaning of the red tray system and the need to provide additional support to these patients as required.
- Volunteers visited wards at meal times. We spoke with two volunteers who described how they assisted staff on the wards by sitting with people who required assistance. They told us how some patients simply needed encouragement to eat whilst others needed physical assistance. We saw that volunteers were in attendance on the ward and observed them carrying out an initial check with ward staff to confirm which patients they should assist.

Patient outcomes

- The trust participated in national audits to record patient outcomes, including the National Bowel Cancer Audit (NBOCAP), National Emergency Laparotomy Audit (NELA), Surgical HDU Audit, Peripheral Vascular Surgery Audit and Lower GI Bleed Audit.
- The trust's results for NBOCAP for 2014 were mixed. Data indicated 215 cases were seen in the trust, a higher number than seen by neighbouring trusts. Of these patients,
 - 98.5% were discussed at multi-disciplinary team meetings, which was worse than the England average of 99.1%.
 - 91.5% were seen by a clinical nurse specialist, which was better than the England average of 87.8%.
 - 72.4% of patients underwent major surgery was which was higher than the England average of 63.7%.
 - 23.6% of patients underwent emergency surgery, which is above the national average of 15.5%.
- The trust had identified key areas for improvement following the NELA audit which were discussed at the joint Surgery and Anaesthesia audit day in November 2015. These included
 - early risk assessment and recognition of high risk patients,
 - early review by a senior member of medical staff,
 - early access to theatre

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- consultant involvement in the procedure.

An action plan was being developed to address the areas of improvement identified.

- At the time of inspection, the analysis of audit data for the Peripheral Vascular Surgery Audit and the Lower GI Bleed Audit was in progress.
- The National Hip Fracture Database Audit (NHFD) considers the care of patients with hip fracture and examines the quality and outcome of the care provided. The most recent annual audit data available from 2014 indicates that the trust performed better than the England average in six out of nine indicators. The trust was below the England average of 72.1% for patients receiving surgery on the day or after the day of admission with a score of 67.2%. 7.3% of patients developed pressure ulcers, which was higher than the England average of 2.8%. Patients receiving bone health medication assessments was 94.9%, which was lower than the national average of 96.5%.
- Data from the Lung Cancer Audit 2014 showed the trust was performing better than the England average, for example in percentage of patients discussed at MDT (trust 99.5% against the England average of 95.6%) and percentage of patients receiving CT before bronchoscopy (trust 97.2% against an England average of 91.2%).
- Readmission rates for patients who have undergone surgical procedures but needed to be readmitted to hospital are calculated nationally to help organisations compare their performance. A 'standardised relative risk readmission' is calculated, figures of less than 100 indicate a positive finding and mean that less patients were readmitted than expected. Figures over 100 indicate the opposite
- In a 12 month period between 2014 and 2015 the readmissions rate for elective surgery were better than the national average for trauma and orthopaedics (89) and urology (98), however the readmissions rate for general surgery (125) was worse than the national average. For non-elective surgery the readmissions rate was better than the national average for urology (70) and general surgery (97), however worse than the national average for trauma and orthopaedics (125).
- Patient Reported Outcome Measures (PROMS) were collected, which were responses from a number of patients who were asked whether they felt things had 'improved', 'worsened' or 'stayed the same' in respect to

three surgical procedures at the trust. PROMS for groin hernia and hip replacement surgery were better than the England average; however, outcomes for knee replacement surgery were worse than the England average.

- The surgical core services we inspected also undertook a number of local audits. The local audit programme included 61 individual audits including audits of central venous catheter sepsis and management and management of orbital floor fractures. Trust provided data showed that 20 local audits were completed with 41 being in progress. We saw action plans produced as a result of issues identified in audits, for example; following an audit of monitoring and equipment availability for intubations outside of the theatre / ICU environment. There was education of nursing staff and doctors regarding the importance of the availability of continuous monitoring equipment, with a recommendation that continuous monitoring should be available within all resuscitation bays.

Competent staff

- An Appraisal and Revalidation Policy for Medical Staff was in place which was reviewed in March 2015. The policy outlined the requirements and approach to enhanced medical appraisals for revalidation to ensure that licensed doctors remained up to date and fit to practice. Staff we spoke to were aware of the policy and could access it through the trust intranet.
- In December 2015, data provided by the trust showed that the appraisal rate for medical staff was 92.2% for the Surgery Directorate, 92.0% for the MSK Directorate and 94.7% for the Theatres and Critical Care Directorate.
- Junior doctors that we spoke to within surgery reported that they received good surgical supervision, which they felt enhanced their training opportunities.
- Nursing staff that we spoke to reported that they were able to discuss development opportunities in meetings with their managers; however, due to staffing capacity they were sometimes unable to be released to complete the development opportunities.
- All medical staff were required to complete advanced life support (ALS) training, the trust target for completion is 85%. On 14 January 2016, the MSK Directorate had an average completion rate of 86% across all staff; however, medical staff had a completion rate of 71%.

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The Surgery Directorate had an average completion rate of 89% with medical staff achieving 85% completion. Medical staff in the Theatres and Critical Care Directorate achieved 72%.

Multidisciplinary working

- Multidisciplinary daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required.
- We observed a good working relationship between all members of the healthcare team.
- Doctors carried out daily ward rounds and participated in the daily multidisciplinary team meetings.
- We saw that patients with fractured neck of femur were assessed by the surgeon and the orthopaedic geriatrician prior to being classed as fit for discharge.
- We observed good multi-disciplinary team working on Balmoral ward where a patient being treated was sectioned under the Mental Health Act. We saw their medical needs being provided by ward staff who were working in conjunction with a psychiatric nurse who provided dedicated one to one mental health care.
- We saw theatre staff working well together as a team, discussing patients' needs, equipment required and planning for the theatre lists.

Seven-day services

- Patients had access to consultant cover seven days per week and other support services, such as pharmacy, physiotherapy and theatres were available if required. This was confirmed by doctors and nurses we spoke with.
- Average theatre utilisation for elective surgical admissions in September 2015 was 70.3%; however, main theatre five and eye theatre two had low theatre utilisation rates of 37.1% and 51.3% respectively. All utilisation rates provided to us by the trust were for elective surgical admissions, emergency admissions were not included. The NHS Management Executive recommends that hospitals should aim to use 90% of planned theatre time and that theatre utilisation should be used as a key performance indicator.

Access to information

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems.
- Staff had access to guidelines and protocols via the trust intranet and were able to demonstrate how they accessed information on the trust's electronic system.
- We saw that the trust had two medicines prescribing systems in operation, an electronic and a paper format. We were advised that the electronic prescribing format was being implemented trust wide; however, at the time of inspection we observed delays in the prescribing of medicines when using the paper based system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The average completion rate by medical staff across the surgery, MSK and theatres and critical care directorates for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was 50%. The trust target for completion was 85%. In the Surgery Directorate 33% of staff had completed the training. For nursing staff the average completion rate was 78%. Of the nursing staff in the surgery directorate 67% had completed the training.
- Patients that we spoke with told us that they had been informed of the risks associated with their surgery before they signed the consent form. Staff discussed their treatment with them before commencing care. We saw that consent forms were well completed, signed and available for staff to check prior to treatment being commenced.

Are surgery services caring?

Good



We rated the service as good for caring.

Because:

- We observed staff interactions with patients and their family members. Staff were friendly, polite and professional.
- Patients told us that staff supported them with their emotional needs for example a patient told us, "The staff are really friendly, I am able to ask doctors questions, they treat me as a person not as a number."

However:

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- Between October 2014 and September 2015 the average number of respondents to the NHS Friends and Family Test who would recommend surgical services was below the England average.

Compassionate care

- We saw that patients were treated with dignity, respect and compassion when they were receiving care and support from staff. We observed how staff interacted with patients and their family members. Staff were friendly, polite and professional.
- We received positive comments from patients in relation to the care that they had received. For example, one patient told us, "I would give staff 10 out of 10 they have been brilliant." Another patient told us that they thought there were, "Wonderful staff, they are all good."
- We received positive comments from patients in relation to staff such as, "I have no complaints at all, I could not have been treated better, and the staff could not have been more attentive."
- The NHS Friends and Family Test (FFT) measures the likelihood that patients will recommend services to their friends and family. It was created to help service providers and commissioners understand whether their patients were happy with the service provided, or where improvements were needed. For a 12 month period between October 2014 and September 2015 the FFT response rates to the survey were 29% against the England average response rate of 35.5%. The number of patients who were likely or highly likely to recommend services to their friends and family (80%) was also below the England average for the same time period of 95%.

Understanding and involvement of patients and those close to them

- When speaking to patients there were variations in the responses that we received in relation to the involvement of patients and those close to them in the care being provided; for example, a patient told us, "The doctor comes every day, I have seen the surgeon here on the ward for three days running and can ask them questions, I think that they are very nice and answer my questions," however, another patient's relative told us in relation to the care that their mother had received, "No one has told us what she has had done, she told us that it is a hip replacement, but we don't know."
- We observed positive involvement with a patient by a registrar on Castle Point Ward. The registrar had

admitted the patient, and although the care of the patient had been passed onto another consultant, the registrar took the time to talk to the patient and discuss their condition with them when the patient recognised the registrar from admission. The registrar answered the patient's questions and took time to explain their answers ensuring that the patient understood the information that they were being given.

Emotional support

- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- Patients told us that staff supported them with their emotional needs for example a patient told us, "The staff are really friendly, I am able to ask doctors questions, they treat me as a person not as a number."
- There was a chaplaincy service available for patients' religious or spiritual needs.

Are surgery services responsive?

Requires improvement

We have rated this service as requires improvement for responsive.

Because:

- During inspection, we saw that elective surgery was being cancelled to address capacity issues in the hospital. Between July 2015 and December 2015 there were 1,512 cancellations in surgery and 802 cancellations in trauma and orthopaedics.
- There was a lack of clinical input in the decision making process as to which surgical cases would be cancelled.
- When surgical operations were cancelled the trust performed poorly against the England average for patients being treated within 28 days of cancellation.

However:

- Following our immediate feedback during inspection, the trust has developed and implemented a risk assessment tool which required clinical sign off prior to the cancellation of surgical procedures.
- The average length of stay for elective and non-elective admissions was lower (better) than the England average.

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- Medical and mental health staff worked together to provide care for patients with complex needs.

Service planning and delivery to meet the needs of local people

- The trust worked with commissioners to plan and meet the needs of patients.
- During inspection, we saw that the trust had cancelled elective surgery to address capacity issues in the hospital. Between July 2015 and December 2015 there were 1512 cancellations in surgery and 802 cancellations in trauma and orthopaedics. There was insufficient clinical input in the decision making process as to which cases would be cancelled. Following our immediate feedback during inspection, the trust has developed and implemented a risk assessment tool which requires clinical sign off prior to the cancellation of surgical procedures.

Access and flow

- The hospital had a nurse led pre-operative assessment clinic which was seen to have a positive impact on patient flow. Patients had a pre-operative assessment, which included for example, testing for MRSA.
- Between March 2014 and June 2015 the trust cancelled 45 (7%) of operations where the patient was not then treated within 28 days of the cancellation which was higher than the England average of 5% during the same period. However; based on quarter one data for 2015/16, the trust had improved to the point where the percentage of patients whose operation was cancelled and were not treated within 28 days was lower than the England average. The trust was now averaging 5% whilst the England average had risen to 7%.
- Between August 2014 and August 2015, the trust met the 90% standard for the proportion of patients waiting 18 weeks or less from Referral to Treatment (RTT).
- The ENT speciality had the lowest RTT figure with 67.6% of patients being seen within 18 weeks.
- The trust participated in the National Hip Fracture Database (NHFD), which is part of the national falls and fragility fracture audit programme. The most current audit data showed 67.2% of patients with a fractured neck of femur had surgery within 24 hours of admission, which was worse than the England average of 72.1%. The length of stay in hospital was 12.5 days, which is fewer days than the England average of 20.3.

- The average length of stay for all elective admissions was 2.5 days; this was lower (better) than the England average of 3.3 days.
- The average length of stay for all non-elective admissions was 4.1 days; this was lower (better) than the national average of 5.2 days.

Meeting people's individual needs

- Services were generally planned to take into account the individual needs of patients.
- Staff told us they had access to translation services in person or via the telephone system. There were no patient information leaflets available in different languages on the wards; however, staff told us that these could be printed in another language as required.
- We saw medical and mental health staff working together to provide care for patients with complex needs.
- The trust wide Dementia Team visited all patients identified as living with dementia. We saw that patients living with dementia were identified both within the patient's records and through discreet identifiers on the ward to ensure staff awareness.
- There were facilities available for relatives and carers to remain onsite in the dedicated learning disability ward for general surgery patients.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns directly.
- Information was available to patients on how to make a complaint in the main hospital areas. The PALS provided support to patients and relatives who wished to make a complaint.
- Between January 2015 and January 2016, the Surgery Directorate received 177 complaints, 40 were upheld and 27 were on-going. The MSK Directorate received 155 complaints, 35 were upheld and 36 were on-going. There were five complaints for the Theatres and Critical Care Directorate, 3 were upheld.
- Learning from complaints was shared locally to staff at team meetings, which was evidenced through minutes of meetings.

Are surgery services well-led?

Surgery

Good



We rated this service as good for well led.

Because:

- We saw strong local leadership across the surgical core services.
- During inspection staff told us and we saw that the senior management team were visible and approachable.
- Staff that we spoke to were aware of the trust values.
- A governance framework was in place to monitor performance and risks and to inform the executive board of key issues.
- Surgery Directorate and MSK Directorate held monthly governance meetings which were attended by clinical leads for each speciality, consultants and clinical nurse specialists.
- There were a number of innovative practices in place to improve patient outcomes. For example, the Early Rehabilitation and Nursing Team supported the early discharge of primary hip surgery and knee surgery patients.

Vision and strategy for this service

- The trust launched a new set of values in November 2015 in conjunction with staff and patient representatives. The values included, "Care with compassion," "Working together," and, "Professional and accountable." Staff that we spoke to were aware of the values and we saw them displayed within wards and on the computer system screensaver. Staff within surgical services had been included in the development of the trust values.
- There was a trust wide five year strategy being developed which identified strengths and opportunities for improvement across the trust; however, there was no surgical divisional strategy. There was a theatre strategy in place.
- Surgical, MSK and Theatres and Critical Care Directorates were included in the Clinical Transformation Project. The project is trust wide with the aim to improve clinical pathways across all directorates to improve efficiency.

Governance, risk management and quality measurement

- A governance framework was in place to monitor performance and risks and to inform the executive board of key variance.
- The Surgical Risk Register reflected the risks we identified within the service. We saw that all risks recorded had mitigation and control measures documented and dates for completion of actions.
- Surgery Directorate and MSK Directorate held monthly governance meetings which were attended by clinical leads for each speciality, consultants and clinical nurse specialists. Agenda items discussed at the meetings included incidents, complaints, national guidelines, national and local audits, directorate risk registers and training.
- There were also monthly directorate specific performance meetings where performance indicators in relation to patient experience, quality, safety and risk, operational efficiency, financial performance and workforce were discussed. Action plans were populated for each performance meeting with actions to address outliers being assigned to a named lead.
- The leadership had safety high on their agendas this was demonstrated for instance by their attendance to the twice daily meetings to maintain patient and staff safety during the black alert status of the hospital.

Leadership of service

- We saw strong local leadership across the surgical core services.
- Consultant surgeons were reported as supportive and encouraging by junior surgical doctors. Junior doctors told us they felt well supervised by consultants.
- Nursing staff told us that they felt supported by their direct line management and were able to raise any issues or concerns with them directly.
- Staff told us that the senior management team were visible and approachable. During inspection we saw the Head Nurse speaking with staff on surgical wards.

Culture within the service

- Staff that we spoke to were enthusiastic about working for the trust and how they were treated. They also felt respected and valued.

Surgery

- We observed that there was open communication within theatres with staff of all grades of medical and nursing disciplines able to provide feedback and raise concerns where required.
- Senior managers told us that they felt well supported by the executive team, however felt that on some occasions there were delays in actions being implemented during change processes across the trust.

Public engagement

- Patients were encouraged to give their views on the services provided to help improvement and with the planning and shaping of future services.
- The NHS Friends and Family Test (FFT) data over a twelve month period between October 2014 and September 2015 showed that the percentage of friends and family who would recommend the trust was below the England average of 95%. The wards scored as follows; Balmoral Ward (87.2%), Castlepoint Ward (86.5%), Chalkwell Ward (87.4%), Hockley Ward (89.5%), Shopland Ward (89%), Southbourne Ward (94.4%) and Stambridge Ward (87.4%). The FFT data only included wards with total response rates above 100 for each month.
- There was a period of consultation during the development of the trust's five-year strategy. The trust engaged the public and invited them to provide feedback. The trust undertook communication with the public in a number of ways, including, stakeholder engagement events, publication of the consultation document on the trust's website, the use of local media and social media to raise awareness.







Staff engagement

- Staff told us that they were encouraged to share their views at team meetings. During inspection however, staff told us that on Castlepoint Ward there had been no team meeting for 12 months, we saw that the last documented minutes of a team meeting were dated September 2014.

Innovation, improvement and sustainability

- Staff were encouraged to help with the continuous improvement and sustainability of the trust.
- The Surgical Directorate had introduced Emergency Surgical Ambulatory Care to an area on the Surgical Assessment Unit. The service was consultant led with experienced nursing staff. Patients with certain conditions were seen and treated quickly by clinicians, which reduced inpatient admissions. Ambulatory care had also been introduced on the Balmoral wound management ward.
- The trust had implemented an Early Rehabilitation and Nursing team (ERAN). The ERAN Team supported the early discharge of primary hip surgery and knee surgery patients. The team visit patients in their own home either on the day of discharge or the day after discharge, and continue to support the patient and their carers with their recovery from surgery. We spoke to patients using the service who told us that they felt the service had had a positive impact on their recovery following surgery.
- There was a dedicated Musculoskeletal Infusion unit, which enabled patients requiring intensive drug treatment for inflammatory disease to receive the treatment in one single location and in one appointment.

Critical care

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

Information about the service

Southend University Hospital's Critical Care Unit (CCU) provided a service to patients who needed intensive care (described as level three care) or high dependency care (described as level two care). Patients were admitted following complex and/or serious operations and in the event of medical and surgical emergencies. The unit provided support for all inpatient specialities within the acute hospital and to the Emergency Department.

The ARCU was under the management of the Medical Directorate. Whereas Critical care was part of Theatres, Critical Care and Anaesthetics Directorate.

CCU consisted of 10 beds for levels two and three patients. An Acute Respiratory Care Unit (ARCU) provided 12 beds for level two patients who required support with respiratory problems. There was also a Surgical High Dependency unit, which was inspected by the CQC's surgery team and is reported on under the 'Surgery' core service.

Intensive Care National Audit and Research Centre (ICNARC) data showed the unit had admitted 545 patients between August 2014 and September 2015.

CCU provided a critical care outreach team (CCORT), who assisted with the assessment and management of critically ill patients on wards and departments in the hospital.

Patients being cared for in critical care units are often unable to communicate due to their conditions or treatment. As a result, we were only able to speak with two patients. We also spoke with 15 relatives and 42 members of staff.

Summary of findings

Effective processes were in place to learn from incidents and staff used learning from incidents and complaints to improve their practice and deliver safer, more effective care. The environment was clean and staff followed infection control procedures. Medicines, including controlled drugs, were safely and securely stored.

Medical and nursing staffing numbers did not always follow guidelines laid down in the Core Standards for Intensive Care Units.

Patients received treatment and care according to national guidelines and best practice. We saw effective multi-disciplinary team working across the units, with good consultant input. Junior doctors were adequately supported to provide safe treatment and assessment. Physiotherapists, dieticians, microbiologists and pharmacists were highly spoken of by CCU staff and were available when needed.

Without exception, staff were complimentary about the leadership on the unit. Managers on CCU and ARCU demonstrated commitment to patient care, delivering a positive patient experience, developing and caring for their staff, robust governance and effective strategic planning.

Critical care

Are critical care services safe?

Requires improvement



We have rated critical care services as requires improvement for safe.

Because:

- Nurse staffing on the Acute Respiratory Care Unit did not follow the Core Standards for Intensive Care Units.
- The service did not always meet the recommendations of the Core Standards for Intensive Care Units in terms of medical cover.
- Space on the unit was not sufficient to store the equipment require.

However:

- There were appropriate systems and procedures for monitoring the NHS safety thermometer data and improving practice.
- CCU took part in the hospital's monthly joint theatres, critical care and anaesthetics governance meetings where morbidity and mortality cases were presented.
- There was a critical care outreach team providing a hospital-wide support service 24 hours a day, seven days a week.
- An electronic reporting system was used to track and respond to incidents, which were used as learning experiences.
- We saw an exceptional example of a patient observation chart in use in the CCU.

Incidents

- Monthly morbidity and mortality (M&M) meetings took place and were used to discuss the care of patients who had died on the unit. We saw the meeting minutes and how lessons were learnt including how to improve the service, including a 2016 plan.
- Morbidity and mortality reviews took place at the directorate's monthly governance meetings. Medical staff from CCU and ARCU took part in these meetings, and nurses from the departments were able to attend if they wanted to.
- Staff told us they were encouraged to report incidents and consideration of Duty of Candour was included in the incident investigation process.

- There had been no serious incidents or 'Never Events' (serious wholly preventable safety incidents that should not occur if the available preventative measures have been implemented) on the unit over the last 13 months. Posters were visible for the public to see this on CCU noticeboards
- Between 4 November 2014 and 29 October 2015, the CCU dashboard had reported 212 incidents resulting in low harm and four incidents resulting in moderate harm. They also report on no harm, severe and death incidents.
- We saw information about a 'Never Event' that had occurred elsewhere in the hospital displayed on staff noticeboards, to share learning and reduce the chance of it reoccurring.
- We saw a list displayed on CCU and ARCU staff notice boards giving details of all recent clinical incidents, immediate actions taken and actions required by staff to reduce the risk of reoccurrence. The list had a total of 26 incidents: 12 related to delayed discharges, two to out-of-hours discharges, one to staffing levels, one to a sharps injury, six to pressure ulcers (three from outside the unit), three to documentation issues and one to patient aggression.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient 'harm' and 'harm free care'. It provides a monthly audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolisms (VTEs) and catheter-associated urinary tract infections.
- A safety thermometer display was on a noticeboard at the entrance to CCU and was accessible for relatives and members of the public to see.
- The clinical nurse lead stated safety data was from the Safety Thermometer and results were discussed at the monthly anaesthetic clinical governance group meetings. We saw the minutes from the meeting. From September 2014 to May 2015, data prior to our inspection showed the CCU had no records of falls, no new pressure ulcers, no new blood clots or new urinary infections. However, from May 2015 to September 2015 the unit had two pressure ulcers and one catheter associated urinary tract infection.

Cleanliness, infection control and hygiene

Critical care

- Hand sanitising and personal protective equipment rules for staff were followed. This met guidance for safe hand-washing from the National Institute of Clinical Excellence (NICE) and 'five moments for hand hygiene' from the World Health Organisation (WHO). We observed high standard of practices from doctors and nurse.
- Both CCU and ARCU were visibly clean, cleaning staff were visible at regular intervals and adhered to the hospital's Infection Prevention and Control policies and procedures. Cleaning schedules were displayed on CCU and signed on a regular basis throughout the day. 'I am clean' stickers were displayed in areas and on equipment cleaned on that day, which meant staff could be confident this environment protected their patients from avoidable harm from infection.
- All of the staff we saw in clinical areas on CCU and the ARCU followed 'bare below the elbow' guidelines.
- Hand sanitising gel was available throughout both the CCU and ARCU and signs were displayed reminding staff and visitors about hand hygiene. Similar signs were displayed outside both units.
- We saw results of the CCU and ARCU hand hygiene audits, which demonstrated staff had achieved 98.8% from April 2015 to August 2015 and in August 2015 it had increased to 100%.
- The ICNARC quality indicators and outcomes for 2015 showed there were no cases of Methicillin-resistant Staphylococcus Aureus (MRSA) or C. difficile acquired by patients while on CCU.
- Microbiologists did daily rounds on CCU which meant they could offer advice and support to the clinicians and staff said this meant they could discuss patients antibiotic regime, validate results or offer support to further investigate patients' conditions.

Environment and equipment

- The CCU was not in a purpose-built or designed area, and as a result the environment was not ideal. Senior managers were aware of this and several issues regarding the environment were listed on the CCU risk register. These were: not enough storage space for consumables and disposables; nowhere to store a standard bed if a patient required a specialist bed, such as a bariatric bed; Plans were in place to build a new CCU which would resolve this situation.

- We checked the condition of the resuscitation trolleys and saw they were checked, tested and visibly signed for on daily basis.
- We checked a sample of 15 consumable items in the CCU store room and found them all to be properly stored, packaging was intact and they were within date.
- We looked at 10 items of equipment which were all visibly clean and free from damage.
- We checked 10 items of electrical and medical equipment on CCU and ARCU. All of them were in date for safety testing or external company servicing.
- An intercom and buzzer system was used to gain entry to the Critical Care Unit, to identify visitors before allowing them access to the unit Therefore staff were able to keep themselves and patients safe.
- CCU had three side rooms used to nurse patients who needed to be isolated to protect them or others from the risk of infection.
- A Healthcare Assistant managed the equipment store on CCU. They were responsible for cleaning and maintaining reusable equipment, stock-checking, ordering and receiving deliveries of consumable items. They told us they ordered consumables weekly and deliveries from the hospital's central stores always arrived on time and were correct.
- Equipment on CCU was stored safely in a dedicated room, on wipe-clean shelving to prevent anything being stored on the floor. Access to the storeroom was controlled with a combination keypad to ensure only CCU staff were able to gain entry to the room. Intravenous fluids were also stored securely in this room.

Medicines

- Medicines were stored safely and securely in a medication storage room
- Medicine refrigerator temperatures were monitored daily; this ensured medicines were maintained at the recommended temperature. We looked at temperature checks covering December 2015 and January 2016 and saw they were completed daily, signed by the staff member carrying out the checks and temperatures recorded were within safe limits for the medicines stored in the refrigerators.
- Controlled drugs which are controlled under the misuse of drugs legislation were checked twice daily and signed for once completed at handover.

Critical care

- We looked at five medication charts and we saw they were all dated and signed for when medication were given. The pharmacy department had developed a Medicines Optimisation (MO) strategy (July 2015) to ensure medicines were managed safely and effectively with emphasis on a patient centred approach. This included gradually moving from a paper-based prescribing system to an Electronic Prescribing (EP) system to support the MO strategy.
- Medicine incidents were reported with lessons learnt and positive action taken to prevent them happening again. We were shown lessons had been learnt from a previous medicine incident where an incorrect dose was administered. Learning from the incident included a change to the medicine management guidelines.
- A dedicated Critical Care Pharmacist provided clinical pharmacy services to the unit. They explained they try to visit every day but are not always able to attend the consultant ward rounds. An Antimicrobial Pharmacist also visited the unit as part of a multidisciplinary antimicrobial team to provide advice and support on the effective prescribing of antibiotics.

Records

- We saw standardised nursing documentation at the end of each bed, observations were recorded clearly and demonstrated patients were being reviewed, these were audited by senior staff on a regular basis.
- Medical records were securely locked in a trolley at the end of each bay on both CCU and ARCU.
- Patient notes were in paper form and were detailed, clear, legible and contained appropriate information. They were written and managed in a way to keep patients safe. . Doctors' notes were written on yellow paper in order to make them distinguishable from other notes. Documents were clearly written in chronological order, and were dated, timed and signed. Contributors printed their name and added contact details.
- Records of multidisciplinary team assessments were clear and detailed. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided.
- Observation charts had been individualised for specific patients' for CCU, all observations taking were available on one sheet which was easily accessible for all the medics to see.

Safeguarding

- Staff demonstrated an understanding of safeguarding procedures and their reporting process, and were able to give us examples of situations which would trigger a safeguarding referral.
- Staff said they were up to date with their safeguarding training covering vulnerable adults and children. The amount of staff who had completed their Safeguarding training at the time of the inspection were in level one and two children's' safeguarding was 87% with level one and two in adult safeguarding 89%. The trust target was 85%.
- Staff on CCU said they had a safeguarding lead who was the 'go to person' available if and when they needed support and guidance.

Mandatory training

- Mandatory training ranged between 59% for Mental Capacity and Deprivation of Liberty Safeguards to 89% for safeguarding children and adults. With 86% completing Information Governance and 96% completing Infection Prevention Control. The trust target was 85%.
- Some mandatory training had to be completed online via an e-learning system. Some staff told us this was difficult to manage at times if the unit was busy and they preferred classroom training.

Assessing and responding to patient risk

- Medical rotas demonstrated that medical staff were available to offer support for deteriorating patients on the wards.
- The Critical Care Outreach Team (CCORT) could be bleeped by any staff at the hospital. The CCORT provided a 24 hour, seven days a week service to anyone who was concerned about a deteriorating patient. The CCORT was made up of a band seven lead nurse and seven band six nurses.
- The CCORT also provided a service called 'calls for concern', which allowed recently discharged patients and their relatives to contact the team directly.
- The nursing team and medical staff assessed and responded well to patient risk through regular review. Ward rounds in the CCU took place twice daily in the morning and evening and was led by the consultants on duty.
- Patients in CCU were monitored closely at all times so staff could respond to a patients deterioration. Patients in CCU were nursed by recommended levels of nursing

Critical care

staff. Patients who were classified as needing intensive care (level three) were nursed by one nurse to each patient. Patients who needed high dependency care (level two) were nursed by one nurse for two patients', however, on ARCU level two patients were cared for by one nurse to three patients. Where possible, nurses would be placed with the same patient throughout the patient's stay so there was consistency of approach. An indication of something starting to change for the patient may then be picked up faster as patient care and response was closely supervised by a nurse at all times who was familiar with the patient.

- Patients were monitored for different risk indicators; for example, each ventilated patient was, monitored using capnography, which is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. Equipment was available at each bed on the unit and was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertion.
- Since National Early Warning Score (NEWS) had been implemented in 2014, CCORT referrals have increased. Data from January 2015 to January 2016 showed referrals have increased up to 1,158.
- When they were not actively committed with patients who had been referred to them, nurses on CCORT proactively reviewed patients on the electronic observations recording system and visited wards to assess any patients who might need their support.
- CCORT nurses reviewed all patients who were transferred to other wards or units in the hospital, before the discharge took place, then visited and reassessed those patients within 12 hours of their transfer.
- Staff received regular safety briefs at the start of each ward round.

Nursing staffing

- CCU had a total of 62 staff including healthcare assistants, nurse managers, specialist nurse practitioners and staff nurses. This represented 52.1 full time equivalents.
- The National Critical Care Alliance standards stipulate the minimum nurse to patient ratios within critical care units as one nurse to one level three patient (intensive care) and one nurse to two level two (high dependency) patients.

- During our inspection we saw nine nursing staff plus one extra nurse to cover breaks and give the extra support if needed for the 10 bedded CCU. During our inspection on CCU there were seven patients requiring level three care and two patients requiring level two care. Nursing staff rotas from 28 September 2015 to 17 January 2016 showed that level three patients were provided with one to one nursing care. However, on ARCU the ratio was one nurse to three level two patients. This was below the minimum standard set by the National Critical Care Alliance.
- Sickness on CCU had increased to 9.9% from September 2015 to January 2016. At the time of our inspection much of this was due to long term illnesses and injuries which were not work-related. CCU did not use agency staff as shift shortfalls were covered by CCU nurses.
- A nurse in charge was always on shift as a supernumerary member of staff and would cover breaks and assist if CCU required extra support.
- On initial recruitment, nurses were always supernumerary for their first six weeks on the unit. Newly recruited staff members told us they felt very supported from all the team, they had competencies to complete specifically for CCU and were given induction starter packs.
- Nursing handovers took place twice a day at 07:30am and 20:00 where staff communicated any changes to patients' conditions to ensure effective actions were undertaken to minimise risks of harm.

Medical staffing

- Copies of the medical rota showed Consultants were covering five days or seven days but not in block, according to the core standards for intensive care units consultants must work majority in blocks of five to seven days at a time, five day blocks of day shifts on ICU/CCU have been shown to reduce burn out in intensivists and maintain the same patient outcomes as a seven day block. The rota lacked continuity and this did not meet the intensive care core standards. However, good will of the team meant on-call consultants would join day time ward rounds and handovers.
- The CCU was staffed with eight doctors including intensivists, anaesthetists and physicians. Two of the unit's doctors were dual trained in the care of paediatric patients.
- There was a good commitment of consultant time on the unit; they did not use locum doctors.

Critical care

- Trainee doctors received appropriate clinical supervision and education from consultants.
- We observed the ward round from nightshift to day shift. This was an organised, structured approach with considerations of patients pain control. There was appropriate consideration of nutritional support and involvement of dietetics. Physiotherapists were involved in discussions for weaning and rehabilitation.

Major incident awareness and training

- Staff including CCOT were aware of their roles and responsibilities in the event of a fire.
- The major incident policy was accessible within critical care and staff knew how to access the policy.

Are critical care services effective?

Good



We rated critical care services as good for effective.

Because:

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- People had comprehensive assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Information about people's care and treatment, and their outcomes was routinely collected and monitored. This information was used to improve care.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet these needs. Staff were supported to maintain and further develop their professional skills and experience.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act and Deprivation of Liberty Safeguards 2005.

Evidence-based care and treatment

- In 2014, critical care managers had introduced the National Early Warning System (NEWS) for staff on all hospital wards and departments to monitor and

recognise patients whose conditions were deteriorating. NEWS uses a scoring system to interpret several physiological observations, including patients' pulse and breathing rates, temperature, blood pressure, oxygen levels and level of consciousness. NEWS meets the standards specified in the National Institute for Health and Care Excellence (NICE) guideline CG50: Acute illness in adults in hospital: recognising and responding to deterioration.

- Any patients whose NEWS score was seven or higher when their observations were taken would be referred to the Critical Care Outreach Team (CCORT). Hospital staff outside the Critical Care Unit (CCU) could also refer patients to the CCORT if they had any clinical concerns, even if the patient's NEWS score was below the trigger score of seven. This process also followed the recommendations of NICE guideline CG50.
- Nurses in CCU were trialling 'patient diaries', detailing events throughout the patient's stay on the unit. While there was no definitive evidence, among critical care professionals this process was widely considered to be an aid to patients' psychological wellbeing and recovery following a stay on a critical care unit, as it could help to fill in the gaps in patients' memory during periods of unconsciousness.

Pain relief

- Audit data showed 100% of patients admitted to CCU and ARCU in October 2015 had a pain assessment on admission and discharge, action was taken as a result of the pain assessment and the outcome of their pain relief was recorded.
- CCU used a nationally recognised system, the 'Critical Care Pain Observation Tool' to assess pain levels in patients who were sedated or less responsive because of their conditions. This tool used observations such as facial expression, body movements, compliance with ventilation equipment, vocalisation and muscle tension to monitor the effectiveness of pain relief for patients who are unable to express their pain levels in words. We saw examples of situations when the tool had been used and pain relief administered as a result.
- We were shown a copy of the acute pain link team's document on pain assessment in critical care, which was used during training for new staff on the unit. The document explained how pain assessment and management on critical care units differed from other hospital wards and units and gave two pain scoring

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methods: one for patients who were alert and oriented and another for patients who were sedated, ventilated or otherwise unable to communicate. It also explained when and where pain scores should be recorded.

- Patient experience surveys included questions about how effective pain relief had been during people's time on CCU. We saw a number of responses from patients, which said that their pain had been well controlled.

Nutrition and hydration

- Audit data showed 100% of patients admitted to ARCU in October 2015 had a nutrition assessment completed within 24 hours of admission, had their weight recorded, core care plans and referrals to dieticians provided where appropriate and had their weight and nutritional assessments reviewed when necessary.
- Nutrition on CCU was managed differently to other hospital wards as many patients were unable to eat or drink independently. Audit data showed that 100% of patients admitted to CCU in October 2015 had their weight recorded on admission and were referred to a dietician if they were assessed to be at high risk of malnutrition.

Patient outcomes

- The ARCU maintained a database of patient attendances on the unit and long-term outcomes. We saw a copy of the database, and staff told us they used the information to monitor patient outcomes and identify trends, to improve care and treatment.
- The 2014 National COPD Audit had recommended that the trust "develop a COPD pathway to ensure patients presenting with COPD have a rapid assessment with appropriate investigations requested, appropriate management commenced promptly (including documentation of escalation plan) and [are] transferred to the most appropriate ward". COPD covers a range of conditions such as emphysema and bronchitis, all of which have a long-term effect on patients' breathing. In response to this recommendation the trust was developing a COPD pathway, which was out for consultation at the time of our inspection.
- CCU contributed data to the Intensive Care National Audit and Research Centre (ICNARC) however ARCU did not. The Faculty of Intensive Care Medicine's 'Core Standards for Intensive Care Units' states "The intensive care unit should participate in a national database for

adult critical care". Part of its definition of an intensive care unit also says it "encompasses all areas that provide Level 2 (high dependency) and/or Level 3 (intensive care) care".

- ARCU provided level two care to their patients and as such should contribute data to national research although they were undertaking local audit benchmarking. Information received from the trust informed us that initially they had been advised by their finance committee they were not required to submit data to ICNARC. They thought it would have financial implications. They had not fully understood that it was used for benchmarking patient outcomes; as such it was their intention to rectify this in the coming months. Other than ICNARC, CCU had taken part in several national audits, including the national cardiac arrest audit and the potential organ donor audit. Senior staff discussed audit outcomes at critical care delivery group meetings and used data to change practice and improve patient outcomes. We saw minutes of delivery group meetings which included audit results as a standing item.
- CCU had participated in a peer review programme and by critical care staff from another NHS trust had inspected the department. We saw the action plan written in response to the 10 issues raised in their report. CCU managers had addressed each point and made improvements where possible or escalated issues where changes could not be implemented.
- The Faculty of Intensive Care Medicine's 'Guidelines for the provision of intensive care services' states unplanned readmission rates to intensive care units within 48 hours of discharge should be minimal. ICNARC data showed that for the first three quarters of 2015, CCU performed similar to the national average and to similar-sized units in other NHS trusts for this performance measure.
- ICNARC data for mortality showed CCU had performed better than the national average for the most recent period reported, from April to June 2015, when compared both to all other critical care units and to those similar in size to themselves.

Competent staff

- Staff who had recently gone through the supernumerary period told us they had been well supported throughout and were given an induction pack to complete to evidence their competencies on specialised critical care

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equipment. They told us the length of time they spent on induction was flexible and they could have extended it beyond the six week minimum if they felt they needed a longer supernumerary period. This was followed by a two week period of being 'buddied.' During the 'buddying' period the new nurses led on patient care while being observed by an experienced colleague. This complied with standard 1.2.7 of the Core Standards for Intensive Care Units.

- Nursing staff working on CCU and ARCU completed the Critical Care Networks National Nurse Leads' 'National Competency Framework for Registered Nurses in Adult Critical Care'. This was a nationally-recognised three-stage programme that progressively built on and improved skills needed in CCU, and formed part of the post registration award in critical care nursing.
- Nursing staff on CCU also completed an internal induction and development programme during their first year on the unit. We saw a copy of the programme given to nurses when starting work on CCU. It included sections on the CCU philosophy, a list of study days which were to be arranged in the nurse's first year, areas to record evidence of clinical skills and knowledge, a section for clinical review and reflection documents, and a section for specialist and advanced critical care competencies.
- Standard 1.2.6 of the Faculty of Intensive Care Medicine's 'Core Standards for Intensive Care Units' states there should be one clinical nurse educator per 75 nursing staff. CCU had 67 staff and had one permanent Clinical Nurse Educator supported by two nurse trainers in development posts, which was better than the standard.
- A senior critical care nurse had worked on plans for a simulation suite to be used to train staff in complex or infrequently used procedures. We were shown the simulator suite, which had opened a few weeks before our inspection and was identical to a real critical care clinical environment. It contained state-of-the-art equipment including a clinical manikin which could be controlled remotely by trainers to mimic clinical conditions. Trainers could use a remote microphone to make the manikin 'speak' to staff using it, and were able to alter its breathing rate, blood pressure and pulse along with other physiological responses. Staff using the suite could practice all of their physical observation and intervention skills, including cardiopulmonary resuscitation and defibrillation. Training was facilitated

by senior nurses from CCU, and the suite was used to help nurses and doctors to recognise when patients were deteriorating, what emergency treatment to use and when the CCORT should be called for assistance. The training provided by this facility met the recommendations of section 1.7 of NICE guideline CG50: Acute illness in adults in hospital: recognising and responding to deterioration. Staff from other wards and units in the hospital were also able to use the simulation suite for training.

- We were given details of additional training made available to nursing staff working in critical care as they progressed through their career. Examples of these were:

Study days on respiratory illnesses, haemodynamic and renal conditions, within 12 months of starting.

Between 12 and 24 months, a mentorship course and, for CCORT staff, an assessment and consultation course at a local university

Leadership training for band six and seven staff

- One staff nurse and one band six or seven nurse from critical care attended the British Association of Critical Care Nurses' conference each year, and cascaded new information and from the conference back to other staff in the unit. This meant that staff on critical care were kept up to date with changes to practice and developments in critical care nursing.
- Nurses working on ARCU were able to undertake the critical care nursing module offered at a local university. Courses on managing deteriorating patients, interpretation of arterial blood gas results and in palliative care were also available.
- Senior medical and nursing staff from ARCU ran a yearly study day on respiratory conditions, which was open to all hospital staff.
- The CCORT was staffed by experienced, senior critical care nurses, all of whom had a post registration qualification in critical care nursing.
- Post registration awards in critical care nursing were held by 45 (67%) of CCU's 67 nurses. This exceeded the 50% level stipulated in standard 1.2.8 of the Faculty of Intensive Care Medicine's 'Core Standards for Intensive Care Units'.
- We were shown records of update training required on eighteen kinds of specialised equipment, which staff had to undertake yearly, three-yearly and five-yearly

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depending on the individual equipment. Records showed that, of those who needed to complete it, 99% of the unit's staff had completed the yearly competencies, 94% had completed the three-yearly ones and 82% had completed the five-yearly training. The five-yearly updates (82% completion rate) were last held in 2014, and the majority of staff who had not attended that training had started working in the department after that date. Further training was planned to address the shortfall, and until trained and competent staff would not use the relevant equipment unsupervised.

- We saw records which showed that 89% of CCU staff had had an appraisal during the financial year 2015/16, against a trust target of 85%.
- One senior nurse, who was supernumerary to core nursing staff on the CCU and ARCU, was a nominated clinical nurse educator and took responsibility for planning, monitoring and delivering ongoing training for nursing staff. This complied with standard 1.2.6 of the Faculty of Intensive Care Medicine's 'Core Standards for Intensive Care Units'. The qualifications held by the clinical nurse educator far exceeded the recommendations made in the additional considerations attached to that standard.
- Student nurses on CCU were provided with a 'learner orientation book'. We saw a copy of the book, which covered a range of subjects including an introduction to the unit and its philosophy, how to recognise a deteriorating patient and know when to call for help, the 'SBAR' (situation, background, assessment and recommendations) handover tool and an example case scenario.
- Junior doctors working on CCU and ARCU completed a two-day 'ill medical patients acute care and treatment' (IMPACT) course. IMPACT courses were designed by the Federation of Royal Medical Colleges and the Royal College of Anaesthetists for new doctors working in medical specialties.
- We were shown details of the induction programme used for trainee doctors at the start of their critical care placements. The programme was split into three sections: a basic, first day induction conducted by an intensive care consultant; a general induction carried out by senior nurses and further training on specialised equipment and procedures used in CCU.

- A dedicated CCU pharmacist visited the unit every day and attended ward rounds during most visits, and an antibiotic specialist pharmacist took part in daily microbiologist ward rounds.
- Managers from CCU had gained trust board agreement for an electronic anaesthetics rota management systems to co-ordinate the availability and use of anaesthetists across different hospital departments.
- Daily multidisciplinary ward rounds took place on CCU. We observed one such round during our inspection. Staff on the round included a physiotherapist, two consultants, nurses and two junior doctors, all of whom were able to discuss and make recommendations about the clinical needs of each patient reviewed by the team.
- Daily multidisciplinary ward rounds took place on ARCU. These included doctors, social workers, physiotherapists, activities of daily living assistants and nurses.
- Nursing and medical staff on CCU and ARCU were able to refer patients to speech and language therapists through the trust's intranet. Staff were able to demonstrate the referral process.
- CCU and ARCU worked closely together to assess and reassess patients' needs on each unit, which meant patients could be 'stepped up' or 'stepped down' to more or less intensive care as needed.
- When patients were transferred between CCU and ARCU, or discharged to other wards in the hospital, a standard format, 'SBAR', (situation, background, assessment and recommendation) was used to structure the handover procedure and ensure no salient information was missed. Staff told us they used this system and we saw stickers in patients' notes confirming the process had been followed.
- We were shown the standard document used to plan patients discharges from CCU and saw it included sections for details from doctors, nurses and therapists. This demonstrated multidisciplinary team working during discharge planning.
- When patients were discharged home, the CCORT sent summaries of their discharge documentation and plans to the patient's GP.

Seven-day services

- CCU, ARCU and the CCORT all operated 24 hours a day, seven days a week.

Multidisciplinary working

Critical care

- Speech and language therapy, physiotherapy and dietician services operated six days a week, from Sunday to Friday.
- Consultant intensivists were available on CCU and as part of the CCORT seven days a week, 24 hours a day.
- Outside normal working hours, pharmacists provided an on-call service. Staff in CCU and ARCU had access to stocks of emergency medicines which could be administered by staff who were authorised through patient group directions, or after telephone advice from the on-call pharmacist.

Access to information

- We saw noticeboards for staff which displayed information on ventilator-associated pneumonia, patient nutrition, outcomes from cardiac arrests suffered by patients on CCU and ARC and details of accountability and responsibility for nurses.
- Folders on the nurses' stations in CCU and ARCU contained information for staff, including how to care for patients who required close supervision, trigger tools such as NEWS, manuals for specialised equipment used on the unit and guidance on acute pain management.
- All of the information held in hard copy on the CCU nurses' station was also available on the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Folders on the nurses' stations in CCU and ARCU also contained information for staff on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- A ward manager on ARCU told us 99% of the unit's staff had completed their MCA and DoLS training. We saw training records which confirmed this.
- We were shown two completed MCA assessments and DoLS applications for patients being cared for on ARCU. All of the forms were clearly and fully completed, contained detailed information about the patients' capacity to consent to treatment, the nature of restraint that was required to keep the respective patients safe, and the rationales behind the applications. All were signed by appropriately qualified staff, dated and regularly reviewed.

- There was at least one nurse and one doctor on duty at all times in CCU who were able to carry out assessments of patients' mental capacity. They were also able to provide this assessment to other wards and units in the hospital if required.

Are critical care services caring?

Good



We rated critical care services as good for caring.

Because:

- Staff cared for patients in a kind, compassionate and professional manner.
- Patients and relatives were kept fully informed and staff treated them with kindness and understanding.
- Relatives told us that they were very happy with the level of compassion and commitment of staff and they felt their relatives were in good hands.
- Staff were supportive and responsive to patients individual needs. We observed between staff, patients and relatives, we saw a consistent approach to open and honest communication that was sensitive and empathic.

Compassionate care

- We observed caring and compassionate care of patients by nurses on CCU and ARCU. Relatives also said staff were compassionate and caring. One person said: "I have no complaints, staff are all very committed and very caring, they look after my family too". Another family member reported the care that her mother had received was "excellent, communication was excellent, my mother was in safe hands". Another relative stated: "staff are lovely, very supportive, I am able to contact them anytime and they give me good information".
- We felt that overall the staff, were caring, well-meaning and showed they genuinely cared for the patients. We saw staff provided dignified and respectful care to patients and they had good knowledge of the patients' individual needs.

Understanding and involvement of patients and those close to them

Critical care

- We observed good attention from all staff to patient privacy and dignity. Curtains were drawn around patients and doors or blinds were closed in private rooms when necessary. Voices were lowered to avoid confidential or private information being overheard.
- Patients' physical and psychological needs were regularly assessed and addressed; this included their nutritional and hydration needs. Pain relief and personal hygiene were discussed.

Emotional support

- Staff understood the impact a patient's care, treatment or condition might have on their well-being and on those close to them both emotionally and socially.
- Follow up clinics post discharge provided emotional support to patient and their families

Are critical care services responsive?

Good



We rated critical care services as good for responsive.

Because:

- Care and treatment was coordinated with other services and other providers.
- People could access the right care at the right time. Access to care was managed to take account of people's needs, including those with urgent needs.
- Waiting times, delays and cancellations were minimal and managed appropriately. People were kept informed of any disruption to their care or treatment.
- It was easy for people to complain or raise a concern and they were treated compassionately when they did so. There was openness and transparency in how complaints were dealt with.
- Complaints and concerns were always taken seriously, responded to in a timely manner and listened to. Improvements were made to the quality of care as a result of complaints and concerns
- There was private space available on the unit for relatives to have quiet reflective time with or without staff.
- There were open visiting times for visitors
- Staff told us they had access to a learning disability nurse and psychologist to provide additional support for patients, who responded quickly to referrals.

Service planning and delivery to meet the needs of local people

- The CCORT operated a scheme called "Calls for Concern". This allowed patients, carers and relatives to contact the team directly if they had any worries or needed advice after patients had been discharged home. Staff in CCU staff told us they used the scheme regularly, and we saw posters and leaflets publicising it in several areas of CCU and ARCU.
- Both CCU and ARCU operated open visiting hours, which meant relatives and carers of patients in those units were able to visit at any time of the day or night.
- In accordance with NICE guideline CG83: Rehabilitation after critical illness in adults, CCU offered patients a follow-up clinic appointment within three months of their discharge from the unit. The follow up clinic had been running for six months prior to our inspection, and while CCU were gathering evidence about its effectiveness they did not yet have enough data to make any judgements.
- Psychological problems following discharge from intensive care units have been documented and researched by a number of professional bodies in the UK and worldwide. As well as follow up from the CCORT, patients discharged home from CCU at Southend University Hospital were referred to local NHS mental health trusts for proactive follow up care to reduce the impact of any problems.

Meeting people's individual needs

- We saw a wide range of information displayed in CCU and ARCU, for patients, relatives and carers. This included leaflets and posters about tissue donation, the Intensive Care Foundation, palliative care services, and the hospital's charity.
- Staff did not have access to any literature in languages other than English, however a formal translation service was available through the hospital's switchboard and staff were aware of this and knew how to access it. ICNARC data for the period April to June 2015 showed over 95% of CCU's patients were from a white British background.
- Minutes of the critical care governance meeting from October 2015 mentioned that the CCU team had expressed concern when the translation service had been required "recently"; a translator was only available

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over the telephone, not face to face. The minutes recorded that this was considered to be totally unacceptable and inappropriate as interpreters should attend CCU in person, and that it would be addressed by the Critical Care Management team.

- The unit had adapted the 'this is me' information folder designed by the Alzheimer's Society and used in the care of patients living with dementia and created an 'all about me' document. This was completed by patients where they were able or by families and carers if patients were too unwell to do so. Staff showed us a copy of the document. It contained, for example, details about the patient's family, their home and work background preferred name and other information. It was used to help staff understand more about their patients when the patients were not able to communicate.
- Staff on CCU and ARCU were provided with an e-learning course about caring for people living with learning disabilities.
- CCU and ARCU had learning disability link nurses who assisted with staff education and advice about care of any patients who were living with learning disabilities. On admission to the hospital, any patients living with learning disabilities were flagged on the hospital's electronic records system and the learning disability clinical lead was automatically made aware.
- On ARCU, we saw a nurse providing care for a patient who was living with learning disabilities. The manner in which they spoke and otherwise interacted with the patient demonstrated an understanding of their different needs and allowed care to be provided without any distress to the patient.
- A private room was available for relatives and carers of patients being cared for on CCU. This room was comfortably furnished, had information about critical care services and had a toilet and shower room. There was no dedicated room for relatives or carers to stay overnight if they wanted to. Staff told us this was discouraged as relatives needed a break from attending the hospital, but they had folding beds and relatives and carers could stay overnight on the unit if they wanted to.
- The CCORT had the 'calls for concern' service that patients and relatives can contact for advice 24 hours a day seven days a week. Along with follow up clinics for patients five days post discharge from CCU onto the wards for the extra support from staff.

- The CCU had space constraints which senior managers were aware of there was nowhere to store a standard bed if a patient required a specialist bed, such as a bariatric bed; cramped clinical and office areas, and inadequate space to carry out non-clinical duties. Plans were in place to build a new CCU which would resolve this situation.

Access and flow

- Between April 2014 and March 2015 244 patients had their discharge from CCU delayed by over four hours. This represented just over half of the 484 patients admitted to CCU in the same period.
- Senior staff in CCU told us discharges from the unit to other areas of the hospital were sometimes delayed due to wider capacity issues, but that this never had an adverse effect on patients as they were still receiving optimal care in CCU. Delayed discharges did not prevent patients from being admitted to CCU; however delays of up to four hours could occur on occasion. When this happened the CCORT would manage the patient while they were waiting for a CCU bed to be made available. In times of capacity pressure, discharges from CCU were treated as a priority at bed meetings. Managers told us delayed discharges were always recorded on the hospital's electronic incident reporting system.
- The CCORT also provided critical care support to paediatric nurses in the hospital's emergency department, if seriously ill paediatric patients were being cared for there while waiting for transfer to another hospital with dedicated paediatric intensive care beds.
- Figures provided by the trust showed that between December 2014 and October 2015 CCU had an average of 73% bed occupancy and ARCU had 89%. The highest occupancy levels during this period occurred in December 2014, when on average CCU had 82% of its beds in use and ARCU had 91%. This meant that apart from short periods of time, beds were always available for patients requiring level two or level three care. Data showed patients requiring level two or level three care had been nursed outside CCU, in the theatre recovery area, on four dates during this period.
- Between March 2014 and December 2015 only four operations were cancelled because of unavailability of critical care beds.
- The Faculty of Intensive Care Medicine's 'Guidelines for the provision of intensive care services' recommends

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that transfers from CCU to wards between 10pm and 7am should be avoided wherever possible. ICNARC data showed for the first three quarters of 2015 CCU had performed better than the national average, and similar to comparable units in other NHS trusts, for out-of-hours discharges to wards elsewhere in the hospital. During that nine month period, 12 patients had been transferred from CCU to wards between the hours of 10pm and 7am, compared to a national average of 20. We saw a list of recent incidents that had been reported in CCU, displayed on a staff notice board. Two of the incidents mentioned related to out-of-hours discharges. Reporting these incidents also complied with the Faculty of Intensive Care Medicine's guidelines.

- ICNARC data and figures provided by the trust showed that during 2015 the average length of stay on CCU was 5.3 days per patient. This was slightly worse than the most recent available national average of 4.8 days.
- All patients referred to CCU in 2015 had been admitted within four hours of referral.
- Between July 2015 and October 2015 there had been no non-clinical transfers out of CCU or ARCU.

Learning from complaints and concerns

- We were shown agendas and minutes from critical care delivery group meetings, which included discussions about and learning from complaints, audits and patient feedback.

Are critical care services well-led?

Good



We rated critical care services as good for well led.

Because:

- Governance and performance management arrangements were proactively reviewed and reflected best practice.
- Managers had an inspiring shared purpose, and worked to motivate their staff to succeed.
- Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.

- There were very high levels of staff satisfaction. Staff were proud of the units and the hospital as a place to work and spoke highly of the culture and of the support from managers.
- There were consistently high levels of constructive engagement with staff. Staff at all levels were actively encouraged to raise concerns.
- There was strong collaboration and support across all staff functions and a common focus on improving the quality of care and people's experiences.
- Innovative approaches were used to gather feedback from people who use services and the public, including people in different equality groups.
- Rigorous and constructive challenge from people who used services, the public and stakeholders was welcomed and seen as a vital way of holding services to account.
- The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation and suggestions for improvement were celebrated. There was a clear, proactive approach to seeking out and embedding new and more sustainable models of care.

Vision and strategy for this service

- The trust's vision was "to be a leading provider of seamless healthcare that will support every person who needs our services, whether in or out of hospital to achieve their best health possible, and to deliver high quality care for every patient, every time." Senior managers in CCU were able to tell us the ethos of this vision and told us that it "sat well" with them and with their staff who see it as treating patients in the best way at the right time.
- We spoke with four qualified nurses and two healthcare assistants on CCU and ARCU, all of whom told us they identified with the trust's values and saw them as putting patients, their families and carers first.
- Managers in CCU were writing a vision for their own directorate, based on a culture of working together and providing excellent care for their patients. The outline of the directorate vision would be presented to the trust board first to ensure it fitted with the trust vision, then to staff for their suggestions and input before the final version was produced.
- We were given a copy of the theatres, critical care and anaesthetic directorate's five year strategy. The strategy was structured around five main headings: excellent

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patient experience, financial and operational sustainability, engaged and valued staff, excellent patient outcomes and “our aim in five years is to be:” This demonstrated the senior managers responsible for CCU and ARCU were sighted on the medium- to long-term plans needed to maintain the units’ performance and staff satisfaction while keeping its focus on its patients.

- Induction and learning documents for students, nurses and doctors on CCU all included the unit’s philosophy, which said they were:

“A multidisciplinary team with an interdisciplinary approach who, through experience, knowledge, current research and compassion provided timely, effective and holistic patient centred care.”

- Staff were aware of this philosophy, identified with it and worked to achieve the standards of care and professionalism it set out.
- We were shown a copy of the CCU and ARCU senior managers’ plan for developments on the units in 2016. This included plans to acquire new equipment and to replace older items, plans for training and improvements in practice and moves towards being a ‘paperless’ unit. All of the items on the plan had nominated leads and projected dates for completion or implementation.

Governance, risk management and quality measurement

- CCU held its own risk register, which fed into the trust’s overall risk register through the CCU governance lead’s meetings with governance leads from other hospital departments.
- We were given a copy of the CCU risk register, which listed four moderate risks and five low risks. The moderate risks related to potential breaches of same sex accommodation (although critical care units are not subject to same sex accommodation rules), CCU not being purpose-built and therefore providing a less than optimal environment, patient care being affected by short-term staff shortages, and transfers of critically ill patients to other facilities in the hospital. The low risks were recorded as failures in or poor supply of piped medical gases, unavailability of the Children’s Acute Transport Service to transfer paediatric patients from the hospital, risk of harm to patients due to equipment failures during internal transfers, and power failure. All

of the risks had been comprehensively assessed, actions had been taken or were planned to reduce the risks and all had dates set to be reviewed. None of the recorded risks were over their review dates. This demonstrated that managers were aware of the need to regularly review and take action about any risks to patient safety on CCU.

- A copy of the CCU risk register was displayed on a notice board in a public area of the unit where it could be read by visitors. This demonstrated a culture of openness and honesty from the unit’s managers.
- We were shown copies of minutes of the monthly theatres, critical care and anaesthetic directorate governance meetings, which included discussions about nutrition, critical incidents, audit results, ICNARC results (including comparison with other similar trusts), patient deaths and early readmissions.
- CCU was inspected by the Critical Care Networks of England, Wales and Northern Ireland in 2015, and had met or partially met 91% of the 91 specification standards against which they were judged.
- We were shown minutes of critical care governance meetings, which included discussions about audits, incident reporting, safety thermometer performance, pain assessments, delayed discharges and risk assessments. This demonstrated the department’s managers were aware of performance, safety and governance issues and were taking action to maintain or improve them as necessary.

Leadership of service

- CCU reported to the trust’s theatres, critical care and anaesthetic directorate. Locally, CCU was managed by a consultant intensivist and a band 8a lead nurse who also fulfilled the role of Clinical Nurse Educator. Local managers were supported by the directorate’s associate clinical director and clinical director, who were a nurse and doctor respectively. This complied with standard 1.2.6 of the Faculty of Intensive Care Medicine’s ‘Core Standards for Intensive Care Units’.
- Without exception, every member of staff we spoke with in CCU and ARCU spoke positively about their managers. They told us managers were approachable, trustworthy, supportive and were constantly working to improve the service their units provided.

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- Junior doctors working in CCU and ARCU were encouraged to take part in research and audits. We were shown details of presentations made to the Intensive Care Society by junior doctors from the units.

Culture within the service

- Two senior managers told us one of the things they were most proud of was the respect with which staff and managers at the hospital treated each other, and the culture of support and teamwork between all grades of staff.
- Another senior manager told us there was a culture of two-way support and 'challenge and support' across the trust, to improve services for patients.
- A Consultant Anaesthetist told us doctors and nurses on CCU and ARCU had an excellent rapport and there was a good working atmosphere on both units.
- Three allied health professionals on CCU told us they were made to feel a part of the team on the unit and felt included in plans and decisions.

Public engagement

- CCU and ARCU used feedback from the NHS Friends and Family test, and directly from patients, to influence the way their staff practised.
- CCU had conducted surveys on patient and relatives' satisfaction. We were shown the results of both surveys, which asked questions about the experience from admission to post-discharge follow-up, from both patients' and relatives' points of view. Feedback from the surveys was fed back to staff on CCU and used to improve care and treatment provided for patients.
- Following discharge from CCU, patients and their carers or relatives were invited back to the unit to discuss their experience with senior critical care staff. We saw records of these meetings which showed a bias towards finding out how services and people's experiences could be improved before, during and after their stay on CCU.

Staff engagement

- We saw a 'communication board' in a staff rest room on CCU, displaying information about sickness rates, infection prevention and control, incidents, the Mental Capacity Act 2005, invitations for staff to take part in meetings about the department's vision and plan for 2016, and medicines.
- Staff were involved in writing the vision and values to be used for the department.

- Staff said their views were important to the department's managers and that managers consulted them on and involved them in plans for CCU and ARCU.







Innovation, improvement and sustainability

- One member of staff on CCU had formerly been a patient on the unit. They had shared feedback about their experience as a patient with the unit's staff, and all staff members had been asked to respond with one change they would make in their own practice to improve their patients experience.
- Senior nurses from CCU were instrumental in the ongoing roll-out process of a wireless electronic observation recording and alerting system. Nurses using the system in wards across the hospital would record patients' observations, such as pulse and breathing rate, blood pressure, level of consciousness and temperature on a hand-held device similar to a smartphone. The device linked to a central co-ordination area in the hospital and if any patient's observations exceeded set levels on the National Early Warning Score (NEWS) an alert would automatically be sent to the manager of the ward where the patient was being nursed, and to the CCORT. The system also allowed ward managers and the CCORT to view real-time information remotely on patients across their department or the hospital respectively and to work proactively if they identified patients whose condition was deteriorating. This was a significant improvement on 'traditional' methods of monitoring 'track and trigger' scoring systems such as NEWS, which relied on the individual nurses escalating patients to senior nurses, doctors and outreach teams manually. It also reduced time spent locating patients' notes and provided a robust audit trail.
- Managers from CCU had written business plans, bid for and gained agreement for electronic pre-operative assessment and anaesthetics rota management systems, to improve assessments of patients and identify those at higher risk, and to co-ordinate the availability and use of anaesthetists across different hospital departments.
- Managers on CCU had secured funding for two band six development posts for nurse trainers. Nurses who were interested in these posts had to go through a formal recruitment process within the department and, if successful, then spent six months in the role. The posts were supernumerary to the unit's core staffing and those in the roles planned and delivered training on critical

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care-specific subjects. This helped to develop nurses in the development posts and offered continuing professional development to other staff in CCU at the same time.

Maternity and gynaecology

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

Information about the service

At the maternity unit at Southend University Hospitals NHS Foundation Trust between January 2015 and December 2015, there were 3800 births.

The trust was registered to provide termination of pregnancy services. We did not inspect this as a full service as it is not required to meet the Department of Health standards of a stand-alone termination clinic. However the service is part of the Women and Childrens directorate in which midwifery and gynaecology are run which we did inspect.

The antenatal service provides antenatal clinic appointments for women with problems during pregnancy, a specialist fetal medicine unit, ultrasound scans, and an antenatal triage unit. The antenatal triage unit is an assessment ward for women who have a variety of pregnancy related issues from 17 weeks gestation until the onset of labour. The central delivery suite provides care to women during, labour and after giving birth. There were six birthing rooms, one used for high dependency, a five bedded extended care area, a bereavement room and two theatre suites. The new midwifery led birth centre due to open on the 18th January is adjacent to the delivery suite and had four birthing rooms, two with birthing pools. A phone line is manned by a midwife to triage calls from women and give them advice. The maternity ward provides care to antenatal women with complications of their pregnancy and women and babies postnatally.

The community midwifery teams provide maternity services in partnership with general practitioners and health visitors. The service had a very high home birth rate.

The gynaecology service offers an Early Pregnancy Assessment Unit (EPAU) and a 24 hour emergency triage service, and an inpatient ward for planned surgery. A team of gynaecologists are supported by gynaecology nurses, support workers and allied health professionals.

During our inspection we had feedback from focus groups; we visited all the ward areas and departments relevant to the services. We spoke with 16 women, two relatives, 43 members of staff including medical staff, midwives, nurses, nursery nurses, support workers and administration staff, we reviewed 12 medical records.

Maternity and gynaecology

Summary of findings

Overall we rated the service as good but safety required improvement. This was because we saw there were established local and divisional risk and governance arrangements. Staff felt the service had a profile on the trust board agenda. There were processes in place to share lessons learnt from incidents and investigations.

The trust promoted breastfeeding and women were supported in their chosen method of feeding. Women were positive about the care they had received. We observed staff interacting with women and their partners in a respectful compassionate way.

Women and their partners felt involved with their care and were happy with explanations given to them. Partners had the choice to stay to support women throughout the night.

There was an effective multidisciplinary approach to care and treatment, which involved a range of staff in order to enable services to respond to the needs of women. All staff told us that that working relationships between the professional groups was excellent.

Staff wanted to continue to develop the service and demonstrated this through implementing new ideas. For example the development of a range of specialist clinics to meet women's needs.

Women using the maternity service received evidenced based care on the maternity service's guidelines and national guidance.

However medical staffing and the numbers of supervisors of midwives were not in line with national guidance.

There were no displays of information for people using the services about how to make a complaint if they were dissatisfied. The majority of women and their families we spoke with did not know how to make a complaint.

Are maternity and gynaecology services safe?

Requires improvement



We have rated this service as Requires Improvement for Safe.

Because:

- There were medical staff to cover 60 hours a week consultant presence on the delivery suite although they were not exclusively on the unit
- Safeguarding compliance for staff was insufficient, and put adults and children at risk.
- Cardiotocography (CTG) training rates were below the trust target and put new-borns at risk.
- Medical records were not kept securely in all areas.
- Staff did not complete the trust risk assessment booklet for gynaecology patients.
- Post-operative information was not always handed over on the gynaecology ward.
- Staff attendance at mandatory training did not meet the trust target.

However:

- Staff reported incidents and lessons learned shared widely in practice.
- There was an effective process for the investigation of serious incidents and a good understanding and use of the Duty of Candour.
- Medicines were managed safely.

Incidents

- Staff understood their responsibilities to raise concerns, record, and report safety incidents, and near misses. Staff received feedback of the incident they had reported.
- There were five serious incidents reported to the NHS strategic executive information system (STEIS) between November 2014 and October 2015. We reviewed summary notes in relation to three reported serious incidents. We saw recommendations and signed off actions demonstrating a culture of learning from such incidents.
- There was good evidence of learning from incidents. Staff received information about learning from incidents

Maternity and gynaecology

from a range of sources such as individual feedback, minutes of meetings and a maternity and gynaecology governance monthly newsletter. Staff gave an example of trust wide learning following a never event of a retained swab. Women wore a yellow band which indicated a swab needed removing, once removed the yellow band was taken off.

- We observed incident reviews that demonstrated changes in practice and guidelines, completed action plans and emails informing staff of those changed practices.
- Duty of Candour is regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person.
- Staff we spoke with had a good understanding of the Duty of Candour Regulation (DoC), a new law from November 2014 for all NHS bodies. This requires NHS trusts to be open and honest with patients when things go wrong. We saw evidence of DoC in the three serious incident reports we reviewed, a written apology had been sent and a meeting arranged with the patient to discuss the report.
- The service held monthly multidisciplinary perinatal mortality and morbidity meetings. Babies that had difficult births, became ill after the birth, or had a poor outcome were discussed. Clinicians and staff shared improved practice and monitored agreed actions at each meeting.

Safety thermometer

- The service were not using the maternity safety thermometer nor expressed any plans to introduce it in the future. This meant that they were not able to demonstrate harm free care in the specified areas of the maternity safety thermometer. The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. This is a system of reporting on harm free care. The areas of harm for which they recommended reporting were: perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from the baby and psychological safety. Also included were admissions to neonatal units, and babies having an Apgar score of less

than seven at five minutes. (The Apgar score is an assessment of overall new born well-being). This is a system of reporting on harm free care specific to maternity services.

- Maternity services had engaged with the trust wide safety thermometer (where relevant) which reported general nursing indicators rather than maternity specific measures. They were 100% compliant from December 2014 to December 2015 with those areas relevant to maternity services.

Cleanliness, infection control and hygiene

- All areas of the maternity unit appeared visibly clean, tidy and uncluttered.
- Staff labelled equipment when cleaned with 'I am clean' stickers which clearly identified what items had been cleaned.
- There were sufficient hand gel dispensers with instructions on how to cleanse hands. We observed that staff followed good hand hygiene and were bare below the elbow. However, some midwives were wearing nail varnish. This is a recognised poor practice for infection prevention and control. The trust was informed at the time and action was taken.
- There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy.
- Outpatients waiting areas had chairs with washable material to prevent the risk of infection.
- Cleaning audits reported 95-100 % compliance and the August 2015 hand hygiene audit 100%. We observed a birthing pool that was being cleaned. Staff explained the process to us.

Environment and equipment

- The maintenance and use of the premises, facilities and equipment were designed to keep people safe. All equipment had been appropriately tested.
- Babies did not have electronic tags they wore name band and the doors to gain entry to the ward areas were locked and staff gained entrance with swipe cards. Staff identified visitors and who they intended to visit, and then allowed them entry. We were asked to present our identification badges by staff when gaining entry to the wards.
- There was a system for checking equipment. Staff completed daily checks on lifesaving baby and adult resuscitation equipment.

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- There were electronic signs on the labour room doors to indicate if they were in use. We observed staff knocking and waiting to be asked to enter.
- Adequate equipment was available to run the service safely. There was bariatric equipment to use for women with a high Body Mass Index (BMI).
- Cardiotocography (CTG) machines were available for women whose babies needed monitoring. This monitors the baby's heartbeat in high risk cases.
- Staff followed best practice with infection prevention and control principles in relation to management of waste, including sharp items, and clinical waste.

Medicines

- Medicines were stored in locked cupboards, and disposed of safely.
- Controlled drugs were checked according to trust policy in all areas. Staff referred to their medicines policy, the up to date British National Formulary (BNF), or they asked for pharmacy support if necessary.
- Fridge temperatures were checked daily in all areas and were maintained with the manufacturers recommended range.
- Prescription charts were legible and dated. Discontinued medicines were documented appropriately. Allergies were documented and if identified women wore red name bracelets.

Records

- Medical records were not kept securely in all areas. We observed medical records on the desk unattended on the gynaecology ward and the maternity ward.
- Hospital records were paper format. Midwives gave mothers their records to keep with them and bring to every appointment.
- Mothers were given the personal child health record, often called the red book, before they were discharged home. The red book was used to record the child's health and development.
- We reviewed five sets of maternity records. They were legible, dated and signed.
- There was a white board on the wall in a room on central delivery suite to ensure patient confidentiality. It contained information about the woman's condition. It also stated the reason for the women's admission and any risk factors. This enabled staff to have a quick overview of the issues on the labour suite.

- We reviewed seven records for patients on the gynaecology ward. The records were legible, dated and signed.

Safeguarding

- All staff we spoke with were aware of the trust's safeguarding policy and the reporting procedure. Staff followed safeguarding legislation and local policy for reporting concerns to safeguard adults and babies from abuse.
- There was a named safeguarding midwife who provided support and supervision. Midwives told us they were able to raise concerns and knew how to report a safeguarding incident. If there were any known safeguarding issues, there was a tab to identify this in the medical records and an alert on the electronic system to alert staff.
- Staff were aware of the female genital mutilation (FGM) guidance. There was a flow chart in each area with the process of notification to the safeguarding midwife and the Department of Health (DOH). This was in line with national guidance.
- Safeguarding children training for nurses and midwives, 87% had completed level one, 84% level two and 57% level three. Attendance was below the trust target of 85% for level three safeguarding training.
- Medical staff that had completed safeguarding training was 64% level one, 54% level two and 50% level three. Attendance for all levels was below the trust target of 85%.
- Adult safeguarding training attendance was 51% for nursing and midwifery staff and 49% for medical staff this was not in line with the trust target of 85%.

Mandatory training

- All maternity, gynaecology and medical staff told us they were supported to attend mandatory training. However the data received did not support this information.
- Maternity staff described attending yearly multidisciplinary skills and drills training. This included maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, recognition of the severely ill pregnant women, epidural update, suturing update. Attendance for midwives between January 2015 and December 2015 was 84%.
- Newly qualified midwives had a comprehensive training programme to complete in their preceptorship (where they are assessed by and signed off by a mentor) period.

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They were supernumerary for the first eight weeks of employment which helped them to observe and feel more confident. Experienced appointed midwives completed a different induction and competency pack.

- CTG (**Antenatal** Cardiotocography) training compliance was reported in 2015 at were 79% for midwives and community midwives were 76% compliant. We requested but could not get the compliance rates for middle grade doctors and obstetric consultants.
- Maternity and gynaecology staff completed mandatory training in the following areas; conflict resolution, cardio pulmonary resuscitation, equality and diversity, fire, infection control, information governance, manual handling, venous thromboembolism, slips and falls, blood administration and five steps to safer surgery training. Completion was between 54% to 80% none were in line with the trust target of 85%.
- Practical obstetrics multi-professional skills drills training was developed for the maternity services. This is an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the new-born.

Assessing and responding to patient risk

- Women were assessed by midwives on admission to determine if they were high or low risk and this was clearly identified in the medical records we reviewed. This meant that it was easy to quickly recognise which pathway of care the woman should follow.
- We reviewed five maternity records; in these all risk assessments were completed.
- We observed equipment to evacuate a mother from the birth pool in an emergency. There were pool evacuation nets for water birth, staff were trained how to manage an emergency in the pool.
- Staff used early warning scores to monitor women to identify when their condition may be deteriorating. Early warning scores enabled early recognition of a patient's worsening condition by grading the severity of their condition and prompting staff to get a medical review at specific trigger points. The charts we saw were completed and scored correctly. Staff told us that when the score was high response from the medical staff was good and the outreach team would support the team to plan care.

- Neonatal early warning scores (NEWS) were not used. At the time of our visit we were told that the service was exploring the future use of a NEWS chart. Staff used an observation chart to record observations taken and escalated concerns when observations were abnormal.
- Women who required closer observation but not high dependency care were looked after by a midwife in the extended care area. They were transferred to the maternity ward when stable.
- We were told that the critical care outreach team, interventionist, and obstetric anaesthetist supported midwives and medical staff with the care and management of critically ill women. Women defined as level two high dependency care (increased amounts of one to one observation) were transferred to the critical care service.
- We observed good communication and teamwork in the operating theatre on the labour suite. We observed the theatre staff completing the World Health Organisation (WHO) checklist (designed to reduce the number of surgical errors) appropriately to ensure patient safety. Audits showed 100% compliance from January 2015 to September 2015.
- We reviewed seven gynaecology patient risk booklets. Documentation was poor not all entries were timed dated and signed and risk assessments absent. During our inspection the senior management team commenced a daily audit to improve the standard of record keeping.
- Gynaecology patient risk booklets we reviewed were not consistent and some had pages missing. Staff told us this was because they did not have printed copies and had to photocopy booklets. There was a delay with the suppliers; the trust did not have a central ordering system each ward had to order their own supplies. Numerous emails had been sent to the supplier but staff had not escalated the issue to senior management. This meant that with pages missing there was an inconsistency with the risk assessments documented some patients were having all the risk assessments prior to surgery. We escalated this to the head of service who immediately implemented a plan to improve the compliance of completing all of the risk assessments required.

Midwifery staffing

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- The information from the trust stated the midwife to woman was (1:29) which was comparable to the RCOG (Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour) expectation of 1:28.
- There were no staff vacancies within the maternity and gynaecology service. If they were short staffed due to sickness staff told us they would follow their escalation policy. The senior team told us they planned to recruit four whole time equivalent staff in excess of their normal staffing level to cover maternity leave. They did not use agency, staff employed by the service would do extra shifts to cover any shortfalls.
- Labour suite coordinators were supernumerary on every shift, so they could have an oversight of the department and be available for any urgent or emergency situations. We were told by staff that this was achievable.
- Senior staff told us that labour suite were starting to use a staffing acuity tool at the end of the week we visited to determine staffing levels in response to the amount of care the women needed. The staffing acuity tool calculates the required staff on each shift based on one to one care for women.
- Midwives rotated to the delivery suite and the maternity ward as this allowed flexibility when the unit was busy.
- Staff worked 12-hour shifts on the maternity wards and nine to five in the clinic areas. Staff told us they were happy with this shift pattern. When on call the community midwives were based on the delivery suite to work a night shift
- Support workers were on duty in all areas to provide additional support to midwives. Support workers attended a specific training day. Staff informed us that they did not undertake extra duties unless trained to do so.
- The sickness rate for nursing and midwifery staff was 4% compared with a trust average for similar staff of around 5%. For medics in the W&C div they have a rate of 3% compared with a trust rate for all medics of 1%. The senior team had explained that there had been high sickness however they were supporting those staff and revising all job plans for the medical team.

Nursing staffing

- Staff worked 12-hour shifts on the gynaecology ward. Staff told us they were happy with this shift pattern.
- Staff vacancy on the gynaecology ward was a junior sister full time on maternity leave; they planned to have

a member of staff act up into the post for six months for professional development. They were currently recruiting a full time band five nurse and part time four days a week support worker.

- The matrons hosted a weekly staffing meeting with all the ward managers. The team reviewed staffing levels for the following week and managed any issues to ensure sustainable services.
- Sickness absence in maternity and gynaecology was covered by staff working extra shifts in an effort to cover these shortfalls. If necessary they would use bank staff known to them who were familiar with the trusts systems and processes.

Medical staffing

- There were planned to be 60 hours a week of consultant cover on the central delivery suite between 08:00 to 19:00 Monday to Friday, with a consultant on call at all other times. However, the consultant was not dedicated to the central delivery suite they had other duties; they were needed to cover gynaecology too. The meant that the 60 hours was not dedicated to the delivery suite. This was not in line with national recommendations. Staff told us that when called the medical staff were supportive and attended the central delivery suite when called.
- There was a dedicated on call consultant obstetric anaesthetist who supported the resident on call anaesthetist. The anaesthetists supported the medical and bariatric (obese women) antenatal clinics.

Handovers

- We observed two handovers on the central delivery suite which were structured and flowed well. All the information needed was handed over in accordance with the 'situation, background, assessment, recommendation' (SBAR) format. This format is recognised good practice in maternity services.
- Midwives undertook hand over twice a day. Staff individually handed over their woman to the midwives on the next shift using the SBAR format.
- We observed a multidisciplinary handover by the theatre team of a woman on the elective caesarean section list, which followed World Health Organisation (WHO) safer surgery guidelines.
- We attended a nursing handover on the gynaecology ward, the information was discussed but not in a structured format. Staff did not handover all of the

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post-operative patient's observations. For example patients returning from theatre did not have their post-operative observations discussed to inform the staff coming on duty if the patient was stable and how often the observations needed to continue to be taken.

Major incident awareness and training

- The hospital had a major incident business plan on the intranet. Staff were aware of the policy, which covered processes when there were no beds available, and major external emergencies.

Are maternity and gynaecology services effective?

Good



We have rated this service as Good for effective.

Because:

- Women's care and treatment reflected relevant research and guidance, including NICE guidance.
- Staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards legislation.
- The outcomes of women's care and treatment were monitored and actions taken to make improvements.
- There was a good multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of women using the service.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- There was participation in local and national audits to improve care.
- Consent to care and treatment was obtained in line with legislation and guidance.

However:

- Women's names were displayed on a board on the gynaecology ward that could be viewed by the public.
- It was difficult to locate maternity guidelines on the trust intranet.

- Not all medical, nursing and midwifery staff had attended an annual appraisal.

Evidence-based care and treatment

- Guidelines and policies were based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE), and the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth guidelines.
- We reviewed five guidelines/policies, which were all based on NICE or RCOG guidelines. They were in date and version controlled. Staff had access to the policies and guidelines using the trust's intranet. Some staff told us they found it difficult to find the guideline they required, which delayed access to information. We witnessed this on two occasions where staff typed in the name of a guideline and could not find it due to a complex list which appeared to be in no particular order.
- A CTG was used to monitor the fetal heart. This should be reviewed and classified every hour using a sticker to document the assessment (NICE Intrapartum care 2014). We reviewed five CTG traces and they each had hourly reviews documented. This meant there was adequate monitoring of the fetal heart.
- The maternity team held weekly meetings to review CTG's to identify any learning. We saw a book for staff to document interesting cases to be taken to the meetings. Any learning points were shared with all members of staff by email. Midwives and nurses told us that this was how they received feedback if they were not at the meeting. The directorate recognised the importance of the development of new processes to improve patient care. They achieved this by carrying out local and national audits, reviewing findings and implementing change. For example, an audit showed the caesarean section (CS) rate was high. We observed an action plan discussed at clinical governance and minuted, training sessions were delivered to all staff, and women invited to attend a birth options clinic to discuss their choice of birth.
- Audit showed the service was not meeting the target of booking women before 13 weeks of pregnancy. In response, the service launched an online service for women to book their pregnancy with the service at a time that is convenient for them. This provided an improved personalised service with women having earlier contact with their named midwife and

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individualised care according to their needs. Over 98% of pregnant women during the last year were consistently meeting the booking target since it was introduced.

- The infant feeding coordinator trained clinic midwives to teach women with diabetes to obtain colostrum (the first milk breasts produce) antenatally to have available at birth to reduce the risk of baby being admitted to the neonatal unit.

Pain relief

- The central delivery suite offered a range of options for pain relief for women in labour. Options included a pool birth, Entonox, (a medical pain relieving gas) and stronger painkillers by injection.
- An anaesthetist was available so women had the option to have an epidural inserted to numb the body from the waist down to the toes. This was available 24 hours a day, seven days a week.
- Women told us they were able to access pain relief giving birth, and during the day. One woman told us on the postnatal ward during the night there was occasionally a delay.
- In gynaecology, analgesia was offered regularly. Women we spoke with felt their pain was managed well.

Nutrition and hydration

- The trust promoted breastfeeding and the important health benefits known to exist for both the mother and her baby.
- The service was UNICEF Baby Friendly Initiative stage two accredited. The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breastfeeding. They were working towards stage three with an assessment due in April 2016.
- Breastfeeding statistics for initiation within 48 hours of birth were between 68% and 78% the trust target was to be confirmed by the trust.
- Staff supported women on the maternity ward who were getting used to feeding their baby day and night.
- There was a clinic to divide tongue tie in babies, (a condition that may cause feeding difficulties). This enabled a prompt response to solve any identified feeding problems. Trained breastfeeding volunteers came to the maternity ward to provide extra support for mothers.

- Women we spoke with did not have any problems with the hospital meals; two women told us they were 'lovely.'
- Drinks were available at all times, and staff completed fluid balance charts. On the gynaecology ward we observed staff giving assistance to patients who required help with feeding.

Patient outcomes

- Senior midwives and clinicians monitored the outcomes of people's care and treatment before, during, and after birth. The outcomes were recorded monthly on the maternity dashboard which was discussed and actions agreed at the clinical governance meeting; however it was not displayed for staff to see.
- There were 10 still births during the period from June – December 2015. This equates to 2.35 per 1000 births.
- Between October 2014 and September 2015, 62% of women had a normal delivery, which was below, (worse than), the trust target of 65%. The home birth rate was 5% and this was better than the national average of 2.3%.
- The total caesarean section rate was between 29% and 35% which was higher (worse) than the national average of 25.5%, and the trust target of 25%. The elective caesarean section rate between October 2014 and September 2015 was 15% and the emergency rate was 18%. Staff told us they thought their performance was due to the number of women choosing a caesarean section.
- The trust wide instrumental delivery (forceps and ventouse extraction) rate was between 5% and 7%. This was less (better) than the trust target of 12%. Feedback was given to staff and trends were discussed at labour ward forum.
- The service performed the same as other trusts in all areas in the CQC Survey of Women's Experiences of Maternity Services 2015.
- Between September 2015 and November 2015 maternity services had no readmissions. Gynaecology had a total of 4% of women readmitted to the service.
- The number of women between January 2015 and March 2015 who had third degree or fourth degree tears was between 0.5% and 3% this was in line with the trust's target of 5%.

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- Women who had obstetric haemorrhage (bleeding following birth) greater than two litres between October 2014 and September 2015 was in line with the clinically agreed level of no more than four a month.
- No women developed sepsis following birth between January 2015 and December 2015.

Competent staff

- Newly qualified midwives were allocated a mentor and were supernumerary for eight weeks. They completed a competency pack before progressing to a higher grade. Staff told us it took around 12 months to complete.
- Midwives reported having access to, and support from, a Supervisor of Midwives (SoM). SoMs provided an on call service. There were one SoM for every 17 midwives. The service had recently seconded three midwives to the supervisor of midwives course to enable them to have a smaller caseload.
- Midwives rotated to each area of the service. This enabled flexibility to move midwives to work in other areas if required. A small number of senior midwives did not do this which enabled stability and expertise in that area.
- All of the staff we spoke with told us that they had attended an annual appraisal. Staff told us they found appraisals very useful to discuss their issues and to plan their objectives for the following year. The data the service provided showed 68% of nursing and midwifery staff and 20 to 22% of consultants and other grades of medical staff within the service had completed appraisals.
- Medical staff in training told us they had educational supervisors and regular appraisals. Not all of the medical staff felt supported by the consultants. The senior team were aware of this and shared with us minutes of meetings and plans to address these concerns.
- The service employed a midwife 12 hours a week to focus on face to face CTG teaching sessions and assessing staff competency for interpretation of the CTG trace.
- Some midwives were trained to scrub in theatres due to a long term vacancy; the senior team increased the salary to attract applicants. The trained midwives were competency assessed by a theatre nurse to ensure they were safe to practice.

Multidisciplinary working

- The maternity service promoted multidisciplinary team working, including staff working in the community. Community midwives, health visitors, GPs, and social workers were all linked through joint working with women and their families to plan the women's care throughout their pregnancy and after birth.
- The physiotherapists and occupational therapists supported patients after surgery on the gynaecology ward and for assessments prior to discharge home.
- There was effective joint working with the mental health teams. We observed a prompt response from the mental health team following a referral from the postnatal ward.
- Staff reported good working relationships with the neonatal team which included attending joint meetings.
- The gynaecology ward had effective team working with all disciplines and allied professionals.

Seven-day services

- Maternity and gynaecology services were available 24 hours a day, seven days a week. Women accessed maternity care by a self-referral booking line. This enabled a prompt response from the community midwife who arranged a booking appointment to suit the woman.
- Physiotherapists and occupational therapy services were available during day time hours.
- Portable ultrasound scanners were available in maternity and gynaecology which meant that medical staff could scan pregnant women, postnatal women, or gynaecology patients out of hours.
- A supervisor of midwives was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided midwives with access and support at all times.
- Community midwives provided an on call service to facilitate home births. When on call they were rostered on a night shift and worked on the central delivery suite until required to attend a home birth.

Access to information

- Staff could access guidelines and leaflets from the trust intranet to deliver effective care and treatment to women.
- Women on the gynaecology ward had their names displayed on a board on the wall which could be viewed

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by the public. We discussed this with staff who told us this had been highlighted as an issue by the Director of Nursing (DoN). Other than initialling the first name, no action had been taken to change the system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental capacity act training and Deprivation of Liberty training was 51% attendance for nursing and midwifery staff and 46% for medical staff this was not in line with the trust target of 85%.
- Women gave verbal consent for some of their care and treatment, for example, examinations and induction of labour. We saw that this was documented in the women's records. We saw signed consent forms for operations in the maternity and gynaecology records we reviewed.
- Maternity and gynaecology staff had an awareness of the MCA. The majority of staff were familiar with Deprivation of Liberty Safeguards (DoLS). The Safeguards aim is to ensure that those who lack capacity and are in hospital are not subjected to excessive restrictions. Staff could not fully explain the process but they knew how to access help from the safeguarding adults nurse.
- We were able to observe three gynaecology records which contained the correct consented paperwork required for a surgical termination of pregnancy.

Are maternity and gynaecology services caring?

Good



We have rated this service as Good for caring.

Because:

- The women we spoke with told us staff were very caring and respectful.
- Women felt they were supported emotionally.
- Women understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.

However:

One woman felt that a member of staff spoke to her abruptly.

Compassionate care

- Women and their partners were positive about the care they received. All of the women and partners we spoke with told us that they had been treated with kindness, dignity, and respect.
- We saw good interactions between staff, women and their relatives. For example, a woman with a learning disability was not coping with her labour, the midwife arranged for her mother to attend to support her.
- Family and Friends Test (FFT) results for August 2014 to July 2015 were below the England's average for antenatal care, about the same for birth and the postnatal ward postnatal better than England's average for community care. The trust scored similarly to other trusts in the questions in the 'Care Quality Commission Survey of Women's Experiences of Maternity Services 2015'.
- On the whole women were extremely happy with their care. They told us that staff were supportive, caring and answered their questions honestly.
- One woman felt that a member of medical staff was abrupt with her and her birth partner but the midwife at the birth was 'wonderful'. Another woman told us that the care on the postnatal ward was excellent and she had good breastfeeding support.
- We observed staff respecting the women's dignity by knocking and waiting to be invited in to rooms, or behind the curtains around the woman's bed space.
- We saw staff introducing themselves to the women and their relatives.
- Women on the gynaecology ward were very happy with the care they received. One woman told us that staff were wonderful from clinic, to pre-assessment, to theatres, to the ward. Women found staff were kind and respectful.

Understanding and involvement of patients and those close to them

- Staff told us they supported women to make informed choices and be involved with their care.
- People who used the service were given appropriate information and support regarding their care or treatment. Staff told us they provided patients and their families with the information they needed, both verbally and in the written leaflets.

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- The women we spoke with shared their birth experiences with us and told us that they were listened to and supported at all times by the midwife caring for them.
- Partners we spoke to were very happy with the care and their involvement.
- Midwives provided women before being discharged home with information about the signs and symptoms of complications they should look out for and told if they experienced any of them to seek advice from the maternity ward.

Emotional support

- A support clinic ran called the 'missing pieces clinic', a midwife was available to see women with emotional concerns postnatally. The midwife explained the care they received and any other questions the woman asked.
- Staff dealt with bereavements compassionately. They provided support to parents, relatives and each other. Staff offered the chaplaincy service to women to provide extra support. There was a dedicated bereavement midwife who supported women throughout their experience, visited them at home and attended appointments with them if they wanted her to.
- Women using the gynaecology service felt involved with the decisions made about their treatment, they felt that they were treated with dignity and staff respected them.

Are maternity and gynaecology services responsive?

Good



We have rated this service as Good for responsive.

Because:

- Maternity and gynaecology services were planned and delivered to meet the needs of the local population.
- The fetal medicine unit provided service to neighbouring trusts.
- Women were given an informed choice about where to give birth.
- Services were arranged to meet women's needs with a range of specialist maternity and gynaecology clinics.
- Care and treatment was coordinated with other services.
- Individualised needs of women were taken into consideration when planning care.

However:

- A large number of gynaecology operations were cancelled and appointments for treatment delayed due to bed pressures.
- There had been delays in handling complaints. Women told us they did not know how to make a complaint.

Service planning and delivery to meet the needs of local people

- The trust planned and delivered services to meet the needs of local people.
- The Fetal Medicine unit opened in October 2014 and also received referrals from neighbouring trusts. It comprised of fetal medicine consultants, specialist midwives, and a research midwife and research fellows. It enabled women with complications to be seen locally. This included the assessment of fetal growth and wellbeing, and the diagnosis and management of fetal disorders (including fetal abnormalities).
- The fetal medicine unit was led by an expert clinician. The department offered advanced services, with eight ultrasonographers which enabled women to have localised care at a one stop clinic.
- The unit worked in collaboration with the fetal medicine unit at Kings College Hospital, London. staff attended weekly MDT meetings.
- The antenatal assessment unit provided a postnatal hypertensive clinic to ensure women received 'NICE guidance' best practice treatments for raised blood pressure in the postnatal period. Six weeks after the birth, women were then transferred to the care of their general practitioner (GP)
- The trust provided high quality individualised care for women with diabetes. The trust ran a clinic for women with diabetes, jointly run with the diabetes specialist midwife, diabetes specialist nurse, consultant obstetrician and dietician. They cared for pregnant women who were diagnosed with diabetes before their pregnancy and those who developed diabetes during their pregnancy.

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- A multiple pregnancy clinic was held in the fetal medicine unit with specialist staff to provide care and advice to women who were expecting two or more babies.
- Women with obesity were invited to attend a pregnancy lifestyle clinic, where they were supported by a specialist midwife to make healthy lifestyle choices.
- The service offered a birth options clinic to promote normal birth wherever possible, and provided women with the correct information to make informed decisions regarding their birth options. A specialist VBAC (vaginal birth after caesarean) service has been developed by midwives to help support women in their individual choices for pregnancy and birth. This clinic was run by an experienced midwife who facilitated discussion and advised pregnant women regarding their birth choice if their previous baby had been delivered by caesarean section.
- The trust changed its practices in relation to medication given to induce labour for women wanting a vaginal birth after caesarean. This was as result of a coroners ruling in 2014. The trust sent us their response to the coroner and the guidance to staff reflecting the change in practice.
- Midwives could access specialist colleagues for support. This included an infant feeding coordinator, a midwife with specific skills, knowledge and experience to care for women with infant feeding problems. A safeguarding midwife with special responsibility for safeguarding vulnerable women and a bereavement midwife who supported women following the loss of their baby.
- Women were given an informed choice about where to give birth depending on their assessment of clinical need. The community midwives offered an on-call service to support mothers who planned to have a home birth.
- The antenatal clinic had boards displaying pregnancy related information such as healthy lifestyle choices and antenatal fitness classes.
- The midwifery led birth centre was due to open within a week of our visit. The centre had four recently refurbished home from home birthing rooms which were through double doors adjacent to the central delivery suite. Staff were extremely enthusiastic about the planned opening and committed to making it work.
- Babies who required extra monitoring and transitional care were cared for by midwives and nursery nurses on the maternity ward. Mothers were able to stay with their baby until they were fit for discharge home.
- Women had a choice regarding the management of miscarriage. They could choose a surgical or medical management. Women were supported by the nurses, and were offered chaplaincy support.
- A baby memorial service was held every third Sunday in the hospital chapel for women and their families to access.
- There was a dedicated bereavement room set a suitable distance from the central delivery suite for women and their families to use. The bereavement midwife supported women and their families. The room had kitchen and bathroom facilities. Equipment was available in the room to enable women to birth safely in the home from home environment. There was a cold cot to enable baby to be with the parents and a second cot if they wished to be discharged to their own home with their baby.
- Gynaecology offered a range of clinics:
- Gynaecology general clinics ran throughout the week, and dealt with a range of gynaecological disorders.
- The termination of pregnancy services was led by a nurse and a family planning nurse which enabled continuity for the service.
- A menopause clinic provided advice and care to women relating to all aspects of the menopause. The service were planning to develop this service further to become a one stop menopause clinic.
- Uro-gynaecology clinic provided care and support for female incontinence and prolapse problems, working with physiotherapists.
- Outpatient hysteroscopy offered women examination of the uterus under local anaesthetic in an outpatient setting, which prevented a hospital admission.
- Minor procedures clinic held monthly sessions and facilitated procedures such as biopsies and the insertion of coils (a contraceptive device which is placed into the womb).
- A fertility clinic was led by a nurse and a middle grade doctor and a consultant. We observed a very good handover and discussion of a patient's history prior to their consultation.

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- A registered charity cancer support group, COPES (Cervical, Ovarian, Perineal, Endometrial Support) supported women affected by gynaecological cancers. This was accessed by the women on the hospital intranet or by a leaflet.
- There was a monthly post-operative discharge group for women to access following gynaecology surgery. A nurse was available to answer questions. A physiotherapist also attended to answer questions relating to exercise and demonstrated exercises for the group and, if necessary, gave appointments for the physiotherapy clinic.

Access and flow

- Midwife led New-born and Infant Physical Examination (NIPE) and BCG vaccination (vaccine to prevent tuberculosis) clinics improved discharges; women were no longer having to wait for the NIPE check prior to being discharged.
- Trust wide maternity services reported no closures between January 2014 and June 2015.
- Women were seen by a midwife within 30 minutes of arrival. High risk women were usually seen within 60 minutes by medical staff. If medical staff were delayed by an emergency elsewhere and the women needed urgent treatment, staff said they would call a consultant to attend.
- The maternity and gynaecology service offered an Enhanced Recovery Programme after Surgery (ERAS). This promoted early discharges for women following an elective caesarean section. Staff audited the women's experiences six months after ERAS started. Women reported that their pain relief was not adequate, and in response the medical staff prescribed stronger analgesia to take home. Gynaecology patients were identified as suitable for the programme through pre-operative assessment. Using ERAS had led to shorter stays in hospital for those patients.
- The maternity ward bed occupancy was between 35% and 51% which was consistently lower than the England average of 55%-60%. The service had very effective patient flow and a high home birth rate which influenced this percentage.
- Gynaecology wards had outliers due to winter pressures; the trust was on black alert (highest level of escalation) during our visit. Senior staff told us when the acuity of patients on gynaecology increased they used

bank nurses to increase staffing. All medical outliers were assessed for suitability to be transferred to the gynaecology ward they must have been assessed and have a documented plan of care.

- Gynaecology which is part of the Women and Childrens directorate cancelled 95 operations between September 2015 and December 2015 due to bed pressures. Eight of those were patients with cancer. This meant patients were delayed in having their planned surgical procedures.

Meeting people's individual needs

- Specialist midwives were available for women with specific problems such as: infant feeding, drugs and alcohol, teenage pregnancy, antenatal screening, diabetes, antenatal triage, and bereavement.
- Women, who needed complex fetal medicine management, were referred to the fetal medicine department for care. A midwife had completed her ultrasonographer training to support the service further.
- The fetal medicine team worked with the genetics team and held a joint clinic monthly. If the fetus was diagnosed with cleft lip and palate (an abnormality of the mouth) the woman was referred to the specialist team for early intervention.
- Babies found to have talipes (a problem with the positioning of the feet) were seen early by the local team.
- Staff used both telephone and face to face interpreting services for women whose first language was not English. Staff were able to refer to maternity leaflets on the trust intranet and the leaflets had a phone number for women to call to request a version in their spoken language.
- Midwives and gynaecology nurses knew how to access support from the learning disability nurse for women with a learning disability. Staff told us about using 'This is me' documents for women living with dementia or with a learning disability.
- Staff we spoke with described how same sex couples were welcomed within the maternity service.

There were quiet rooms in antenatal assessment centre, antenatal clinic and the central delivery suite, which enabled privacy for difficult conversations.

Maternity and gynaecology

- Birthing partners were able stay overnight with women after the baby was born. Allowing partners to stay provides extra support to women and enables early bonding for the family unit.
- The trust website had videos for people with learning disabilities to access explaining useful information. There are examples from people with a learning disability to give reassurances to others.

Learning from complaints and concerns

- Patient Advice and Liaison Service (PALS) information leaflets were available. The leaflets informed patients of how to raise concerns or make complaints. Information on how to complain was not displayed. All but one woman we spoke with did not know how to make a complaint.
- The trust had a target of 10 working days to provide a written response to a complaint. Between September to December 2015 the Women and Children's Directorate, did not meet the target. The senior team explained that the matron responsible for governance and complaints resigned, but they have advertised and appointed to the vacancy since. In the interim the two remaining matrons supported the directorate by absorbing the additional work on a temporary basis.
- Complaints were discussed at clinical governance meetings. Information was fed back to the staff via ward meetings and at one to one meetings with staff.

Are maternity and gynaecology services well-led?

Good



We have rated this service as Good for well-led.

Because:

- The service proactively engaged staff and the public to comment and be involved with the development of the service.
 - There was a culture of openness and transparency within the service.
 - Staff told us that senior managers were visible and approachable.
 - The senior team were knowledgeable about their service issues and continually made plans to improve the service.
 - National reports were used to assess the quality of the service.
- However:
- While staff were aware of the vision and values of the service, there was not a defined maternity strategy.

Vision and strategy for this service

- The senior team had a vision to improve midwifery led services. Staff were aware of this and were excited about the progress being made. The senior management team had made the decision to embrace the trust's corporate values. All staff could explain the trust's values and gave us examples of how they contributed to them.
- The senior team were aware of the improvements needed and actively sought to make a difference to improve services. The trust had recently launched the new vision and values which had not yet been transferred into a maternity strategy with well-defined objectives.

Governance, risk management and quality measurement

- There was a well-established culture of continuous quality improvement.
- A good governance framework was in place for maternity and gynaecology services. Meetings were monthly and multidisciplinary; all grades of staff were welcome to attend. The meetings covered topics including serious incidents, the risk register, staffing levels, and patient experience. Previous actions were reviewed and monitored which were documented in the minutes of the meeting.
- The risk team had very good working relationships with all members of staff. There was a lead for maternity and a lead for gynaecology. They supported each other and were prompt at reviewing incidents and closing them in a timely manner.
- The senior team told us they had effective working relationships with the executive team. They were assured that escalated issues were reviewed, and the senior team was supported.
- Risks identified within the service were scored and agreed at the risk management meeting. We saw the

Maternity and gynaecology

maternity and gynaecology risk register which included 29 risks. Sixteen of the risks were out of date by one or two months. We discussed this with the head of service who was aware and agreed that this needed an immediate review.

- The government had commissioned an independent investigation into maternity and neonatal service nationally to examine concerns raised by the occurrence of serious incidents. The report of its findings was published in May 2015, and included recommendations directed nationally at the NHS, to minimise the chance that these events would be repeated elsewhere. The maternity, senior team and the SoM's had used the report to assess their services. A plan was produced in response, which had a number of actions allocated to staff for completion in set timeframes.

Leadership of service

- All midwives we spoke with told us they were supported and they had good working relationships. Staff said the senior managers were regularly visible and performed daily walks of their areas. Staff told us that the Head of Midwifery was visible, approachable and supportive.
- The senior team demonstrated a proactive approach to improving the services for the women. This was observed in the service quality improvement document 2015 three of the four proposals had been completed which improved women's choices and experience.
- Staffing was reviewed at the ward managers' meetings which were held fortnightly. The named employer relations advisor attended the meetings to discuss managing long term sickness.
- Matrons were included in the trust on call rota. The senior team found this integrated them with the wider trust and ensured they had an understanding of corporate issues. Matrons were also able to share trust wide learning and initiatives within the women's & children's directorate.

Culture within the service

- Staff we met were all welcoming, friendly and helpful. They were passionate about their role and said they were happy working for the service.
- Staff told us that they felt maternity services had a high profile in the trust, especially since the appointment of the head of midwifery as the Clinical Director of Women and Children's directorate.

- Some medical staff told us they were not adequately supported by senior doctors. The senior team were aware and shared a plan that was being implemented to address this problem.
- There was a culture of openness, flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed between the multidisciplinary teams and other agencies.
- Gynaecology staff said they enjoyed their job, worked together as a team and were very proud of their department. The staff we spoke with felt supported, and said the manager and matron were visible on the ward area.

Public engagement

- Women could communicate their experiences using the trust website. This was available for the public to view. We reviewed the website and it invited people to share their experiences.
- We reviewed minutes of the Maternity Service Liaison Committee (MSLC). This was a forum for maternity service users, providers, and commissioners of maternity services to work together ensure services met the needs of local women and their families. The team told us they had secured funding to run the meetings and had a lay person to chair.
- The senior team encouraged women to join their meetings and a user representative attended the central delivery suite meeting.
- The senior team explained that they actively sought women's views from the groups that they held. For example, the user representative of the MSLC group was undertaking a woman to woman experience audit which was on-going at the time of our visit.
- In the ward areas there were 'You said' 'We did' notice boards which demonstrated implementation of longer visiting hours in response to women's feedback.

Staff engagement







- Staff felt engaged by the managers and that their opinions are reflected in the planning and delivery of services.
- Staff told us that there was a can-do approach within the service and they were supported to try new ideas to improve care.

Innovation, improvement and sustainability

Maternity and gynaecology

- Staff were very proud of the new birth centre and fetal medicine unit, which added to the services and choices offered to women.
- A named representative for finance attended monthly meetings with the matrons and ward managers, which increased their awareness of budget allowance and position. It aided the monitoring process of pending vacancies; maternity and sickness leave which has enabled a more effective recruitment process.
- The maternity service was involved with three national research studies:
 - To examine if the prophylactic use of low-dose aspirin from the first-trimester of pregnancy in women at increased risk for preterm preeclampsia can reduce the incidence of the disease.
 - This study aims to explore if the addition of this testing to maternal risk factors, cervical length and blood biomarkers yields a significant improvement in the detection of spontaneous preterm birth.
- To develop and evaluate non-invasive prenatal diagnosis
- Antenatal services planned to improve the assessments of fetal growth by increasing the number of ultrasound scans women had in pregnancy to reduce still births.
- The maternity service initiated research trials to assess if oral glucose tolerance test (to identify diabetes in pregnancy can be performed between 11-14 weeks gestation. The research has received favourable opinion from the ethics committee and recruitment will start February 2016.
- The gynaecology sister received an improvement award for setting up a manual vacuum evacuation day clinic to enable women to get timely treatment of miscarriages under local anaesthesia.

Services for children and young people

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

Information about the service

Southend University Hospital NHS Trust children's unit cares for around 4388 children each year, aged from birth to 16 years. Young people aged 17 and 18 are admitted to adult in-patient wards.

Neptune children's ward and Paediatric Assessment Unit (PAU) are on the first floor of the Cardigan Building. There are currently 21 inpatient beds and seven PAU beds. All specialty patients are admitted to this ward. The Neonatal Unit is located on the second floor of the Cardigan Building. Ophthalmology have up to four paediatric beds in the Eye Unit. The Accident and Emergency department opened a paediatric Accident and Emergency within the last 12 months; this is currently run by accident and emergency staff rather than paediatric staff. The Adult Surgical Day Stay Unit becomes a Paediatric Surgical Unit for one day every two to four weeks when paediatric trained staff join the surgical adult ward staff to care for paediatric patients. The Paediatric Outpatient Department is in the Carlingford Centre, which is attached to the main campus but is a separate building to the main hospital. The Lighthouse Child Development Unit is at an offsite facility located approximately 15 minutes from the main campus by car.

There are 16 neonatal cots at Level Two; comprising two intensive care cots, three high dependency cots plus 11 further cots. None were at Level Three.

We visited Neptune Children's ward including the Paediatric Assessment unit (PAU), the Neonatal Unit,

Radiology Outpatients, Paediatric Outpatient's, the Lighthouse Child Development Centre, Anaesthetic Department, Paediatric Accident and Emergency, Surgical Department, Eye Unit, and Maternity.

We spoke with 12 children and their families and 78 members of staff. We reviewed six sets of notes on the Neptune ward and established the standard of documentation.

Services for children and young people

Summary of findings

Overall, we rated Children's and Young People's services at Southend require improvement.

We rated safe as requires improvement for a number of reasons including: poor documentation of patient notes, observation of poor hand sanitisation on entering and exiting the children's ward, and poor hygiene maintenance in patient and parent's bathrooms on the Neptune ward, robustness of incident reporting, the robustness of consent discussion and recording, and awareness of the Gillick competence as these were not audited on the ward. From our review of notes and information regarding gaining of consent there was no evidence that all staff were fully aware of the trust procedure. The children's ward had no dedicated pharmacy cover including for controlled and cancer drugs. There were waiting lists for electroencephalogram (EEG) tests which record electrical activity produced by the brain and Autism Spectrum Disorder ASD appointments. There were concerns about adults staying on the children's ward and the security risk this posed. Additionally, there were concerns about children receiving surgery on adults wards and whether staff competency levels on those wards were sufficient to deal with a paediatric medical emergency.

We rated effective as requires improvement because there was low compliance with the service own audit plan, which meant opportunities to improve were lost. We saw that the diabetic audit action plan had not been completed. Also, only 53% of children had received their antibiotics within the nationally prescribed one hour.

We rated caring as 'good' because the friends and family rating for December 2015 returned a positive response rate of 83% and positive parent and family feedback had been received for both paediatric outpatients and the Neptune children's ward. There were good supportive systems in place for parents or carers dealing with the bereavement of a child, and volunteer members of staff organised provision of memory boxes in such instances which could contain objects to remind parents of positive experiences they had shared with their child.

We rated responsive as 'good' as the service had designed orientation sessions for children before attending hospitals for procedures to aid with alleviating any anxieties they may have had. Dermatology services had previously been provided off-site and had been relocated so children could be treated within a familiar environment. However, there was an issue with patient waiting lists where clinic appointment had been cancelled due to staff annual leave as this could in some cases add an additional six month wait for a follow up appointment for a child.

We rated well-led as requires improvement because local governance needed to be improved in relation to incident management. The leadership had failed to recognise the importance of this group of staff being part of any major incident response and as such ensure training was offered. There was an inconsistent approach to the cancellations of clinics, which increased the risk to those attending.

Services for children and young people

Are services for children and young people safe?

Requires improvement



We rated safe as requires improvement;

Because:

- Infection control procedures were not robust in terms of regular cleaning of both parent and paediatric bathroom areas, and the second daily clean had been missed on the Paediatric Assessment Unit (PAU) for ten consecutive days. Also hand sanitiser was not routinely used.
- Record keeping was poor with assessment templates and the quality of notes relating the chronological entries and the identity of healthcare staff making those entries.
- The robustness of incident reporting and categorisation of clinical incidents needed to be improved. Associated action plans were produced but lacked time frames for completion such as the diabetes action plan.
- Duty of Candour was not fully understood and undertaken. This was in part due to the categorisation of incidents.
- High risk drugs such as morphine and cancer treatments were not subject to regular pharmacy checks on the Neptune children's ward and the trust lacked a robust audit trail for highly toxic medication.
- There was no ward-based pharmacist and this presented a risk with paediatric medications. However the trust had committed to using locums until recruitment had been completed.
- There was no formally recognised do not attempt resuscitation (DNR) form or flagging system for children. There was no documented approach to end of life care for children with a life limiting illness.
- We were not assured that medical challenge posed within the child mortality meetings in relation to appropriate thresholds for treatment of children diagnosed with bronchiolitis on the Neptune ward was addressed or formally documented.
- Staff had not received training in the event of a major incident.

However:

- Nursery rooms in the Neonatal unit had a member of nursing staff present at all times, and all babies were monitored appropriately with apnoea monitors until discharge.
- Medicine information was available for the safe use of medicines and we saw up to date advice about the safe dose of an injectable antibiotic displayed on a medicine cupboard door on the Neptune ward as a reminder to staff.
- We observed observation charts being correctly completed on the Neonatal unit for all 12 babies.
- Within the Neonatal unit, we saw feed charts completed for that week up to the point of review and these were transferred to baby notes at the end of each week.
- Neptune ward staff said they felt reassured by the new manager's strictness and the ward would operate in a safer manner as there had been a focus on staff ensuring they were up to date with mandatory training and the timely recording of competencies for nursing validation.
- Medical handover provided positive learning opportunities for junior colleagues and the handover content included; safeguarding, staffing numbers and shared care details.

Incidents

- Children's and Young People's services had no never events reported within the last 12 months. There were concerns about safety within Children's and Young People's services in terms of there not being an open incident reporting culture.
- In the August 2015 women and children's governance minutes, the Head of Paediatrics discussed concerns about a reduction in incident reporting.
- Southend hospital's Children's and Young People's service had 283 incidents within the last 12 months; all were categorised as 'low' harm with the exception of two; one was graded as 'moderate' harm in relation to failed or delayed diagnosis and one graded as high in relation to deteriorating patient. There were also eight clinical incidents graded 'moderate' to 'severe' across the combined women's and children's divisions
- We were not assured the correct grading of harm was being applied to each incident reported for example; there were six antibiotic incidents over a six month period graded as 'low' harm on the Neptune ward; one resulting in ill health of a child. .

Services for children and young people

- 28% (79/283) of incidents in the Children's and Young People's services were medication errors and were all categorised as causing no harm. There was no evidence of the Neptune ward requesting an educational session from pharmacy for staff members.
- We saw an incident log of nursing staff omitting two doses of insulin for a child in April 2015 which was graded as 'low' harm. There was no documentation within the record that appropriate glucose tests had been performed to establish if any complications had resulted because of the omission. There was another incident log for a diabetic child missing a dose of insulin in June 2015. This was also graded as 'low' harm and there was no documentation to evidence that any harm had come to the child for missing the dose in terms of elevated blood glucose levels.
- There were a low number of self-harm incidents recorded within the Neptune children's ward: one reported as a near miss and the other included an injury but was reported on the incident system as no harm.
- Children's services had had one occurrence of an information governance incident where adult ears nose and throat (ENT) procedural patient notes had been misfiled in a set of children's notes. This incident had been graded as 'low' harm on the incident reporting system but the women's and children's directorate were below the mandatory training threshold at just 72% compliance with completion of information governance training. Within the staff room on the Neptune ward there was incident reporting information displayed on the noticeboard, along with a number to call to report clinical incidents if staff did not have access to a computer.
- Learning from medicine incidents that occurred on the Neptune ward was shared on the ward as lessons learnt. Medicine information was available for the safe use of medicines. Up-to-date advice about the safe dose of an injectable antibiotic was displayed on a medicine cupboard door as a reminder to staff.
- We saw evidence of eight clinical incidents graded 'moderate' to 'severe' across the combined women's and children's divisions, (one was in children's) which triggered the need for the service to provide Duty of Candour for parents. All eight incidents occurred within the neonatal unit within the last 12 months. In 38% (3/8) of incidents, staff complied with providing verbal Duty of Candour within the nationally required 10 day timeframe.
- Following verbal feedback provided to the trust at the end of the site visit, an action plan was produced. One of the elements addressed was Duty of Candour which should be used when something goes wrong with a patient's care and causes 'moderate' to 'severe' harm. In this case, trusts should provide an explanation of what has happened and offer either an apology or regret for any harm caused. Trust-wide Duty of Candour work had been undertaken by family liaison officers who were appointed to make contact within 10 days of identification of the incident. This enabled the serious incident investigation team to make contact with the patient and/or family to hear their concerns and answer any specific questions raised within the root cause analysis investigation reports.
- Child mortality meetings were held by medical staff and we saw two sets of meeting minutes for July 2015 and November 2015. The July notes gave three case reviews of child deaths, and the November minutes contained a brief update from the child death review panel. Each individual case identified only via patient initials was briefly discussed and minuted, with three to six members of medical staff including the chair involved in the meeting. Details recorded included the reason for admission, details of clinical interventions, last wishes, location of death and any post mortem and/or funeral plans. A doctor raised the question of whether or not there should be thresholds for keeping children diagnosed with bronchiolitis on the Neptune ward, but the decision was not discussed in the following set of November meeting minutes. The November meeting discussed the cases of eighteen paediatric deaths.

Cleanliness, infection control and hygiene

- We observed three members of staff: a consultant, a paediatric physiotherapist and a nurse enter the Neptune ward, without using the hand sanitizer gel on entry or exit of the ward on the second day of our inspection.
- Both of the parent and patient toilets on the PAU ward area had not been cleaned at all on the second weekend of January 2016, and also the second clean of the day had not been completed for 10 consecutive days. One of the ward managers said the team would speak to the cleaning staff however, when we returned the following day the evening clean had still not been completed.

Services for children and young people

- Women's and children's governance minutes from August 2015 discussed a mock Care Quality Commission (CQC) visit made to the Lighthouse Child Development Centre and the Paediatric Lead anticipated there could be some health and safety as well as cleaning issues raised.
- Hand Hygiene audits demonstrated 98.8% compliance with audit standards in April 2015.
- The neonatal unit received 99% compliance on its last cleaning audit.
- Equipment on the neonatal unit was marked with a sticker demonstrating it had been cleaned, along with the date on which it was cleaned.

Environment and equipment

- There was a shared entrance from the main corridor onto both the Neptune children's ward and the PAU. There were security cameras in the ceiling of the corridor viewing access up and down the corridor to the children's unit, with swipe card staff access or the ability to contact reception to request entrance onto the ward for parents and visitors.
- The Neonatal unit was accessible by either swipe cards for staff or by using the intercom system for parents or relatives which was answered by the reception staff on the unit.
- Ward Managers told us equipment training was provided on a rolling programme to Neptune ward staff and by a specialist trainer for PAU staff members. Staff were currently 100% compliant with this training.
- There was a paediatric resuscitation trolley stored within the Lighthouse Child Development Centre, the Neptune children's ward, and another within the Paediatric Outpatient Clinic areas and these were checked and documented daily. Expiry dates of drugs contained within the trolleys were printed on laminate sheets and attached to each trolley for ease of reference. The Lifepak defibrillator and suction devices were also checked on a daily basis and nursing staff said there was always a European paediatric life support (EPLS) trained member of staff on each shift within the Neptune children's ward and the Neonatal unit.
- Effective controls had been put in place with regard the security of the children's ward with adult patients separated by one set of fire doors. We were assured these doors were locked internally from the children's ward side, with a camera monitoring the children's side of these doors which was visible on the ward's reception

desk. There was no security on-site at the Lighthouse Child Development Unit, but the managers said this was not a problem as staff working on the site felt secure. There was one patient hoist in the Lighthouse Child Development Unit This was a fixed unit and did not allow any flexibility to aid with the movement of patients which was a health and safety concern for staff who may need to move heavy children.

- The Neonatal unit was a very compact environment to work in which required the team to work effectively in the confined space, which we observed them doing at the time of inspection.
- Paediatricians said there was an unreliable ultrasound scanner which made viewing radiology images very difficult. The scanner was the responsibility of the Outpatient Department who had recognised this piece of equipment was due to be replaced. There was a plan in place for the department to refresh pieces of equipment however; we were not assured of how robust this plan was as there were no timeframes for the refresh programme.

Medicines

- The controlled drugs audit conducted in November 2015 demonstrated that for that month the Neptune children's ward achieved 100% compliance with controlled drugs guidelines, results from previous audit cycles since 2013 had had variable compliance rates between 74-95%.
- Controlled drug keys were retained by the Nurse in Charge of each shift on the Neptune ward.
- Controlled drugs were checked on each shift on the Neptune ward.
- The contents and temperature of the drug's fridge on the Neptune ward was checked each day.
- There was no ward based pharmacist service on the Neptune ward. Prescription charts were therefore not checked or reviewed by a Pharmacist on the ward. The nurse in charge told us they could ring a named pharmacist who specialised in paediatric medicines for advice if needed. However, they commented: 'we would like a regular pharmacist.' we raised concerns about this at the verbal feedback session post inspection.
- The Neptune ward used paper prescription charts and as there was no ward based pharmacy service the prescriptions had to be sent to pharmacy for any new medicines not kept routinely as ward stock. This led to delays in children receiving prescribed medicines.

Services for children and young people

- We saw evidence that pharmacy staff checked the drug charts in the neonatal unit on a daily basis
 - Following our inspection the trust produced an action plan detailing how they were going to address the lack of pharmacists on the wards. In the interim period they would use locums to support the ward.
 - A security audit was conducted in the women's and children's directorate in November 2015 which looked at 15 criterion in terms of medication security. The Neptune children's ward failed to meet the compliance threshold on three elements: pharmacy supplied medication was not locked away, medication was routinely stored outside of locked facilities, and blue medicine return boxes were not routinely closed with tamper evident seals or locked inside cupboards. The neonatal unit also failed to fully comply with these audit criterion, because not all medicine cupboards were lockable, and locked at the time of data collection. There appeared to have been improvements made as we did not see evidence of any of these issues at the time of inspection.
 - A July 2014 Audit of antibiotics for early onset of neonatal sepsis demonstrated some concerns such as; 53% of patients did not receive antibiotics within the one hour national guidelines, less than half (47%) of patients had accurate date and time of sepsis identification of sepsis recorded. Actions following the audit included the sepsis care pathway, teaching sessions to support intravenous access and electronic neonatal sepsis guideline. This was due for re-audit in March 2015. We asked the trust for more up to date information in relation to the percentage of patients who did not receive antibiotics within one hour, but they did not have any additional data.
- charts was inconsistent and did not receive pharmacy checks for administration of high risk drugs such as morphine and cancer treatments. None of the notes were filed chronologically.
- There was no clear evidence that the trust had followed national guidelines for insertion of a central line using radiological images to ensure accuracy of insertion. Documentation of discussion with patients and/or parents or carers was poor for matters such as treatment plans and options, and consent in five of six sets of notes.
 - Following verbal feedback provided to the trust at the end of the site visit an action plan was produced. One of the elements addressed was record keeping within Children's and Young People's services. The trust advised us that reminders about documentation requirements were sent to all staff and shared at the Paediatric Operational Group (POG) meeting in January 2015. Plans were put in place for the Nurse in charge (NIC) and the Consultant to audit a sample of notes on a daily basis and address any concerns immediately with the member of staff, where possible. These audits would be reviewed on a weekly basis by the Clinical Director and Associate Director. It was also planned to complete trust-wide monthly record keeping audits to ensure compliance with best practice standards.
 - Name stamps had been ordered for the Neptune ward and the Neonatal unit to prompt clinicians to input their names when writing in the patient notes.
 - We reviewed five sets of neonatal patient notes and these were in chronological order, had parental consent for blood spot checking documented, were well filed with no loose sheets of paper and were signed by clinician's with their designation recorded.
 - Name stamps were ordered on the Neptune ward and the Neonatal unit on 15 January 2016 to ensure clinician's names were clear and easy to refer to in the patient notes. Weekly summaries of record keeping audits are being reviewed by the Clinical Director and Associate Director. Furthermore, a trust-wide audit of record keeping will be carried out monthly to allow departments to benchmark themselves with colleagues across the trust.

Records

- During the inspection we reviewed six sets of notes on the Neptune ward and these were a random selection of medical, surgical and shared-care patients. Hard copy notes held on the Neptune ward were not safe as notes were not in chronological order and diagnosing or treating clinicians were not easily identifiable as there was no printed name or contact number in all six cases. Where signatures were present they were not legible or backed up by the printed name of the clinician. Care plan templates were being used in draft format without formal committee approval, and completion of drug

Safeguarding

- The Chief Nurse is the accountable officer within the trust for safeguarding, and there were dedicated adult and children's safeguarding teams.

Services for children and young people

- Review of 2015 data in relation to paediatric accident and emergency admissions for children aged 16 and under showed that 19% of these (15/79) were due to psychological issues the child presented with, such as manic behaviour.
- Staff were required to complete safeguarding children training Levels one to three with a compliance rate of 85%. Level one and two were compliant with the trust target at 98%. However, compliance with Level Three safeguarding children training was below target at 78%.
- Adult safeguarding which was important for staff dealing with parents of patients to have an understanding of and know how to deal with challenging situations, had been completed by 41 members of paediatric staff and was above the mandatory training threshold having achieved 94% compliance.
- On the noticeboard in the staff room of the Neptune ward there was information relating to female genital mutilation along with mandatory incident reporting forms. Nursing staff advised us they were all undertaking the mandatory training in relation to this, but had not yet needed to report an incident of this occurring within paediatrics.
- The Mental Capacity Act – Deprivation of Liberties (DOLs) mandatory training was applicable to 157 members of staff working within children's services, and compliance rates were below target at 78%.

Mandatory training

- Overall, the Neptune children's ward was compliant at 85% for completion of staff's mandatory training (192/227).
- Mandatory training compliance within the Neonatal Unit was 93%, and this included two members of staff on long-term sick leave. Of the 153 paediatric members of staff required to complete either basic life support (BLS) or advanced life support (ALS) training, the majority of staff groups were compliant with training requirements. The two staff groups not reaching acceptable compliance levels were: paediatric consultants and paediatric rehabilitation additional clinical services.
- Ward managers from the Neptune children's ward and the PAU told us that paediatric study days had been arranged in four hour sessions to enable staff to complete a number of mandatory training requirements including pain management in a half day. All staff had been booked onto these.

Assessing and responding to patient risk

- Southend Hospital does not have a Child and Adolescent Mental Health (CAMHS) in-patient facility; the nearest in-patient facility for children aged 14 and above was located at Rochford. Within 2015, there were 95 cases of paediatric self-harm; 36 of these were children up to the age of 16, and 59 of these were 16 to 18 year olds who were generally treated on adult wards. All admitted patients would have been admitted to the CAMHS crisis team on admission as per the patient pathway.
- A new paediatric observation chart incorporating a paediatric early warning system (PEWS) tool had been created and was working well to enable staff to escalate patients requiring urgent medical review by either the registrars or consultants.
- Appropriate arrangements were in place for the right anaesthetists to work with children as young as six months old for elective minor surgery; there was a policy for pre-operation starvation in place.
- We attended a paediatric handover meeting and noted within the meeting the consultant provided training for junior colleagues, and demonstrated a caring attitude towards patients. A complex patient was discussed in detail and we heard how there had been frequent contact with the other shared-care specialist paediatric centre to ensure continuity of care. Within the handover meeting safeguarding, staffing levels and patient specific links with the Royal Brompton Hospital were discussed.
- Children's do not attempt resuscitation (DNA CPR) forms were kept in a red folder with the patient list for ward rounds. There was no official form in the patient notes or a flagging system for ease of recognition or which allowed staff to respond promptly.

Nursing staffing

- Nurse staffing within the neonatal unit ranged from 88-90% of planned from July 2015 – December 2015. For the four week period ending in the week we inspected the neonatal service, the nursing cover was 40% to 100% which had previously been 66-73%. Rota gaps were due to short term sickness and filled using long-term bank and agency staff. Around the Christmas period some substantive nursing staff worked bank shifts to provide cover.

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- Neptune paediatric ward and the Neonatal unit have existing vacancies, short term sickness and maternity leave. Long-standing bank and agency staff were used to cover any rota gaps. Neptune ward had recently recruited 10 Paediatric nurses, three of whom would rotate between the ward and paediatric A&E. Five registered nurses had been recruited from overseas and commenced in September 2015. They attended a comprehensive induction to the trust, which included the same induction processes that all nursing staff completed along with induction into trust policies.
- Children's and young people's services also had four newly qualified paediatric nurses start employment with the trust in September 2015 and recruitment activity continues to fill vacancies across the service.
- Senior nurses and managers expressed concerns about trust-wide vacancies and recruitment difficulties. They told us these were recorded on the risk register. They also said it was usual practice for five of the seven trained nurse requirements to be met through substantive nursing staff, with agency or bank staff members covering the other two posts. Ward staff told us the trust had developed an embedded work process to ensure bank or agency staff were sufficiently inducted and trained to the same levels as that of substantive staff members in terms of mandatory and statutory training.
- Nurse staffing within the neonatal unit ranged from 88-90% of the planned establishment from July 2015 – December 2015. For the four week period ending in the week we inspected the neonatal service, the nursing cover was between 40% to 100% for trained nursing staff. Nurse staffing within Neptune ward between July 2015 and December 2015 was 66-73% of planned establishment. For the four week period ending in the week we inspected the service the nursing cover was 67% to 133% of the planned numbers for trained nursing staff, some of the gaps were due to short term sickness. Gaps in rotas were generally filled using long-term bank and agency staff, but around the Christmas period some substantive nursing staff worked bank shifts to provide cover.
- Senior nurses on the Paediatric Assessment Unit expressed concern about difficulties recruiting to vacancies with the PAU, and they felt that they were competing with London hospitals and London wages to attract staff.
- The number of paediatric beds available within children's services had been reduced from 28 to 21 in 2015 due to the acuity of patients presenting, and the inability to successfully recruit to the service's nursing establishment. The ward had 21 children's bed at the time of inspection in January 2016.
- The paediatric assessment unit (PAU) had six beds; the unit was open 24 hours a day with separate nursing staff assigned to it from 9:00am to 10:00pm, sharing Neptune Children's ward staff at all other times, all of whom were paediatric trained. Staff on the PAU told us they would take child patients from A and E to help relieve pressure on the unit when this was appropriate. They told us they also took general practitioner referrals and provided a children's phlebotomy service within the children's ward.
- The Neonatal unit did not use any agency staff; if they required additional staff they used bank members of staff, who are usually experienced colleagues who used to work in the department and would like a few extra shifts.
- The neonatal team reported that staff retention was an issue with no level three beds in Essex, which would necessitate the need for specialist critical care trained staff who could support either patient's breathing ability or two or more organ systems.
- Neonatal nursing staff reported that they had a good working relationship with the acute neonatal transfer (ANT) retrieval teams.
- Neonatal teams have a nurse-buddying system to develop teams and learn from each other's experiences.
- Of the 26 whole time equivalent nursing staff (WTE) on the Neonatal unit, 14 of these are registered children's nurses with the remaining 12 registered as adult nurses. Eighteen members of staff (72%) have neonatal qualifications.
- Neptune children's ward is staffed by 26 children's nurses and two adult speciality trained nurses.
- The children's outpatient department is staffed by children's trained nursing staff, none have adult specialisms.
- We had concerns about insufficient numbers of paediatric trained staff available for day surgery on the adult ward for the two days in a month that the ward was opened purely to children.

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- The sickness vacancy rates for clinical support staff who retrieved patient notes, booked patients in, and managed discharge letter completion to patient's General Practitioners was high for the months of July 2015 to November 2015 at between 6.3% and 7.5%.

Medical staffing

- Between 9:00am to 5:00pm there were four to five doctors in the Neonatal unit. Within Neptune ward and PAU at the same time there were four to five doctors, with dedicated cover for PAU. Between 5pm and 10pm there is one foundation year two doctor on Neptune, and one foundation year two doctor on the neonatal unit. There are also a middle grade doctor and a resident consultant available at this time.
- There were 10 paediatric consultants for Children and Young People's Services with a further two located in the community, 20 doctors at ST1-7 level and two clinical fellows working on the middle grade rota.
- There were two consultants from 9:00am to 5:00pm Monday to Friday carrying the on-call phone, covering the general paediatric ward and the Neonatal unit. The consultant covering the paediatric ward also covered A and E and PAU. From 9:00am to 10:00pm there was a consultant on-call and resident in hospital. This was currently being covered as a locum arrangement, with plans to incorporate into the consultant rota in the near future. From 10:00pm to 9:00am there was one on-call consultant, who was on-call from home but came in immediately as needed. A paediatric consultant confirmed some consultants are doing extra 'locum' shifts between 5:00pm – 10:00pm on site five evenings a week, and added this is not sustainable.
- Within the Neonatal unit from 9:00am to 5:00pm there were four to five doctors. Within the Neptune ward and PAU between 9:00am to 5:00pm there were four to five, with dedicated cover for PAU. From 5:00pm to 10:00pm, there is was one doctor on the Neonatal unit and one covering PAU and one on the Neptune ward. There was one middle grade doctor and the resident consultant until 10:00pm, with one doctor covering neonates, one covering Neptune ward and one shared between both areas.

At weekends between 9:00am to 10:00pm there was one ST1-3 doctor and one middle grade doctor covering the

Neonatal unit and the Neptune ward. The on-call consultant arrived at 9:00am on Saturday and Sunday and leaves after the ward rounds. The consultant was then on-call from home for the rest of the weekend.

We spoke with a paediatric registrar who said they had been placed at Southend Hospital as a junior doctor and had witnessed significant improvements within the last three years in terms of more consultant availability for the Paediatric Assessment Unit, and spoke of the benefits of having the two registrars at night for the busy winter months. They were pleased to be rostered to work at Southend Hospital and would recommend the trust for trainees.

- Paediatric Consultant staffing ranged between 83-100% of the planned establishment from July to December 2015. Junior Doctor staffing for the same period ranged between 88-96%.
- We saw that the Neptune ward had four general practitioner (GP) trainee members of staff on the senior house officer (SHO) staff rota.
- Registrars covered A and E paediatric referrals, delivery suite and paediatric in-patients on the Neptune ward and GP referrals on PAU.
- Paediatric consultants attended the delivery suite in the case of twins or for the delivery of premature babies of less than 26 weeks.
- The Paediatric Clinical Lead told us that there were plans to recruit a paediatric consultant to work in the A and E department alongside A and E colleagues
- Parent feedback received on the NHS Choices website August 2014 stated: "The professionalism and attitude of all doctors encountered in our time there has been excellent and we have always left the ward feeling confident and reassured."
- One of the concerns raised by the Paediatric Clinical Lead was the issue of recruitment to paediatric registrar posts. This had been heightened due to the recent increases made in paediatric medical presence on the wards with consultant cover available until 10:00pm, and two registrars available for on-call cover 24 hours a day, seven days a week.
- Junior doctors told us there were currently eight junior doctors with no gaps. They were rostered to work alternate weekends which provided two junior doctors

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on the day shift and two junior doctors on the night shifts. They said this rotation had provided lots of emergency calls to learn from, and enabled them to pursue their specialist interest in radiology.

- An anaesthetist told us paediatric anaesthetisation was provided to all children down to the age of three.
- Anaesthetic staff said children of all ages can be stabilised whilst waiting for the Children's Acute Transport Service (CATS).

Major incident awareness and training

- Senior nursing staff told us they did not receive any major incident training and an electronic copy of the mandatory training matrix for staff confirmed this.
- There was a major incident plan mounted on the wall within the store room within paediatric outpatients. However, the Nurse in Charge told us staff received no training; either e-learning or face-to-face scenario based, to prepare for a major incident, but were assured that this would be escalated by the Nurse in Charge.
- We saw the trust's major incident policy, and noted that there was currently no formal training provided in relation to this. We discussed this with the practice facilitator on the Neptune ward who assured us this would be escalated.
- Staff confirmed paediatric team members had not been routinely asked to participate in major incident scenario training, but future involvement was planned. The previous associate director for the Women and Children's Directorate took part in the Emergo Exercise in 2013 and the current Assistant Director took part in major incident training whilst working in the Medical Directorate.

Are services for children and young people effective?

Requires improvement



We rated effective as requires improvement;

Because;

- The 2015/16 audit plan demonstrated just 29% of the registered audits measured compliance against explicit criterion; the remaining projects were either surveys or service development projects as they did not measure against defined local or national standards.

- No paediatric record keeping audit was completed within 2015/16, but it was registered for completion within 2016/17.
- The paediatric diabetes audit relating to readmissions had an action plan but actions had not been taken.
- The Neonatal Sepsis Audit of July 2014 raised issues with documentation however; there was no evidence of a record keeping audit having taken place within the last 12 months.
- 53% of neonatal septic patients did not receive their antibiotics within the nationally prescribed hour.

However;

- There was 24 hours a day 7 days a week registrar support for Children's and Young People's Services.
- The Neptune ward had a telemedicine suite to enable discussions between the patient and/or parents and the child's other shared care provider where appropriate; for example, Great Ormond street.
- We witnessed one baby admitted to the High Dependency Unit (HDU) and all procedures were completed correctly.
- Medical staff held weekly audit meetings to review practice, and trial and monitor service improvements to benefit patient care and experience.
- The service was progressing work to enable a compliant status to be given for incorporation and alignment to national institute for health and clinical excellence (NICE) recommendations for clinical guidelines and quality standards.
- Parents reported there had not been any unreasonable delays in their child receiving requested pain relief.
- New paediatric observational charts had recently been introduced to the Neptune ward and these included the use of the Paediatric Early Warning System (PEWS).

Evidence-based care and treatment

- The Neptune children's ward had a telemedicine suite which is currently used for inter-hospital telemedicine sessions, for children who may be on a shared care pathway with another NHS hospital which otherwise may involve lengthy journeys to specialist care centres.
- Within Children's and Young People's Services, all doctors and consultants held weekly audit days to share knowledge and learning.
- Following historic nasogastric (NG) tube children's clinical incident's the children's and young people's

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service had introduced NG tube guidelines and implemented NG tube competency frameworks which were both based on the National Patient Safety Agency (NPSA) guidelines.

- Two consultants share the paediatric diabetic caseload, and were involved in both regional and national training.
- Although there was evidence of both local and national audits, in 2014 90% (18/20) had registered criterion to measure against and 45% (9/20) had actions following the audit. The 2015 audit plan demonstrated that 29% (6/21) measured compliance against set criterion. The audit plan for 2015 did not document the policies or guidelines to demonstrate evidence-based practice.
- Southend performed worse than the national average for paediatric diabetes audits in 2012/13 and 2013/14 in terms of paediatric diabetic emergency readmissions, and an action plan had been devised. One of the actions was to purchase the learning modules from Diabetes UK. The action plan also stated training was being rolled out in 2015/16 however; there was no progress updates included in the action plan.
- We requested to see evidence of any record keeping or documentation audits completed within the last 12 months in paediatric services, and were told there weren't any but an audit is currently in progress.
- The service was not able to demonstrate full compliance with NICE guidelines and audit activity around best practice guidelines was inconsistent.
- There was a programme of local audit for Children's and Young People's services in 2015/16 and one of the audits conducted was the Paediatric Early Warning System (PEWS). We saw results of the November 2015 audit which tested compliance with six criteria. This audit tested a sample of eight patients. The areas which achieved compliance targets at 100% were: patient observations being recorded on admission, observations were recorded in accordance with the frequency documented on the chart for the previous week; documentation was in place to demonstrate a patient had triggered, and action had been taken for patients with identified triggers. The two areas which failed to meet the compliance target were: recording of observations on the chart as required at 29% and if a patient required a cumulative fluid chart to be completed; (this column of the data stated 'nil' which may indicate 'not applicable').

Pain relief

- There was a full staff notice board devoted to demonstrating the measurement, monitoring and management of paediatric pain levels showing the new observational charts as well as the pain management policy.
- Paediatric observational charts had recently been revised and were being rolled out across the Neptune ward, these included pain scoring using the PEWS chart. Parents in the six bedded dolphin area on Neptune ward told us that there was never a delay in providing pain relief to their child when they had requested it from nursing staff.

Facilities

- There were good parent facilities available on the Neptune ward including a parent's kitchen and bathroom, and there was the availability of single beds which could be placed next to the child's bed enabling the parent to stay overnight with their child.
- The starfish area on the Neptune children's ward was designated for treating higher dependency patients and had piped and pure oxygen available to each of the four beds.
- The dolphin area on the Neptune children's ward consisted of six beds with piped air and pure oxygen available.
- We visited the radiology department within the hospital and found there were no radiology child specific clinics, and there was no children's play area. Radiology staff said children were prioritised within clinics and there was a box of books and toys behind the check-in desk. We spoke to a child and father in the radiology waiting room who had arrived from A and E following an injury at school and both were happy and pleased with the care received both in A and E and x-ray.
- The Lighthouse Child Development unit has a toy library and equipment which it loaned out to a local charity who work with schools. The rehabilitation team could request particular toys to aid with development. The toy library was open three days a week from 9:00am to 1:00pm.
- There was a separate recovery area for children in all of the theatre suites.
- Sensory rooms were available for children and young people both on the main hospital site and also at the Lighthouse Child Development Centre. These rooms

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offered a place where parents or carers and their child could escape from the pressures of being in hospital. The sensory room used lights, textures, sounds and water therapy to stimulate the senses and is evidence-based good practice.

- The general facilities in the paediatric outpatient area were clean and well-presented however, the staff room was very small (approximately two, by eight waiting chairs in size) and we did not feel this offered staff the opportunity to take their breaks with enough space to relax in.

Nutrition and hydration

- Parents on the Neptune children's ward told us that a trolley service was available every few hours providing children with drinks and snacks, including healthy fruit options, and there were refreshments that parents could help themselves to in the parent's room.

Patient outcomes

- Paediatric diabetes patients treated at the trust had a high multiple re-admission rate for patients between the ages of 1-17 at 27.3% which was significantly higher than the England average at 13.6%.
- Paediatric asthma patients aged between 1-17 had a lower than the England average re-admission rate – 11.8% and 16.8% respectively.
- Re-admission rates for paediatric diabetics was higher than the England average. There had been multiple re-admissions associated with diabetes. The trust took part in the 2014 National Paediatric Diabetes Audit, which had a number of recommendations and action points. Following the national audit results, a restructure of the diabetes team had taken place. The new team of two specialist diabetes consultants, three clinical nurse specialists, one paediatric dietician and a paediatric psychiatrist, had positively affected care provided and reduced paediatric readmission rates.
- Children's services were involved in the Epilepsy 12 (Childhood epilepsy) national audit between 2012 and 2014. Outcomes of this national audit included the planned development of a database or register for children with epilepsy, and following that implementation – a local audit was completed
- Children's services participated in the 2014 National Neonatal Audit Programme (NNAP) screening for visual impairment. Action recommendations from this audit

included: improved temperature control for preterm babies during stabilisation in the delivery suite, and improved Retinopathy of Prematurity (ROP) screening for Small for Gestational Age (SGA) babies.

- Within a five month period from June 2015 to November 2015 there were 1,958 discharges from paediatrics, 5% of these patients were re-admitted within 30 days. There were diverse reasons for re-admission but the three most commonly occurring categories were for chronic lower respiratory diseases at 9% (9/98), general symptoms and signs at 9%, and signs and symptoms involving the digestive system and abdomen at 8%.

Competent staff

- Ward managers told us, and electronic recording software confirmed that staff appraisals on the Neptune ward were 91% completed and the average across all Children's and Young People's services for December 2015 was 99% completion.
- Appraisals within the Neonatal unit are managed in a cascade system to share the responsibility across staff grades. The ward managers were appraised by their corporate managers, and then appraised the Band six staff; the Band Six staff appraised the Band Five staff, and then the Band Fives appraised the health care assistants.
- There was a comprehensive 25 point revalidation action plan for members of nursing staff to follow to ensure nurses were aware of professional updates. This action plan involved a number of monitoring and reporting processes, as well as learning packages to ensure all members of nurse staffing were involved in regular revalidation checks.
- We saw the Appraisal and Revalidation for Medical Staff policy which was created in 2011 and had last been revised in 2015. This policy was aimed at all medical practitioners working in the trust, and was based on national guidance supplied by NHS England and the General Medical Council (GMC). Revalidation for medical staff included following the above trust policy and GMC guidelines as well as completing their appraisal in a timely manner, preparing their portfolios for review at their appraisal and completing feedback surveys on the revalidation process.
- Staff had attended the Acute Life-threatening Events Recognition and Treatment (ALERT) and Midwifery update (MUD) courses following identification of knowledge gaps from a serious incident about

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deteriorating patients. The MUD courses had a reasonably static agenda and were run ten times a year to cover mandatory training as required by the nursing and midwifery council (NMC), to keep staff updated with new initiatives on the midwifery unit and to provide training on issues identified through supervision and clinical governance.

- A junior doctor said they would recommend the children's and young people's directorate for training opportunities as they were exposed to many opportunities.

Multidisciplinary working

- The Lighthouse Child Development Centre was multidisciplinary based with allied health professionals providing physiotherapy, occupational health members of staff providing play therapy and these staff members linked in with external organisations for specific individual child requirements.
- The Neonatal unit held multidisciplinary case reviews for learning from adverse clinical incidents with a debriefing session for staff, and this included nursing, medical and midwifery staff from the delivery suite.
- On the first day of the inspection there was the January 2015 junior doctor's strike taking place. Within the Neonatal unit, junior roles were being covered by consultants and we observed that there were no problems.
- Paediatrician's told us about established clinical links with the Royal Brompton Hospital for cardiology and respiratory patients. They confirmed that echocardiograms are completed onsite. Endocrine clinics were able to provide a wide range of investigations and treatments, resulting in very few patients needing to travel to London for treatment.
- A Paediatric Surgeon told us the surgeons have links with the Chelsea and Westminster NHS trust for infant surgery procedures such as inguinal hernia repairs.

Seven-day services

- There was 24 hours a day, 7 days a week medical registrar support for paediatric services within the trust.
- The paediatric accident and emergency department employed paediatric trained staff but was managed by

the emergency department, not children's services. This department was open between 8:00am to 9:00pm, outside of these hours children would need to present to the adult accident and emergency department.

Access to information

- Blood test and x-ray results were available to clinical staff to access via a hospital software system.

Consent

- Within the Neonatal unit, parental consent was obtained and recorded in patient notes for example, for blood spot checks. We saw examples in all five sets of notes we reviewed.
- Consent documentation within paediatric notes we reviewed on the Neptune ward was inconsistent and not always clearly documented. In one of the sets of notes a parent consented to treatment for their child but a copy of the form was not given to the parent. Within another set of notes a consent form had been signed for a child in October 2015 but the procedure was not undertaken until January 2016 and there appeared to be no re-check of the consenting process. Within a third set of notes we reviewed the child was of an appropriate age to make the consent decision themselves but it was the parent not the child who consented to the procedure and there was no rationale documented for this action. Another set of notes also did not have a consent form and this patient had 'a line' but it was not clear from reading the notes which type of line it was, or whether correct placement had been confirmed. In one set of notes there was no clearly documented consent to insertion of a central line for a 14 year old patient.
- There did not appear to be a standardised format for recording of consent to treatment. We heard and saw that most of the documentation was stored in hard copy form with the exception of test requests and discharge letters which were kept on the electronic patient record.
- Paediatric services do not currently undertake any audits in relation to either Gillick competencies or Fraser guidelines.

Services for children and young people

Are services for children and young people caring?

Good



We rated this domain as good,

Because:

- Friends and family test results for the Neptune children's ward for the month of December 2015 was 83% for the recommender question.
- Patient feedback stated: "excellent nurses in the paediatric outpatients department, always friendly, professional and accommodating."
- Nursing staff on the Neptune ward are of mixed sex which allowed for children and young people to choose to be treated by staff of their own sex if this was their preference.
- A complimentary letter to the Neptune ward talked of nursing staff having: "genuine empathy and instinctive understanding of the feelings and concerns of the parents."
- For parents who experience the death of a child, the ward had bereavement suite staff, and volunteers offered grieving parents a memory box.

However;

- Feedback from parent's in the comments book in the parent's kitchen area on the Neptune ward included the following: "Night shift workers, I beg you, when a child is sleeping, please do everything in your power to keep it this way." (Another parent wrote they agreed with this comment).

Compassionate care

- The Neptune Children's ward received six friends and family survey responses for December 2015, the results of which demonstrated that 83% of children/young people/parents would be extremely likely to recommend the care received on the ward.
- Parents we spoke with told us how they had lost a child and said how supportive the ward staff had been which helped relieve some of the stress of the situation. They told us how the volunteers provided a memory box for their child, adding that it was a truly exceptional service.

Understanding and involvement of patients and those close to them

- Review of NHS Choices in January 2016 demonstrated that children's services at Southend Hospital had received four reviews from March 2015 to January 2016. Three of these had been rated as five stars (the maximum you can give), and the final one although very positive in comments, had not provided a star rating.
- Complimentary feedback had been received in relation to the children and young people's outpatient department, an example being: "excellent nurses in the paediatric outpatients department, always friendly, professional and accommodating with my daughter's care."
- Feedback from the paediatric outpatient's survey completed in September 2015 included: "consistency would be great for a child who attends regularly rather than someone different every time!!"
- The CQC Childrens in patient survey 2014 found the hospital to be about the same overall. However for the question 'Information for parents & carers after an operation or procedure' the trust was rated worse than most trusts.

Emotional support

- We saw complimentary comments via the complaints department from parents, one of which was thanking staff on the Neptune ward for calling for a health update of a child who had been transferred with their parents from the Neptune ward to a specialist tertiary centre.
- Nursing staff said there was a mixture of male and female nursing staff within children's services and one complimentary comment received was: "both men were friendly and helpful and helped take my son's mind off of the blood test. Great with children. Thank you."
- The Neptune ward received a thank you letter in January 2016 from a family of a patient who had been an inpatient on the ward, comments included: "I want to speak particularly about the wonderful nurses on your ward who's genuine empathy and instinctive understanding of the feelings and concerns of the parents (and of course grandparents) was humbling."

Are services for children and young people responsive?

Services for children and young people

Good



We rated 'responsive' as good

Because:

- Saturday clinics were held for children to attend with their family and become familiar with hospital surroundings ahead of their treatment.
- Dermatology patients had previously needed to travel to Basildon Hospital for treatment but this service was now being provided within children's services to avoid the need for additional travel.
- The Lighthouse Child Development centre was a multi-agency location used to provide and facilitate multi-agency person-centred care.
- There were good facilities available for parents or carers to stay overnight with their child.
- Complaints were actively used to change practice for the benefit of the patients.
- Neonatal services were well embedded and included giving grieving parents or carers memory boxes.
- There was a flexible working arrangement for patients with mental health support needs, enabling them to receive specialist support in the most appropriate environment.
- There was the ability to provide longer staying patient's with educational provision which could also link via the play therapists to the child's own school.

However;

- We had concerns about the waiting list system, specifically the process of reallocation of appointments for trust cancelled clinics.
- Communication to parents about appointment cancellations or location changes was not good.

Service planning and delivery to meet the needs of local people

- The Lighthouse Child Development unit is located approximately a 15 minute car journey from the main hospital site and offers a forum in which multi-agency person centred care can be provided to individual children and young people.
- The Lighthouse Child Development unit ran Saturday clubs every fortnight to prepare children in advance for

the experience of going to theatre. All children received an invite prior to admission to hospital. Children's and young people's staff members encouraged parents or carers to attend with their child as it provided an opportunity to ask any questions and allay any fears or anxieties. The aim was to keep parents and carers informed and minimise upset by making the experience of going into theatre as stress-free as possible.

- The trust did not provide any dedicated paediatric critical care beds. If a child was admitted as an emergency and required intensive care they would either be stabilised and cared for in the emergency department, supported by the CCORT, or in an adult CCU bed. This was only done as an interim measure for a maximum of a few hours while arrangements were made for the patient to be transferred to a paediatric CCU in another trust.
- Diabetes, Cystic Fibrosis and Oncology all had transition programmes managed by the paediatric community nursing teams nurse specialist and a paediatrician associated with the specific condition. There was a designated clinic for adolescents who have diabetes where a paediatrician and adult clinician attended to prepare the young person for adult services. Young people who had rheumatological problems also attended a joint clinic with a paediatrician and adult rheumatologist attending who can prepare young people for adult services when appropriate. Children with long term medical conditions are transitioned to adult services according to their individual needs once they are 16 years of age.
- Family voice' is a support group for 16 to 18 year olds and their families, and is run at the Lighthouse Child Development unit.

Access and flow

- Southend Hospital has a longer median length of stay for elective and non-elective treatment than the England average for children under one year of age.
- For paediatric patients less than a year old, admissions were twice as likely to be elective than non-elective.
- For paediatric patients aged 1-17, data suggests admission type was non-elective which aligned to the England averages.
- The average waiting time to see a clinician was one hour, and the average time for treatment decisions to be made was two hours, which are both well within the national target of four hours.

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- Dermatology patients were seen in the department to reduce the need for them to be seen at Basildon Hospital where the main dermatology site is based. Patients who require adrenaline auto-injector training and development of an allergy care plan were seen at Southend.
- Paediatric patients under the age of 16 were admitted to the Neptune children's ward. Patients aged 16 or 17 were admitted to adult wards in the trust, which did not have European Paediatric Life Support (EPLS) trained staff.
- Review of one year's data; January to December 2015 demonstrated that the highest incidence of paediatric patients being admitted to adult wards was to the delivery suite, which accounted for 60% (114/191) of cases for 14 to 17 year olds, and inpatient admission to the gynaecological ward was at 22% for the same age range and time period.
- Referral processes for children to attend the Lighthouse Child Development centre could be received via general practitioners, school nurses, health visitors or speech therapists. The unit is a multi-agency facility for the benefit of children and their families. The centre provides an open environment that is conducive to multi-agency working and focuses on the child using the agencies for support.
- The 'Did Not Attend' (DNA) rate for paediatric patients attending the Lighthouse Child Development unit was between 25% to 30% and this had been reduced by the use of text messages sent to parents to alert them of their child's approaching appointment. The trust had a policy in place for the management of children not attending appointments. All children who do not attend clinic notes will be reviewed by the consultant and a decision made whether to reappoint or discharge back to the GP/referrer. A letter with the details would be sent to the GP and copied to the parents. A Consultant Paediatrician told us if clinics were cancelled due to consultant annual leave, follow-up appointments scheduled for that clinic are put at the end of the list of patients waiting for follow-up appointments. For example, a patient given a three month wait for their next appointment which fell on a cancelled clinic date would be put at the bottom of the waiting list and may then have to wait nine rather than three months to be seen.
- Nursing staff told us that the Child and Adolescent Mental Health (CAMHS) service had recently been taken over by a new provider: and so children's services felt that they were currently in a transformation state adjusting to the new provider. There was a young person's mental health inpatient service available off-site in the Southend and Castlepoint and Rochford area, where patients over the age of 11 were accepted for treatment and support.
- When a young person presented with self-harm injuries the service had a care pathway for 16 to 18 year olds presenting to A&E. If they were medically fit they would be transferred to the paediatric mental health team service was delivered by another provider. If the young person was not medically fit they would be transferred to the Acute Medical Unit (AMU) or a medical ward and the led mental health provider in the area would be contacted as soon as the young person was clinically stable.
- The Starlight Foundation charity assisted with providing a theatre preparation day for all children to help allay any anxieties they may have and provide an opportunity for them to look round the theatre and ask any questions they may have.
- In September 2015 there was a waiting list of 61 Electroencephalogram (EEG) tests for paediatric epilepsy diagnosis.
- Autism Spectrum Disorder (ASD) children's assessments had a backlog of about 100 appointments for the under-fives and 157 for children aged over five. The clinical commissioning group (CCG) were negotiating with additional external providers to address this.
- In September 2015 there was a waiting list for tuberculosis (BCG) vaccinations dating back five months for babies and vaccines were being inefficiently imported in vials of 10 vaccinations which was causing wastage. The October 2015 governance minutes reported that the backlog was being cleared. Six clinics had been booked for August 2015 but the vaccinations had temporarily run out, as soon as they were available again another six clinics were to be set up.
- Parent feedback from the September 2015 paediatric outpatient survey included: "waste of time. Our referral letter clearly states Urology dept. and we've been sent to the wrong dept. Now got to wait again – already waited 4 months" and "staff were very helpful seen as another department had cancelled our appointment with no correspondence to ourselves."
- The eye unit assessed and treated only paediatric cases on Mondays each week. We were told there has been an

Services for children and young people

increase in the number of paediatric referrals as the screening age had recently dropped from the age five to four. A Play Therapist was available to support children having procedures and a Paediatric Nurse was available to assist. There was a paediatric resuscitation trolley available whilst these clinic sessions were occurring, and we noted nursing staff were trained to Safeguarding Level Two and not Level Three.

Meeting people's individual needs

- The trust actively encouraged parents or carers to stay with their child throughout their stay and had a number of facilities available to make things a little easier, including a fridge and microwave, tea and coffee facilities and an evening sandwich and refreshment delivery service.
- Activities available for children aged between three and five years included: painting, soft clay, water play, creative model making and collage. There was also a role play area with a small kitchen and play food. Different activities were set out in the morning and afternoon sessions. Children aged between five and 11 years had the choice of; painting and drawing, board games, craft and use of games consoles. The den was a separate room within the playroom especially for adolescents aged between 12 and 16 years. Within the adolescent rest room children had supervised access to the internet, play computer games, listen to music, watch television and relax. The playroom and den were both open between 8.30am and 4.30pm on weekdays, but not weekends, this was because play support staff did not work weekends.
- Children had access to a school teacher who worked with children of school age staying on the unit longer-term, and was available between 9:15am and 12:00pm on weekdays during term time only.
- We visited the eye clinic to understand the provision of children's outpatient clinics. The Ward Sister told us they only had under 18's on the ward on Monday mornings with a paediatric nurse and a paediatric consultant. On Monday's, staff changed the adult waiting room into a children's waiting area and if required, they requested for play specialists to attend from the Neptune ward. We were told that on the rare occasion a child would need to stay on the ward more than four hours, they would transfer them to the Neptune children's ward.
- The Lighthouse Child Development centre used red flags as indicators to other teams that patients had learning disabilities.
- Young people with learning difficulties were transitioned to adult services in liaison with the clinical teams involved in their care. This would include paediatricians, specialist school nurses, community nurses, rehabilitation staff and social care staff. The age for transition would be decided by the team involved dependant on the severity and needs of the young person and their family. There is an adult learning difficulty clinical nurse specialist who would be involved in the transition process along with the relevant adult teams.
- For non-English speaking families, staff used the language line which is a multi-lingual telephone translation service offered 24 hours a day seven days a week.
- The service worked with the local CAMHS Crisis Team to manage the needs of young people who required acute admission to the children's ward because of mental health issues. Once medically fit for discharge we would refer the young person to the crisis team to be assessed and commence discharge planning. There is a Tier 4 service providing inpatient mental health beds separately from this Trust at the Rochford Hospital and the ward would liaise with the CAMHS team should a young person require transfer to that unit.
- The Neptune children's ward is linked via the play therapists to the local Seabrook centre which would take children who have been excluded from school. For children who were going to be in-patients for a while, the Seabrook centre would send a teacher over to the ward and link to the child's own school for continuity of education.
- There are two clinical nurse specialist's (CNS); one responsible for ambulatory care work, and the other who works with children with constipation. There is also a link nurse for speciality areas such as diabetes, learning disabilities and safeguarding.
- Children's privacy and dignity was maintained in ward areas on the Neptune children's ward and the PAU by the use of curtains which were located around the bed areas which we saw in use.
- The Neptune children's ward allowed one parent or carer to stay overnight with each child. Beds were provided either in the cubicle with the child or next to the child in the six bedded bays. During the day parents

Services for children and young people

or carers had open access and there was a room available for parents or carers to sit in where they could make drinks and snacks with a fridge and microwave available to use. Alternatively, there was a restaurant and several coffee shops accessible within the trust site.

- There was a bathroom/shower for parents or carers to use. The Neonatal Unit (NNU) had two parents rooms designed to facilitate parents and infants preparing for the transition of discharge home; these facilities were also available for families with critically ill/palliative care infants on the NNU. All mothers 'rooming in' received catering which was arranged via electronic ordering systems. We saw a designated parent's room with lockers available for parents to safely store possessions during their visit and a kitchen with microwave and hot water facilities.
- NNU also had a designated parent shower room/toilet facilities in addition to a breastfeeding/expressing room for mothers.
- Within the Eye Unit paediatric patients were day stay only and parents or carers stay with the child for the whole day.
- Planned paediatric day stay surgery is carried out in the trust and children are admitted to the Neptune children's ward. The Adult Day Stay unit becomes a paediatric day stay unit for the day one or two days a month. Day stay surgery undertaken at Southend Hospital includes; general ears nose and throat (ENT), plastics, orthopaedics and oral/dental surgery. Paediatric eye surgery is carried out on the eye unit. Children requiring emergency surgery are admitted to the Neptune children's ward and in general this would be for emergency general surgery and orthopaedic trauma.
- Within the September 2015 paediatric outpatient survey, three of the 37 comments made were in relation to problems parents had experienced with parking at Southend hospital.

Learning from complaints and concerns

- On the Neptune ward there were Patient Advice and Liaison Service (PALS) posters displayed within the entrance onto the ward as well as within the parent's room, but there were no separate leaflets to take away containing contact information.
- January 2015 to January 2016 data showed Children's and Young People's services had received 135 compliments and 52 complaints.

- 39 of the 52 complaints were able to be coded which demonstrated that the most frequently occurring reason for complaint was medical treatment at 28% (11/39). There appears to be no common themes within each complaint in this area other than four relating to delays in treatment. Communication (inadequate) was the second highest complaint category at 18% in relation to poor communication of appointments, wording of clinic letters and unclear plans of care. Appointment issues were the third highest complaint category at 15% and this covered both delays in appointments being available and cancellation of appointments occasionally at short notice.
- Nursing and medical staff told us about a serious incident linked to a complaint in which learning had occurred and clinical practice had changed.

Are services for children and young people well-led?

Requires improvement



We rated the well led domain as requiring improvement; Because:

- Local governance arrangements needed to be strengthened in relation to incident management and training. Incident grading was inconsistent and staff undertaking investigations required specific training.
- Some of the governance processes and escalation procedures were not robust, for example, ensuring clinical audit action plans were fully completed.
- The leadership had failed to appreciate the need for staff to be part of the major incident training response and as such had not received training for at least 12 months, and many staff said they were not familiar with the term.
- The system and communication for cancelled or postponed clinics appeared inconsistent.
- The service was slow to respond to a Royal College review in 2013, which made recommendations relating to the number of consultants which the service had still not achieved.
- The management of the waiting lists needed improvement with regard to ASD and EEG tests, BCG vaccinations plus the management of clinic letters.

Services for children and young people

However;

- The service had achieved UNICEF Baby Friendly stage 2 - Neonatal Standards and the trust were progressing to gain Stage 3 accreditation.
- We saw that lessons learnt from clinical incidents had resulted in positive changes in practice.
- Management was supportive of the staff this could have accounted for the number of staff who had stayed at the trust for a significant length of time.
- The service was represented at board level having one of the non-executive directors was a children's champion.
- The service arranged and offered training opportunities to both nursing and medical staff to improve competence and staff satisfaction. In addition to this training was offered to prospective foster parents.
- The Neptune nursing educator had developed an equipment learning package and this training was being rolled out to all members of staff on the ward.
- Neptune staff were presented with the 'patient choice' award in 2015.
- A patient survey completed in paediatric outpatients demonstrated that; 89% of respondents said the environment was welcoming and courteous.

Vision and strategy for this service

- Children's and young people's services had an action plan which identified five areas for improvement within the service. These areas were:
 - 1. to ensure the Neptune ward was resourced appropriately,
 - 2. to reduce neonatal bed costs,
 - 3. introduce a transitional care unit for babies well enough not to be in the Neonatal unit but not well enough to go home,
 - 4. review paediatric community services and review and improve paediatric outpatients,
 - 5. review and improve the Paediatric Assessment Unit.
- Actions on the plan which had not been completed were; the writing of an operational policy for the Neptune ward, confirmation of whether the cost reduction in neonatal beds would become a Commissioning for Quality and Innovation (CQUIN) for 2016/17, agreement of current position in terms of

paediatric community and outpatient services moving off a block contract with the commissioners. Under point five it had been decided that review of A and E and PAU pathways were not to be undertaken in 2015/16.

- The values had been recently updated November 2015; however staff we spoke with did not mention the new values..

Governance, risk management and quality measurement

- Staffing was a concern achieving for July to November 2015 67-73% of nursing establishment on the Neptune children's ward. Feedback from paediatric governance to the women's and children's governance committee August 2015 meeting demonstrated additional funding for nursing staff had not been agreed by the executive team. Adding that a business case was being prepared which in the interim could lead to the Neptune ward having reduced capacity which was being added to the risk register.
- Nursing and Medical staff told us lessons were learnt and as a consequence, changes to practice were made from serious incidents, complaints and audits. For example, there had been some concern over the use of nasogastric (NG) tubes being used on children, as there had been a few clinical incidents reported in relation to this practice. Following these incidences NG tubes had been placed on the risk register. Actions following this included the production of an NG tube feeding policy linked to the 2011 National Patients Safety Agency (NPSA) guideline and the development of new competency frameworks to monitor staff knowledge against. These were brought into effect in 2012. Competency skills were monitored in both staff and parents or carers with three year intervals and certified approval for parents undertaking insertion upon successful completion of their competency. The implementation of these competency frameworks appears to have had a very positive impact as there have been no further NG tube incidents within the last year.
- Eleven senior members of paediatric staff from nursing, medical and corporate staff groups had received root cause analysis training which had been led by the trust solicitors in October 2013. Further root cause analysis training had taken place in March 2015, but no paediatric staff had attended this session.

Services for children and young people

- The Lighthouse Child Development unit manager told us they felt supported by the medical team, with fortnightly meetings to discuss causes for concern, and also by the executive board. They told us about a visit from one of the non-executive directors (NED) who was a 'children's champion.'
- The November 2015 audit data demonstrated that for that month the Neptune children's ward achieved 100% compliance with controlled drugs guidelines, results for previous audit cycles since 2013 had achieved variable compliance rates between 74-95%. However, for the periods where compliance was Red or Amber, (RAG) rated the frequency of audit data collection did not appear to have been scheduled more frequently to monitor changes in practice and management of risk.
- The women's and children's governance minutes of August 2015 provided feedback from the paediatric governance meetings in which under meeting reference; 04/15 three on-going serious incidents (SI's) are mentioned. These were not on the incident spreadsheet supplied to us.

Leadership of service

- The trust recognised that there had been an unstable executive board for a five year period, and the new Chief Executive had made a number of changes to integrate the board back into the heart of the hospital; including the physical move from the education centre to the main hospital building. Trust-wide there had recently been a change from business unit models to clinically lead divisions.
- Nursing staff told us that on the Neptune ward, there had been a number of medication incidents which had been managed by providing reflective practice with individual staff members concerned, but it was identified that the root cause of these was due to staff working under pressure and subsequent deviation from trust medicines management policy. This had resulted in a strategic review by management with the decision to close some of the beds on the ward to maintain a safe working environment. There is now a change in practice for any medication errors reported on the electronic incident system; they are reviewed by a designated senior nurse who monitors these and if action is required will support staff through a performance management process to ensure safety on the ward.
- Consultant staff told us despite there being agreement within the paediatric team, in alignment with the Royal

College of Paediatrics and Child Health (RCPCH), there needed to be additional paediatric consultants employed within the trust to effectively run services. This had not been agreed by the board.

- Eye unit staff told us management wanted to increase elective work completed on Saturdays however, there were no extra staff at present to facilitate this.
- The August 2015 women's and children's governance minutes highlighted there was a delay in being able to provide epilepsy tests - Electroencephalogram (EEG). This was again reported on in the September 2015 minutes with a backlog of 80 tests and this had been placed on the risk register; all emergency patients were to be sent to a local 'hub and spoke' trust, with a second paediatric centre agreeing to take 10 non-urgent cases to help relieve some of the waiting time. Women's and children's teams were liaising with the medicine directorate to plan ongoing management.
- The waiting list for babies to receive tuberculosis (BCG) vaccinations had been placed on the risk register as reported within August 2015 paediatric governance; the waiting list was four months to April 2015.
- Nursing and support staff on the Neptune ward told us staff morale on the ward had increased with the two new managers.

Culture within the service

- Nursing staff within the eye unit told us senior members of staff within the unit had been there in excess of 20 years.
- Eye unit staff told us many staff members had worked in the unit for in excess of 15 years, adding that historically some surgeons had a reputation as being difficult within theatre, but added that there had been no concerns about bullying within the last two years.
- It was evident from talking to domestic staff working on the Neptune ward they felt included as part of the ward team and able to raise any concerns with the managers.
- Support staff told us there was no segregation between bands of staff, adding that everyone helped each other out and the team often arranged social events.

Public engagement

- Within the parents coffee room on the Neptune ward there was a comment's book which allowed patients or relatives the opportunity to feed comments and suggestions back to the ward.

Services for children and young people

- Children's and Young People's services completed an outpatient's department survey sampling 100 patients in September 2015. Results demonstrated that 89% of respondents said the environment was welcoming and courteous (for which the 'very likely' option was selected).
- The trust engaged with members of the public by responding to comments on the NHS Choices website.







Staff engagement

- Staff comments raised in the 2014/15 staff survey were focused around a lack of dynamic communication and involvement in changes. Corporate responses to this were to provide a quarterly published women's and children's directorate newsletter, to walk around clinical and non-clinical areas once a month, to reserve a space within the women and children's board meeting for members of staff to attend and present, as well as holding meetings in clinical rather than management office areas and making time available to attend ward or departmental meetings to keep staff up-to-date with current issues.
- Nursing and medical staff on the Neptune ward told us the team had two team meetings each month, adding there was good communication between all staff members.

Innovation, improvement and sustainability

- Neptune ward staff were awarded the Patients Choice Award at a recent Hospital Heroes Event. They were nominated by a family of one of the young people who attended the ward regularly in 2015. All specialisms and grades of staff were included in their nomination and staff were very proud to show us their award during the inspection.
- Re-design and implementation of new PEWS Charts, Recognition of the Sick Child study day, Equipment Training for Staff, A and E rotation demonstrated improvement.
- Neonatal Unit: First Neonatal unit in East of England and only the fourth unit in the UK to achieve UNICEF Family Friendly - Stage 2 Neonatal Standards and progressing to gain stage three accreditation in 2016.
- Fostering a baby training for foster parents, Neonatal Bereavement training and education. Medical Staff Consultant evening shift cover, hosting of the post graduate paediatric training (MRCPH) Clinical Examinations. Undertaking ECG's for children who attend paediatric outpatients as requested by a paediatrician. The trust had key trainers within the department who could train others to perform ECG's which demonstrated sustainability.
- October 2015 women's and children's governance minutes reported that there was a backlog in clinic letters being sent out.

End of life care

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

Information about the service

Southend Hospital provided two oncology/haematology palliative care wards, Elizabeth Loury and Kitty Hubbard wards. Palliative care patients could be transferred from other wards to Kitty Hubbard ward if they had complex needs and/or were already known to the ward from previous admissions. The number of palliative beds varied depending on the need. There were some end of life (EoLC) patients on medical wards and on respiratory and renal wards. The trust's Specialist Palliative Care Team (SPCT) visited patients across these wards and supported and trained staff to care for them. The hospital had a bereavement suite, mortuary and post-mortem suite that also provided a service to the local coroner.

For 2015/16 there were 1,564 in hospital deaths of which 1,159 were referred to the palliative care team.

We visited specialist and general medical wards, the Macmillan support centre, the Chaplaincy, the mortuary and the bereavement suite. We spoke to 32 staff across a variety of roles and one volunteer worker. We spoke to one patient and seven relatives of patients; observed the care of three deceased patients; looked at records and specifically focussed on the treatment and care being received by nine inpatients.

Summary of findings

We found the safety of end of life care service (EoLC) required improvement. The mortuary facilities were not secure and installations and equipment were worn out and unreliable. Not all wards looking after end of life patients were fully staffed and there were not enough palliative care consultants working for the trust. However, we also found incidents were reported and learned from, medicines were properly managed and hygiene practices were good.

The effectiveness of the EoLC service was good. Care and treatment followed national guidelines within individualised care plans for patients. This included pain relief and staff were competent. The trust monitored its own effectiveness with clinical audits and compared its performance with other trusts nationally. However, we also found the EoLC specialist service was not available seven days a week and Southend Hospital did not have seven day clinical nurse specialist cover. Specialist consultants were available only on call across South Essex 'out of hours'.

We found EoLC services were caring. Relatives and friends of patients spoke very highly about staff at all levels in the service. Patient's privacy and dignity was respected including after death. Staff gave relatives and friends of dying patients support and help. However, we also saw nurses and doctors were not good at finding out what patient's spiritual needs were to prepare for dying.

End of life care

We found responsiveness of EoLC services required improvement. The trust was not achieving preferred place of care for many end of life patients or able to discharge most of them within 24 hours when requested. The age and condition of the mortuary facilities had a knock on effect on the flow of the service and were often full to capacity. Some beds in the specialist wards were regularly used to care for patients not needing palliative or EoLC when the hospital was under pressure and this created risks. However, we also saw there was a specialist palliative care team available to help nurses and doctors and a weekly outpatient's clinic. Most patients were contacted within 24 hours of being referred and there was a new bereavement suite in the hospital where relatives/friends could register a patient's death.

Leadership of EoLC services required improvement. The short coming in the mortuary related to security, equipment replacement and lack of space which impacted on the service. We also found the trust didn't meet all the key signs of a good quality organisation in a national 2015 audit and not all risks and necessary improvements it identified itself were dealt with quickly enough.

Are end of life care services safe?

Requires improvement



We rated this domain as required improvement,

Because:

- Some key installations and equipment used in the mortuary were unreliable and worn, there were no surveillance arrangements in place over night and security arrangements for one body store facility were not robust.
- Some medical wards were not sufficiently staffed for 28 medical patients, two of whom required EoLC at the time of our visit. Only two qualified nurses were on duty when four were planned and this was an ongoing problem.
- Beds on the day stay infusion unit were used to admit general medical patients and patients requiring palliative care procedures were displaced to other wards that did not have the specialist nursing skills.
- There were insufficient palliative care consultants working for the trust.

However:

- There was a system in development for the specialist team to identify, review and learn from incidents relating to palliative/EoLC across the hospital services.
- Staff caring for palliative/EoLC and deceased patients complied with the trust policies and procedures for infection control and hygiene policies including hand hygiene and systems in place were followed to keep the environment clean.
- Medicines, including anticipatory medicines were managed and administered appropriately.
- Treatment escalation plans were in place and carefully monitored and the electronic prescription system meant doctors could prescribe drugs for palliative/ EoLC patients at very short notice and from wherever they were working in the hospital at the time.
- Most wards providing palliative and EoLC for some patients were fully staffed and/or had flexible arrangements in place to share staff between adjacent wards depending on patient need.

Incidents

End of life care

- No serious incidents relating to palliative or EoLC had been reported during 2014/15.
- The trust had a system in place for reporting and investigating incidents. Until December 2015 there was not a facility on the trust electronic incident reporting system to capture incidents linked to EoLC.
- The specialist palliative care team (SPCT) was led by a palliative care consultant and a palliative care lead nurse.
- They told us any incidents related to palliative care or EoLC were reported through the practice streams within the division in which the patients were being treated throughout the trust.
- The trust was developing a way of identifying incidents relating to palliative/EoLC.
- These incidents were reviewed by the SPCT in parallel with local leaders in the other practice streams to identify learning and changing practice.
- However, local leaders told us differences in reporting culture within practice streams made this a challenge.
- Nursing staff including newly qualified staff told us they knew how to report incidents. They gave us examples of reportable incidents such as patient falls, low staffing levels and pressure ulcers.
- Some nurses said they did not get feedback about incidents they reported.
- Mortuary services staff gave us an example of how improved practice on the wards was brought about by reporting incidents of deceased patients arriving at the mortuary without identification wrist bands.
- Staff in all roles supporting palliative and EoLC services had a basic understanding of the Duty of Candour requirement and they had received training.
- A leader of one medical ward caring for some patients at end of life gave an example of the Duty being recently exercised and the governance arrangements that were followed.
- Senior leaders told us there had been no Duty of Candour issues within complaints about palliative /EoLC services since the Duty came into force in November 2014.
- However, they also said the clinical director had told them the Duty was not being triggered as often as was appropriate.
- The trust had policies and procedures for infection control and hygiene.
- We observed staff caring for palliative, end of life and deceased patients complied with these policies including hand hygiene and personal protective equipment (PPE).
- There were arrangements for separate storage and isolation of decomposed remains in the mortuary.
- The post-mortem room was clean, well-organised and uncluttered with systems in place for managing human tissue and fluids safely.
- We observed mortuary staff cleaning trays after deceased patients had been collected by funeral directors.
- However, they told us the refrigerators were always used to capacity and this made it difficult to clean inside them regularly.
- We saw from records there were regular cleaning schedules for Monday to Fridays and a six monthly deep clean was carried out.
- The cleanliness of the mortuary environment was independently audited and the December 2015 score was 99%.

Environment and equipment

- Staff reported there were sufficient syringe drivers available for use within the hospital and these were calibrated and serviced through a regular contract. We noted McKinley syringe drivers were in use. There was a system in place to ensure drivers were in good order before they were issued for use.
- We saw the mortuary service was functioning in very old buildings.
- The environment in the mortuary suite and additional refrigerated storage in a room underground was cramped.
- We could see from damage to the walls and observing staff working that manoeuvring trolleys safely was difficult in the cramped space.
- Temporary inflatable refrigerator units had been set up in a store room near to but outside of the general mortuary buildings. This store could only be accessed from a pathway that was open to public use.
- Stores of body bags in nine large boxes were piled on pallets in the records room where patients were booked in and out, this reduced the working space further and staff told us there was nowhere else to put them.

Cleanliness, infection control and hygiene

End of life care

- Staff said the lift to the underground store room and tunnel passageway that led to the interior of the hospital used daily, frequently broke down; it was the oldest lift in the hospital.
- This was confirmed by work order records that showed although it was regularly serviced; the lift had broken down seven times between April 2014 and January 2016.
- We noted three report requests between October 2014 and December 2015 to investigate why part of the tunnel was taking in water including one time into the lift. These were signed off as 'resolved.'
- However, we observed water running into the tunnel during the week of our visit and local leaders told us the source could not be identified.
- We saw that a number of the trolleys and lifting equipment in use by staff to move deceased patients in and out of the building and the refrigerated units were old and corroding. The paint finish had long worn away and metal corners had been worn to sharp edges.
- The concealment trolley used for transporting deceased patients through the wards and hospital corridors was rusting.
- Local managers told us new equipment was on order including a bariatric lift.
- Slide boards were available in all the storage rooms to move deceased patients safely between trolleys and storage trays. However, we observed one out of the three patients we saw being moved by mortuary and funeral director staff was moved without using a board.
- Access to the mortuary premises was controlled. However, the security arrangement for the external temporary storage room was a simple key code lock and this was not sufficient.
- There was no arrangement in place to monitor the premises at night and this had meant one incident of injury to a deceased patient could not be accounted for when relatives raised a concern.
- Local managers each told us there was a system in place every morning to check the condition of all deceased patients on the premises and any property on the person, such as jewellery. This was supported by records.
- We observed the temporary 'pop up' refrigerator banks in use for the mortuary had alarms fitted to the temperature gages. Local leaders told us these alarms automatically signalled by phone to the estates manager on duty or on call.

Medicines

- We looked at the arrangements for the management of medicines on the Elizabeth Loury oncology ward.
- We found a dedicated pharmacy team provided chemotherapy services to the unit, and they were available during the unit opening hours.
- The pharmacy team ensured blood results were checked and advice given to support the decision on the correct dosing of chemotherapy treatments.
- Medicines were stored safely and securely in a large dedicated medication storage room.
- Separate storage arrangements were available for the safe storage of chemotherapy treatments.
- Emergency kits for extravasation were readily available as well as special spillage kits for biohazardous substances.
- We specifically focussed on the care of nine patients and noted from their records that medicines, including anticipatory medicines were managed and administered appropriately.
- However, we raised one issue with the trust's lead pharmacist about the number of different drugs being administered together through a syringe driver for one patient.

Records

- We looked at the full sets of notes for nine patients and noted they were clear, well organised and mostly complete.
- They included appropriate medical and nursing assessments for the patient and reviews of those assessments.
- The mortuary service had record systems in place and was working on a paper and electronic system as it was making a transition to fully electronic records.

Safeguarding

- Staff working on wards providing palliative and EoLC for some patients told us they had up to date safeguarding adults and children's training.

Mandatory training

- EoLC training was not mandatory at the time of our inspection. However, the EoLC annual report to the Board 2014/15 reported the SPCT was working with the iLearn team to develop mandatory EoLC role specific programmes, including an e-learning facility.

End of life care

- Nursing staff working on wards where there were patients at the end of life told us their mandatory training was up to date. They said the ward manager and the development team supported them to access update to their training.
- However, on one medical ward caring for three patients at end of life, local leaders told us attendance at the intravenous (IV) training refresher course planned for that day was not possible because staffing levels were too low to release staff.

Assessing and responding to patient risk

- We saw treatment escalation plans (TEP) completed for two patients and reviewed the same day.
- One relative confirmed her husband had become “very poorly” and doctors reassessed his treatment plans in view of his deterioration.
- However, relatives said another patient had not been seen or assessed by a nurse for the appropriate medication or fluids for one whole day and looked thirsty.
- We raised this with a local leader who said health care assistants had regular contact with the patient throughout that day and raised no concerns.
- Doctors told us about the e-prescription system. This meant they could prescribe drugs for palliative and EoLC patients at very short notice and from wherever they were working in the hospital at the time.
- We found on the Kitty Hubbard ward (an 18 bedded oncology unit) had twelve of those beds occupied by medical patients on the day of our visit. Staff on the ward were oncology specialists not medical nurses and the haematology infusion patients had been sent to other wards where oncology nurses were not available.
- Staff told us this was an ongoing issue which had resulted in a recent incident currently being investigated by the trust.
- Senior leaders said deaths were regularly reviewed within the division under governance arrangements. However, they also said the deaths reviewed were not always those which could provide the most learning for clinical improvement.
- In response to Intensive Care National Audit and Research Centre (ICNARC) data on late admissions of sick patients’ mortality rates, critical care staff stated it was due to poor decision-making regarding Do not Attempt Cardiopulmonary Resuscitation (DNACPR).

- However, they also said treatment escalation plans and DNACPR were improving with education and the roll-out of forms across the trust.
- The cardiac arrest review group included critical care, palliative care, a respiratory nurse specialist and cardiology staff. They reviewed all cardiac arrests and if the view was that inappropriate decisions were made by parent team/consultants, this was fed back by the palliative care consultant.
- Last days of life care plans specifically addressed after death care and a checklist including death verification to be completed in line with the trust’s policy.

Nursing staffing

- The SPCT had one full time lead nurse.
- Five clinical nurse specialists (2.36 whole time equivalent) were part of the palliative care specialist nursing team and they provided advice and support to nursing staff on wards across the trust where patients were receiving palliative or EoLC.
- Most wards providing palliative and EoLC for some patients were fully staffed and/or had flexible arrangements in place to share staff between adjacent wards depending on patient need.
- Due to the high number of medical admissions, some wards had their specialisms changed. This impacted on some of the palliative and end of life patients. For instance, we saw the Princess Anne ward was not sufficiently staffed for 28 medical patients, two of whom required EoLC at the time of our visit. Only two qualified nurses were on duty when four were planned.
- The nurses were supported by six health care assistants (HCAs).
- Two of those HCAs were providing one to one support to patients at high risk of falls, or cognitive impairment that made them a risk to other patients.
- Local leaders told us staffing levels on this ward had been a problem since at least autumn 2013 and staff sickness levels were high.
- Staff working on wards providing palliative and EoLC for some patients told us they participated in nursing handovers and multi-disciplinary board rounds where individual patients were discussed.

End of life care

- We observed staff providing palliative and EoLC on wards around the hospital were qualified nurses at a variety of levels of experience supported by nurse ward managers and health care assistants.

Medical staffing

- Senior leaders told us there were insufficient palliative/ EoLC consultants working for the trust at the time of our inspection and the trust needed at least 2.4.
- We found there were two part time consultants making 1.1 whole time equivalent for hospital palliative care services. There was a full time consultant jointly appointed by the hospital and the CCG to provide cover within the community.
- one whole and two part time consultants (one of whom worked part time in the hospital and part time in the community trust).

Major incident awareness and training

- We noted the mortuary escalation plan was to use an on-site physiotherapy gym to provide extra capacity to store deceased patients.
- Local leaders told us the trust had an agreement with another local acute trust to access further storage spaces for deceased patients if necessary.

Are end of life care services effective?

Good



Rated this domain as good ,

Because:

- Evidence based care and practice followed national guidelines within individualised care plans for patients.
- Pain relief was well managed with local guidelines in place, a policy on anticipatory medicines and a new system of e- prescribing which doctors could access without delay in any part of the hospital.
- The trust participated in a national audit relating to palliative and EoLC services and carried out its own audits and re-audits to test action plans for improvement including for example, improved recording of DNACPR in nursing care plans.
- It had resourced participation in the gold standard framework (GSF) accreditation scheme.

- The specialist palliative care team (SPCT) supported nursing and medical staff and delivered training across the trust and this executive supported project was well received by staff.
- A palliative care risk register operated across the local health network. All services locally were supported by a common electronic system template for advanced care planning, power of attorney, preferred place of care and of death and DNACPR. This could be initiated and accessed by all clinicians in the community or hospital.
- There were good multi-disciplinary team working arrangements within the trust to address patient's needs.

However:

- The pilot scheme for the GSF and the planned pace of roll out of EoLC training by the SPCT had been adversely affected by nursing staff shortages.
- The EoLC specialist service was not available seven days a week and Southend Hospital did not have seven day clinical nurse specialist cover. Palliative care consultants were available only on call across South Essex 'out of hours'.
- Most DNACPR Orders did not record whether the patient had capacity to make decisions.
- There was inconsistent attendance by a consultant haematologist to the weekly multidisciplinary meetings on Kitty Hubbard and Loury wards. This meant that end of life care for some patients was not always discussed during the MDT meeting and prior to placing the patient on an end of life pathway.

Evidence-based care and treatment

- We looked at the notes of nine patients receiving palliative or EoLC care at the time of our visit.
- We saw each patient had an individual plan of care in place and completed. Where appropriate there were last days of life care plans.
- Care plans and records of intervention for end of life care were in line with best practice from the Leadership Alliance five priorities for care 2014 'One Chance to Get it Right' guidelines and NICE 2015 Care of the Dying Audit (NCDAH).
- The last days of life care plans followed national guidelines for EoLC for adults CG267 and referenced local policies.

End of life care

- Patients were prescribed and administered anticipatory medicines according to NICE 2015 care of the dying audit guidelines.
- We noted evidence based practice and support for oncology patients.
- Standardised medical and nursing assessments such as MUST and Waterlow were in place and updated.
- Care rounding document documentation was in place and completed for the nine patients whose care we specifically focussed on.
- We saw the sepsis screening tool and vital signs and full medical assessment undertaken for a patient when they were admitted.
- The Gold Standards Framework for EoLC was being piloted by the trust. We noted supporting literature on wards for staff.
- However, leaders told us the two wards had to withdraw from participation as their staffing levels were not sufficiently stable.
- The trust undertook internal audits including a care of the dying audit in September 2014. This provided data on how changing from the Liverpool Care Plan to integrated care plans had affected care in the trust.
- It showed the trust identified dying patients and communicated this information well to patients and relatives; they were also addressing resuscitation status and increasingly discussing this.
- However, it showed the trust was poor at assessing spirituality or at least at recording the assessments.
- It showed patient's ability to drink and eat was being assessed but the trust was less good at discussing the options for artificial hydration and feeding with the patient and relatives.
- During our visit of 12 January 2016, we saw from specifically focusing on the care of nine patients these issues had been largely addressed. However, assessing spirituality had not always been recorded and we saw no records in patient notes of any input the chaplaincy service may have made.
- A hospital wide audit of DNACPR forms on 24 February 2015 looked at every form in circulation and the supporting notes for a patient at that time against the trust's policy for decisions regarding attempting cardiopulmonary resuscitation for patients.
- The key points for improvement identified were: the documentation of decision making and discussions in the notes, the importance of involving the patient and

their relatives in the decision, the avoidance of legally void forms in circulation and the ongoing importance of ceiling of care documentation and the use of treatment escalation plan TEP forms.

- We noted recommendations were made and presented to local leaders.
- During our visit of 12 January 2016 the trust executive told us it was looking to improve the DNACPR methodology as it was not consistent across the services.
- We observed from patient's records that DNACPR forms were generally fully completed.

Pain relief

- The trust used the Essex Group guidelines for pain control and these were on the intranet so staff had easy access to them.
- A pain tool had been recently included in vital signs monitoring.
- the Abbey pain chart was in use for patients with dementia or with a learning disability.
- We did not see evidence of implementation of the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- Junior doctors we spoke with were aware of the trusts policy on anticipatory medicine prescriptions and confirmed they knew how to access this in the e-prescription bundle.
- Nurses understood indications for use of a syringe driver.
- Relatives said they were satisfied the patient's pain was kept under control and reviewed regularly.
- We saw in patient's notes the rounding chart was completed hourly during the day and every two hours at night, including pain control.
- Four hourly checks on syringe driver site, pump setting and lock were recorded in patient's notes.
- However, on one ward which had two patients receiving EoLC at the time of our visit, we observed a near miss with pain relief medication that would have resulted in an overdose.

Nutrition and hydration

- Care rounding documentation for the nine patients whose care we specifically focussed on showed compliance with the plan for each patient regarding their nutrition and hydration.

End of life care

- Last days of life care plans recorded nutrition and hydration had been discussed with the patient and their family and we saw plans for mouth care.
- Relatives confirmed patients received the nutrition and hydration they needed.
- However, for one patient we noted nutrition and hydration was not addressed in the last days of life care plan except for regular mouth care. However, medical notes showed there had been a discussion with relatives about hydration.

Patient outcomes

- We noted the trust participated in national audit relating to palliative and EoLC services such as the annual national prescribing audit and the national care of the dying audit (NCDAH).
- For the national prescribing audit the trust performed well in 2013 but fell to just below the national average for 2014/15.
- We noted EoLC prescribing guidelines had been put on the trust intranet to give staff easy access to them.
- The trust scored better than the England average for eight out of ten of the clinical key performance indicators in the NCDAH.
- In the NCDAH for 2013/14 the trust found, compared with the same questions asked in 2014, all points showed an improvement on all aspects of care. The biggest improvement was seen in symptom control, especially restlessness.
- The trust undertook local audits of its services. For example, the EoLC annual report to the Board 2014/15 acknowledged the local last days of life audit 2014/15 had demonstrated poor compliance in relation to spiritual assessment and care evidence.
- The nursing care plan had been in place for only eight weeks at the time of audit and staff were not familiar with its use and were using old stock.
- We found nursing care plans were generally well completed for the nine patients whose care we specifically focused on.
- A review of the process and communication of the chaplaincy ward based support was undertaken with the Chaplaincy lead during summer of 2014.
- It was agreed the Chaplaincy team would provide formal feedback and communication to the ward nurses to ensure record keeping of patients and families they had supported.
- However, the 2014/15 annual report noted recording and demonstrating input by chaplaincy services remained low and without any improvement despite the feedback system.
- Although the Chaplaincy office kept a range of records of their input to patients and families, there was little added to patients individual records for ward staff to consult.
- The trust had engaged with piloting participation in the Gold Standards Framework (GSF) accreditation scheme in December 2014 when its audit identified two wards that presented the greatest challenge for EoLC.
- Leaders told us this had been withdrawn from those wards until May 2016 because there was consistently insufficient staff for it to be effective.
- Staff who were engaged with the GSF confirmed they had attended training programmes.
- We noted tools available to identify patients in the last year of their life and colour codes green, orange and red were used. There was a care plan for each colour which included general needs and could be individualised to suit the patient.
- Junior doctors told us they received a response from the Specialist Palliative Care Team (SPCT) for advice and support with a patient usually within the day through an electronic referral system.

Competent staff

- Staff providing palliative and EoLC for patients told us they had an annual appraisal in 2015.
- Education and training in palliative and EoLC was coordinated and provided by the SPCT for non-specialist practitioners.
- Nursing staff providing palliative and EoLC to some patients on their wards told us there were no formal arrangements in place for regular one to one or group supervision or meetings.
- During our visit the trust executive told us it had achieved improvement in EoLC knowledge across its services.
- Data provided by the trust demonstrated positive views from staff on the quality of the training when they undertook it.
- However the EoLC annual report to the Board 2014/15 reported: 'The clinical education programmes during 2014-15 remained the same as outlined in the 2013-2014 Annual Report. However, due to changes following the Mortuary Improvement Project, reduction of staff

End of life care

being released from ward areas and also reduced workforce capacity from the Specialist Palliative Care Team has meant the delivery of education in this current year's programme has been slightly reduced.'

- We spoke with Band Five nurses who understood anticipatory medicines prescribed for their patient and indicators. They said they were undertaking the six day palliative care course.
- Local leaders told us care of the dying training which was a one day course, was not a mandatory topic. They said the seven day course staff attended, provided by the trust, covered everything necessary regarding EoLC care.
- Not all nurses caring for patients at the end of their lives had completed specific training.
- For example, one newly qualified nurse on a ward that cared for a number of patients at the end of life told us: "it would be useful to have some EoLC training." They received some as a student nurse but not yet as a qualified nurse.
- Junior doctors and a consultant confirmed they had received information and training on palliative/EoLC care from the trust. This included the GSF, advanced care planning, treatment escalation plan, syringe driver and communicating with patients and relatives.
- We noted the trust had a nursing revalidation action plan that was updated in January 2016.

Multidisciplinary (MDT) working

- Senior leaders told us local health care partners and stakeholders operated a palliative care risk register.
- We noted good working arrangements for internal MDT working between specialities and with allied health professionals. For example, we observed a regular MDT meeting on Elizabeth Lorry ward that included oncology and palliative doctors, nurses, physiotherapists, social workers and occupational therapists.
- Staff discussed each patient in a knowledgeable and caring way and demonstrated their role within a team caring for the person.
- Local leaders in the critical care service confirmed the cardiac arrest review group included palliative care, a respiratory nurse specialist and cardiology staff. They reviewed all cardiac arrests and if inappropriate decisions were made by the 'parent' team/consultants, this was fed back by a palliative care consultant.

- Nurses in the Macmillan unit offering information and support on the hospital site told us about a Hope Course of survivorship after cancer. This was a joint initiative with Coventry University and Macmillan.
- Discharge planning included a fast track transfer pack including information and a tick list for discharge. Local leaders told us fast track meant between 24 and 48 hours but on occasion it could take longer to achieve as a care package and equipment at home needed to be in place
- Ward staff confirmed the palliative care team supported them where they were less used to fast track and rapid discharge arrangements.
- There was not consistent attendance by a consultant haematologist to the weekly multidisciplinary care meetings on Kitty Hubbard and Lorry wards. This meant that haematology end of life care was not always discussed during the MDT meeting and prior to placing the patient on an end of life pathway.

Seven-day services

- The palliative care specialist service was not available seven days a week. Out of hours specialist palliative care advice was operated and provided by an on call palliative medicine consultant.
- There were five consultants available to cover South Essex for 24 hours a day, seven day a week. These consultants were available to offer advice to both hospices, community services and the acute trusts in South Essex ..
- Southend Hospital did not have seven day clinical nurse specialist cover. However the trust told us the business case for increased workforce to implement seven days service was agreed in the middle of January 2016 .
- Junior doctors told us they could contact a registrar or a consultant if needed out of hours.

Access to information

- We noted all services locally were supported by a common electronic system template for advanced care planning, power of attorney, preferred place of care and death and DNACPR.
- This could be initiated and accessed by all clinicians in the community or hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

End of life care

- We looked at the notes of ten patients across six wards where DNA CPR Orders were in place and noted these orders were generally completed properly.
- However, eight did not record whether the patient had capacity to make decisions.
- We saw last days of life care plans in place for two patients. These included mental capacity assessments and information about lasting power of attorney for health and well-being and deprivation of liberties (DoLS) safeguarding if necessary.
- However, on one ward we noted from records a patient's care for positioning to avoid pressure damage was contrary to the advice given by the tissue viability nurse.
- We raised this with the ward manager who told us the patient had capacity and had made their own decision. However, this discussion had not been recorded in their records.

Are end of life care services caring?

Good



The caring domain was rated good,

Because:

- Most relatives and friends spoke very highly about staff at all levels in the service: "Staff get to know the patients and they make time to support them. No one has felt they are intruding on the ward."
- Last days of life care plans specifically addressed privacy and dignity and psychological and support needs. Porters and mortuary staff moved and handled deceased patients with care, respect and dignity.
- Patient's notes documented the discussions and explanations doctors had with patients and/or their families.
- Staff gave relatives/friends support including facilities for staying overnight as comfortably as possible and we saw arrangements were in place to facilitate this.
- There was a wide, well established and diverse network of support from the chaplaincy services and the specialist palliative care team included 2.35 whole time equivalent clinical nurse specialists and one whole time equivalent counsellor.
- EoLC staff training addressed spiritual and cultural care of patients and their bereaved relatives.

However:

- The 2014/15 local Clinical Last Days of Life Audit 2014/15 scored low (below 17%) for assessment of the spiritual needs of the patient, relatives or friends.
- One patient's relatives had to seek out all the information they needed and compared this unfavourably with another hospital locally.

Compassionate care

- The friends and family test question in the care of the dying evaluation (CODE) survey 2015 showed 60% of bereaved respondents were likely or extremely likely to recommend the service (the response rate was 38% from this postal survey which had 28 respondents).
- We noted last days of life care plans specifically addressed privacy and dignity, psychological and support needs.
- One patient told us: "staff have been outstanding and caring."
- We observed porters and mortuary staff moving and handling three deceased patients with care, respect and dignity.

Understanding and involvement of patients and those close to them

- One relative told us their mother had been admitted a number of times during previous months to different wards and the care from all the staff was "fantastic" for the patient and the family.
- Another told us: "Staff get to know the patients and they make time to support them. No one has felt they are intruding on the ward."
- Another relative told us the healthcare assistant caring for her mother was: "absolutely fantastic" at caring for the patient and their family. She also said the personal care was good and staff were very kind.
- We specifically focussed on the care and treatment of nine patients and saw their notes documented the discussions and explanations doctors had with patients and/or their families.
- These included about DNACPR, symptom control, pain control and comfort.
- We spoke with five relatives and one patient, all of whom confirmed this. Most also told us the SPCT had seen them and they felt they had all the information they needed.
- However, one set of relatives told us they had to seek out all the information they needed and compared this unfavourably with another hospital locally.

End of life care

- Relatives confirmed there was open visiting. One local leader told us ward staff robustly resisted any pressure from senior leaders to encourage relatives to vacate the room quickly when a patient passed away.
- Relatives confirmed staff supported relatives to stay overnight as comfortably as possible and we saw arrangements were in place to facilitate this.
- Last days of life care plans specifically addressed support for the family, bereavement needs, personal property and the performance of 'last offices' according to the trust's guidelines.

Emotional support

- The specialist palliative care team included 2.35 whole time equivalent clinical nurse specialists and one whole time equivalent counsellor.
- Assessing spirituality or at least at recording the assessments had been identified as a shortfall in the trust's internal care of the dying audit in September 2014.
- The 2014/15 care of the dying evaluation survey scored low (below 17%) for assessment of the spiritual needs of the patient, relatives or friends.
- We noted the registered nurses end of life training day in January 2016 addressed spiritual and cultural care.
- Emotional and spiritual support provided by the care team was rated overall as good and excellent by respondents to a postal survey in 2015 to seek relatives or friends views about the quality of care given to dying patients during their last two days of life.
- We spoke with the hospital Chaplain and a chaplaincy volunteer and looked at records systems within the chaplaincy service.
- There was a well-established system in place with a network of diverse resources to provide emotional support throughout the hospital for palliative and EoLC patients and their relatives. One patient we were able to speak with confirmed this.
- Chaplains and volunteers visited patients on the wards and we saw records of this within chaplaincy system files.

Because:

- The trust was not achieving preferred place of care for many end of life patients. Less than 50% of patients were discharged within 24 hours.
- The mortuary environment and lack of suitable space did not meet the needs of the local population. The unreliability of installations within the mortuary facilities had a knock on effect on the flow of the service. Deceased patients need for dignity and the reasonable expectations of relatives were not being met by the environment of the mortuary.
- Some beds in the specialist wards were regularly changed (flipped) to care for general medical patients when the hospital was under pressure. This risked a negative impact on patients requiring haematology treatment.
- There had been a delay in the trust's action plan to make necessary improvements to the organisational framework and processes regarding EoLC complaints, identified as needed by a national audit.

However:

- The trust engaged with an 'at risk' register to identify patients with reduced life expectancy via the trust's primary health care partners.
- A specialist palliative care team (SPCT) operated between Monday and Friday 9am to 5pm. This included medical, nursing and counselling services. An outpatient clinic was held weekly.
- A new bereavement suite where the registrar sat on week days to register deaths (and births) at the hospital meant bereaved relatives and friends got the support and services they needed on site.
- There were facilities in place on some wards to enable relatives and friends to stay overnight with patients and staff supported them with meals and refreshments.
- Patients could be transferred from other wards to haematology/oncology/palliative infusion unit wards if they had complex needs and/or were already known to the ward from previous admissions. The trust tried to accommodate patients to specialist wards for their EoLC if they had previously been receiving treatment there.
- From April 2014 to March 2015, 84.9% of palliative and EoLC referrals received a first contact within 24 hours, with 50.3% of that figure receiving a first contact 'within the same day.'

Are end of life care services responsive?

Requires improvement



We rated this domain as responsive,

End of life care

- A trial of a 'peer review' process for EoLC complaints to be reviewed by the SPCT was in place with the intention to enhance action planning and learning.

Service planning and delivery to meet the needs of local people

- The trust worked with a palliative care register operated by primary care partners locally functioned as an 'at risk' register to identify patients with reduced life expectancy with a view to initiating palliative care assessment and intervention.
- Patients could be removed from the register if their perceived life expectancy had improved from any improvements in general health.
- Trust data showed the percentage number of patients discharged within 24 hours was less than 50% but was on an upward trend. During the year April 2013 to March 2014 it was 36% and for April 2014 to March 2015 it was 41%.
- We saw the trust had a new bereavement suite on site where the registrar sat on week days to register deaths and births at the hospital.
- The trust had requested a review of the mortuary arrangements by a mortician from a neighbouring trust for advice.
- Plans to improve this had not been prioritised in the past. We noted an action plan to address environment and operational problems had been put in place during 2015 with an executive lead.
- However despite 'work arounds' the substantive problem remained unresolved. We observed the mortuary environment and lack of suitable space did not meet the needs of the local population.
- Although the trust had recently been involved in negotiations with other stakeholders, leaders told us plans to redevelop the estate through joint funding had not found agreement.
- Trust data showed the number of deceased (including for coroners services and 'brought in dead' by the police) that passed through the mortuary during 2014/15 was 2,221 and for 2015/16 to the time of our inspection was 1,805.
- Fitted storage space was exceeded by demand for at least six months of the year. The health and safety requirements to put out of use low to the floor and above head level body trays in freezer banks had reduced capacity of the existing fittings further.

- The old purpose built facilities could house only 90 trays in two storage areas, one near the post-mortem suite and one underground accessed by the tunnel.
- This meant storage had been increased to include 36 trays in 'pop up' temporary refrigerator banks in a store room close to, but not accessed internally via the mortuary or the hospital.
- Temporary pop up banks were in storage to provide a further 12 trays in an emergency.
- The trust told us the only occasion when it had initiated its escalation plan when demand exceeded capacity, between April 2013 and January 2016, was for five weeks in January 2015.
- The temporary mortuary store in the rehabilitation gymnasium was used to store the deceased for one week. The location was then changed to the non-commissioned paediatric A&E unit for two weeks and then a closed ward for another two weeks, five weeks in total. "We stored no more than two patients in the contingency store over this period."
- Local managers told us there were four decomposing remains refrigeration spaces but they needed eight and four freezer spaces and they also needed eight.

Meeting people's individual needs

- The trust provided up to 12 inpatient beds at a time for patients requiring palliative or EoLC.
- There were two oncology/haematology palliative care wards: Elizabeth Loury and Kitty Hubbard wards.
- Kitty Hubbard ward also had palliative care beds and patients could be transferred from other wards to Kitty Hubbard if they had complex needs and/or were already known to the ward from previous admissions.
- Staff told us the trust tried hard to accommodate patients to these wards if they had been receiving treatment there previously.
- The palliative care consultant told us the number of palliative beds varied depending on the need. The ward manager told us they worked hard to provide a bed if needed for patients they have previously cared for.
- Data provided by the trust showed from April 2014 to March 2015 84.9% of palliative and EoLC referrals received a first contact within 24 hours, with 50.3% of that figure receiving a first contact 'within the same day.'
- There were EoLC champions and this system replaced link nurses as the cascading of information and education did not prove to be effective.

End of life care

- We noted from entries in the patient notes and from speaking to staff, the specialist palliative care team visited patients throughout the hospital and supported the staff caring for them.
- We saw side rooms on some medical wards were used for patients at the end of life.
- There were facilities in place on some wards to enable relatives and friends to stay overnight with patients and staff supported them with meals and refreshments.
- The Chapel of Rest had been recently reappointed as the 'family viewing area' and the trust had made it possible to temporarily disguise much of the Christian design of this old building when appropriate.
- Mortuary staff gave us examples of how they had facilitated religious rituals so far as was reasonably possible.
- We observed deceased patients need for dignity and the reasonable expectations of relatives were not being met by the environment of the mortuary despite mortuary staff constant attempts at engaging in 'workarounds' to meet these expectations.
- The needs of deceased patients as vulnerable people were not being met by arrangements to move them around on public pathways after dark, through a tunnel with a permanent water leakage containing clutter and stores and through the hospital wards and corridors in a 'concealment trolley.'
- Local leaders told us the trust had not considered any method alternative to the concealment trolley for transporting deceased patients through the hospital.
- We noted the patients preferred place of death was identified on the cover page of the last days of life care planning document.
- Senior leaders acknowledged the shortfall in numbers of clinical consultants meant the trust was not achieving preferred place of care for end of life patients and said: "we're a long way off but we're working on it." 62% of patients did achieve their preferred place of death June - Dec 2015, however 38% of patients did not.
- One junior doctor gave an example of staff successfully arranging for a patient who recently expressed a preference to die at home one Friday, by discharging them the following Monday.
- We saw no evidence of translation services specific to palliative and EoLC but the trust had a system in place to access telephone translation and interpreters.

- During the time of our visit we were not able to follow the care of any palliative or EoLC patients identified as having learning disabilities.
- We noted from individual patient records that patients with dementia were identified and their capacity to make decisions including about DNACPR was assessed on admission.

Access and flow

- The specialist palliative care team operated between Monday and Friday 9am to 5pm. This included medical, nursing and counselling services. The trust told us a business case for a seven day a week service was in place at the time of our inspection.
- An outpatient clinic was held weekly on a Wednesday afternoon.
- The age and unreliability of installations within the mortuary facilities, such as the lift breakdown and water leaking into the tunnel had a knock on effect on the flow of the service.
- We saw patients requiring palliative and EoLC cared for on a number of speciality wards such as oncology/ haematology, renal, respiratory and also medical wards.
- However, we noted some of the beds in the specialist wards were 'flipped' to care for general medical patients when the hospital was under pressure.
- We saw one bay comprising of four beds in the haematology ward was functioning as a 'general medical' ward on the day of our visit. Staff told us this had happened seven previous times recently.
- Staff were distressed because this had caused an incident for one haematology patient. We raised our concerns about this with the trust.
- The palliative care at risk register functioned throughout the local primary care network and patients were flagged by GPs when they needed hospital admission.
- We noted the patients preferred place of death was identified on the cover page of the last days of life care planning document.
- One junior doctor gave an example of staff successfully arranging for a patient who recently expressed a preference to die at home one Friday and was discharged by the following Monday.
- Staff confirmed arrangements were put in place with the local hospice or 'hospice @ home' services.

Learning from complaints and concerns

End of life care

- The EoLC report to the board showed four complaints made during 2014/15. The National Care of the Dying Audit in 2013/14 identified gaps in the organisational framework and processes regarding EoLC complaints.
- The trust reported a plan with the complaints team to start classification of EoLC complaints was agreed to start in 2014. However, this was not actioned at that time and this work was set to start towards the end of 2015.
- This included an agreement for a trial of a 'peer review' process for EoLC complaints to be reviewed by SPCT with the intention to enhance action planning and learning.
- Local leaders confirmed at the time of our inspection the SPCT worked with other divisions to establish where any complaints were about EoLC services and peer reviewed them.
- The mortuary service received one complaint in 2015 about an injury to a deceased relative while in their care.
- Local leaders told us this had been investigated, however the trust could not account for the injury as there was no CCTV surveillance of mortuary premises overnight.
- At the time of our inspection, the trust had not taken any effective action to improve this situation although plans were under consultation to improve the estate of the mortuary facilities in general.

- Mortuary security, equipment and space was compromising the service delivery. Although, there was the temporary 'pop-up' mortuary. These issues were on the risk register, but not resolved in a timely way.

However:

- The trust had a clear strategy and vision for EoLC services and leaders and nursing staff were able to tell us about it. There was a non-executive director lead for EoLC.
- Governance arrangements included 'well embedded' regular monthly meetings that were active and inclusive. They were beginning to address the challenges of quality monitoring and risk managing a service that was provided across practice divisions within the trust.
- There was a risk register for EoLC services and action plans in place for the mortuary improvement project to reduce identified risk and improve quality.
- Trust level and local leadership of palliative and EoLC services was strong and leaders reported good communication between the service across the trust and the Board.
- Ward staff found leaders open to challenge and new ideas and pursuing innovative practices. All staff involved in providing EoLC services were encouraged to participate, along with representatives of bereaved members of the public in the EoLC working party.

Are end of life care services well-led?

Requires improvement



We found this domain to be requires improvement;

Because:

- The trust achieved only one out of seven organisational key performance indicators in the 'national care of the dying' hospitals audit (NCDAH) for 2013/14.
- Not all significant risks had been identified. Where risk had been identified, necessary improvements or agreed plans for mitigating those risks within the service had not always been addressed in a timely way.
- Access to speciality beds with suitably qualified staff had been an issue due to the trust decision to 'Flip' beds. This was the solution the trust had put in place to deal with the number of medical admissions.

Vision and strategy for this service

- We found the trust had a clear strategy and vision for EoLC services.
- Leaders and nursing staff were able to tell us about it. For example, they spoke of the projects to improve education to nursing and clinical staff about palliative and EoLC in addition to supporting patients at the earliest opportunity with their decision making.
- The trust Chaplain who was only two days in post at the time of our visit, confirmed he had already been approached to join the SPCT monthly meetings.
- An assistant Chaplain confirmed they had attended the January meeting on the day of our visit.
- There was a non-executive director lead for EoLC.
- However, staff on some wards supporting palliative and EoLC told us the executive team were "not very visible."

Governance, risk management and quality measurement

End of life care

- Palliative and EoLC services operated throughout the trust. Governance of the services sat within the diagnostic and therapeutic directorate. This was headed by a clinical director and associate director.
- The trust achieved only one out of seven organisational key performance indicators in 2013/14 in the NCDAH.
- The specialist palliative care nursing team was made up of three clinical nurse specialists (CNS's), two consultants, a lead nurse and two counsellors.
- Senior leaders told us the governance arrangements included "well embedded" regular monthly meetings that received reports identifying complaints and incidents.
- EoLC services operated within five streams of service and leaders told us the challenge they faced was to get incidents reported consistently and identify risks for EoLC.
- They said some had refined the process to provide a high quality report each month to the division and on to the Board and back to the ward. The directorate was aiming to emulate the best example of a good quality management system to improve reporting across all service streams.
- These arrangements were confirmed as being active and inclusive by local leaders throughout the trust who contributed to the services within their roles for example, medical and oncology ward managers, the Macmillan information and support centre, mortuary services and Chaplaincy services.
- We noted the trust was licensed by the Human Tissue Authority and saw the most inspection report dated 2013. Requirements for improvements had been met from the previous inspection.
- The annual report to the Board for 2015 reported: 'the mortuary had an external peer review at the end of 2014. The report highlighted that the length of stay for the deceased at Southend Hospital Mortuary was double that of neighbouring Essex Hospitals and suggested that if process for discharge and managing the deceased were streamlined this would allow extra capacity to meet the current demand. A multi-disciplinary team was formed to become the Mortuary Improvement Project and led by Pathology and Mortuary Manager being overseen by the Executive panel.'
- EoLC services had a risk register and this was kept under review.
- Redevelopment of the mortuary was rated 'red' (high risk) and identified on the risk register at June 2015 as: 'Reputational damage due to capacity and condition of the Mortuary' and mortuary environment high risk with major consequences due for review in April 2016.
- Mortuary staff told us the problems caused by the old estate no longer being fit for purpose had been raised with the trust for many years without achieving significant change.
- The risk register acknowledged transport of the deceased from the mortuary annex via a public pavement using a concealment trolley 'made it difficult to care for the deceased with dignity and respect. Also the condition of the basement access route and transport method from the annexe could cause distress to relatives.'
- The trust told us it had put in place mortuary improvements and we saw the SMART action plan for the mortuary and bereavement service for 2015.
- We noted from reports and accounts of meetings, the trust had taken some action to reduce these risks for example, it established a service level agreement with local undertakers to remove deceased patients within two days of death.
- However those improvements did not have sufficient impact on this service as some significant 'red' rated risks had actions still not signed off at the time of our inspection.
- For example: replacing rusting equipment and providing surveillance for body stores over night. The trust had not addressed these risks in a timely way.
- Other identified areas had been achieved such as improving record keeping systems and access to records across the trust, particularly between the mortuary and the bereavement service.
- We asked to see the agreed plan for managing in the event of the mortuary lift failure as the impact of this was identified as a key reputational risk for the trust.
- The trust sent us a first draft of version one of a document dated January 2016, which was the time of our inspection. This suggested there had been no agreed and signed off plan previously.
- The trust had actively pursued discussions during 2015 over sharing funding responsibility to rebuild a mortuary facility with other local stakeholders. However, these had not been fruitful.

End of life care

- We noted risk involved in 'flipping' sections of specialist wards to general medical patient beds was not identified on the EoLC services risk register.

Leadership of service

- Palliative and EoLC services within the trust were managed within the diagnostic and therapeutic directorate.
- They were led at a local level by the specialist palliative care team and this team worked alongside other divisions to support, lead and monitor the quality of the delivery of this care throughout the trust.
- We noted the palliative care consultant and the palliative care lead nurse provided strong and visible leadership in parallel with local and senior leaders of the divisions where patients were receiving care.
- Leaders in the Macmillan Unit for advice and support told us of a strategy to develop a voice to the Board through Oncology. They said there was a plan to involve the Board Nurse in their service development plans to ensure this.

Culture within the service

- Nursing and medical staff we spoke with at all levels delivering palliative and EoLC told us they found the leaders open to challenge and new ideas to support them to better deliver care.

Public engagement

- The trust told us there were positions for two bereaved relatives of patients within the palliative/EoLC working party and they contribute to policy development.







Staff engagement

- Ward staff were encouraged to participate in the EoLC working party.
- Local leaders told us the trust was engaging with staff through education and training to work with some resistance to advanced care planning. Medical staff confirmed this.

Innovation, improvement and sustainability

- The trust supported the development of the Macmillan Unit for advice and support situated near the front door of the hospital.
- E prescribing systems had been rolled out to 13 wards within the trust and included chemotherapy in oncology and haematology. The trust told us it planned to run this service trust wide by quarter three of 2016.

Outpatients and diagnostic imaging

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

Information about the service

Outpatient services at Southend University Hospital NHS Foundation Trust are mainly located on the ground floor of the tower block building and served by several reception desks. During July 2014 to June 2015 there were 585,070 outpatient appointments, 21% of these appointments were first appointments and 49% were follow up appointments. The trust runs a wide range of specialities and medical clinics including cardiology, neurology, ophthalmic, rheumatology, diabetes, renal, respiratory and elderly medicine. There were surgical clinics for ear, nose and throat, colorectal, vascular, orthopaedics and trauma including pre-operative assessment clinics. Women's services included gynaecology, family planning and antenatal clinics.

Outpatient radiotherapy follow up clinics, chemotherapy services and phlebotomy services were provided within the outpatient department. The radiology department supported the outpatient clinics as well as inpatients, emergency and GP referrals. They provided imaging for the diagnosis and interventional treatment of a number of conditions.

During our inspection, we spoke with 18 patients along with some of their relatives. We also spoke with 31 members of staff including reception and booking staff, nurses of all grades, radiographers, health care assistants, doctors, consultants, secretaries, managers and domestic staff. We observed care, received comments from our listening events from patients and the public directly. We also reviewed the systems and management of the departments including the performance information.

Summary of findings

We have rated this service as requires improvement for safe. This is because incident learning at directorate level was not well embedded; there were delays in patient follow up which had resulted in patient harm. The WHO check list was not embedded within diagnostic imaging and several pieces of diagnostic imaging equipment were listed as past their replacement dates. However we also saw that departments were clean, sufficient equipment was available to the staff and patient records were well maintained.

Effective was inspected but not rated; we found that multidisciplinary working was evident throughout the departments with excellent interaction from therapies staff. Staff training and re-validation were effective, as were supervision and appraisal systems. There was a good understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards. Sonographers were becoming deskilled in anomaly scans which in turn were adversely affecting recruitment.

We have rated this service as good for caring. Feedback from patients and relatives was positive about the way staff treated people. Interactions between staff and patients were kind and friendly. Patients and their carers' were involved and informed and complimentary about their experiences with staff at all levels, they felt staff took time to explain complex information in a way they could understand.

Outpatients and diagnostic imaging

Responsive required improvement; there were significant access and flow issues in ophthalmology and respiratory services and there were no paediatric facilities within diagnostic imaging. However we also saw that the trust had good partnership working and excellent multidisciplinary team working. Learning from complaints was evident and the trust supported individuals with learning disabilities and dementia.

Well led required improvement; there were significant delays in follow up patient appointments in two specialities, these delays due to miss management had resulted in patient harm. Joint meetings across all outpatients department and diagnostic imaging were not held therefore shared learning was lost. Many items of diagnostic imaging equipment were significantly out of date; there was not a robust plan in place to address this. However we also saw that staff we spoke to were aware of the trusts vision statement and understood their role within the organisation. There was good staff moral despite staff shortages in diagnostic imaging and staff felt valued and innovation was evident.

Are outpatient and diagnostic imaging services safe?

Requires improvement



We have rated this service as requires improvement for safe.

Because:

- Incident learning at directorate level was not well embedded.
- Delays in patient follow up had resulted in patient harm.
- Several pieces of diagnostic imaging equipment were listed as past their replacement dates.

However:

- Departments were clean.
- Sufficient equipment was available to the staff
- Patient records were well maintained.

Incidents

- The trust used an electronic reporting system to record, escalate and respond to incidents. There was a culture of learning from incidents at frontline staff level. Staff in the outpatients department were able to demonstrate this by describing an incident involving staff security and changes to the environment that had since occurred to improve security.
- Between November 2014 and October 2015, 1078 incidents were reported by outpatient and diagnostic imaging department. None were categorised as causing serious harm. Two were classed as extreme risk, two were classed as high risk and eight were categorised as moderate risk. From 1 May to 30 June 2015, 26 incidents were reported by the radiology department. None were categorised as causing serious harm. Three were categorised as moderate harm.
- All staff we spoke with understood the incident reporting process and described how they would report an incident. Feedback from incidents within departments was discussed at team meetings and we saw evidence of this on meeting agendas and minutes.

Outpatients and diagnostic imaging

- Staff told us that they reported incidents such as patient injury, staff security and cancelled clinics through the incident reporting system. We saw evidence of these incidents and the detailed investigation.
- Incident learning from directorate level was not well embedded. A number of waiting list incidents had been identified.
- The ophthalmology department performed a scoping exercise and found that it had a waiting list for follow up appointments of 17,888 patients due to lack of capacity, this was discovered when a new I.T system was installed. Prior to this service managers knew there was a long waiting list but thought it was around 6000 patients. This delay in follow up appointments had resulted in 16 serious incidents where patient's sight had deteriorated due to lack of follow up care. This had impacted on patients waiting for surgery, and had resulted in some patients suffering damage to their eyesight due to prolonged waiting. A triage system had been introduced to identify and re-call the most urgent cases, and a private company had been contracted to work on-site to provide 7500 ophthalmology outpatient appointments, 5000 for glaucoma diagnostics and 2500 for general and retina appointments over a 12 month period commencing in April 2016.
- The respiratory service had a rolling waiting list of around 2,000-3,000 patients waiting for follow up appointments due to capacity, senior management indicated they were concerned as the number of patients waiting was gradually increasing. A plan was in place and at the beginning of implementation to triage all patients on the waiting list and hold virtual clinics to address the delays. Delays of up to 24 months had occurred. Management told us that this had been an issue since 2012. Learning from the ophthalmology incident and the detrimental impact on patient wellbeing had not been communicated or applied to the respiratory service. To date one serious incident had resulted from the delay in respiratory follow-up appointments. Senior management told us that learning was not shared due to the services being divided up between different directorates. There was no overarching view of outpatient as a whole.
- The delayed follow up ophthalmology patients were triaged and assessed as requiring follow up urgently, within 3 months, within 6 months or within 1 year from the date of triage. All urgent patients were offered appointments within a maximum of 4 weeks and all allocated unless the individual patient chose to wait longer, however the patient classed as non-urgent had not yet been given appointments and had not been reassessed to determine if their needs or risk assessment had changed.
- Documents supplied by the trust demonstrated that they did not follow all the parts of the regulations relating to duty of candour. The duty of candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person.
- We saw that the duty of candour regulations were applied inconsistently and not in all cases where it should have been applied. For instance, for all the patients who met the criteria some received an apology but not all.
- Patients were advised what steps to take in the event of a deterioration of their condition for both ophthalmology and respiratory waiting list patients, via letter.

Diagnostic Imaging Services

- There was a good incident reporting culture in diagnostic imaging services and all staff were aware of the reporting criteria. This included statutory notifications to the Care Quality Commission for exposures much greater than intended.
- There had been six recent radiology incidents which have been externally reported and followed up appropriately.
- We saw that the nuclear medicine department had weekly and daily inspection logs conducted. There had not been any radiation incidents in the nuclear medicine department in the last nine years.
- There was an awareness of a recent increase in laterality incidents of low dose appendicular skeletal imaging. The radiation protection supervisor (RPS) lead had made this an action point to improve education of radiographers, introduce "snap bands" to indicate laterality to be imaged. Introduction of the Society and College of Radiographers "pause and check" procedure was being implemented and posters to remind clinicians to check laterality were seen in most x-ray rooms but not all.

Outpatients and diagnostic imaging

- Staff in radiology were aware of the duty of candour and radiation incidents are communicated to the patient with advice taken from the medical physics team and the referrers.

Cleanliness, infection control and hygiene

- We found the outpatient departments, treatment rooms; consultation rooms and sluices were clean and tidy.
- Personal protective equipment such as gloves and aprons were readily available. We witnessed staff using these and washing their hands where appropriate.
- Hand sanitising gel was available throughout the departments and we witnessed both staff and patients using the gel. When we notified staff at one location that the hand gel had run out it was immediately replaced.
- Audits were completed to ensure that infection control measures were implemented, for example the hand hygiene audit for April 2015 to September 2015 showed that outpatient department had achieved 100% compliance.
- Cleaning schedules were in place and we saw they were followed by housekeeping staff.
- We noted that patient and visitor toilets cleaning schedules were only completed 75% of the time.

Diagnostic Imaging

- Although the diagnostic imaging departments were visibly clean, cracks seen in the floor on the nuclear medicine facility could harbour infection. This had been raised with the facility department but no action had been taken.
- Audits were completed to ensure that infection control measures were implemented, for example the hand hygiene audit for April 2015 to September 2015 showed that the diagnostic imaging department had achieved 100% compliance.
- Cleaning schedules were in place and completed.

Environment and equipment

- Staff and volunteers were present and vigilant to ensure patients were in the right place for their appointment.
- We observed ophthalmology equipment that was over its due date for servicing by one year, these were 'slit lamps' and 'head lamps' used for ophthalmic patients. When asked, the ophthalmology manager was not sure if there was a rolling service programme for equipment. It was later confirmed that all equipment had been

serviced but the stickers on the equipment had not been updated, however staff were using equipment that appeared to be out of date without questioning its safety.

- In ophthalmology and renal outpatients the computer equipment was overdue 'safety testing'. This meant the electrical equipment could not be deemed safe.
- The therapy department gym was well equipped. All the equipment was clean and well maintained.

Diagnostic Imaging

- There was good quality assurance which included servicing logs, dose testing and audit of the equipment in the radiology department which ensured that all x-ray equipment was safe and available to use, this was overseen by the trust radiation protection advisor (RPA) with responsibilities for routine testing delegated to RPS' for each area.
- The servicing of all medical equipment was constructed by a central trust equipment managing service. All servicing was up to date.
- A formal peer review of rejected analysis of poor quality images took place. This provided the opportunity for radiographers to improve imaging techniques through audit and education and also to ensure that equipment was functioning correctly.
- There had been an ongoing issue with environment temperature control in the women's clinic, and cracks in the flooring in Diagnostic imaging which had been raised on numerous occasions with the estates department but had yet to be rectified. This issue was noted in the Diagnostic imaging performance report in September 2015.

Medicines

- The trust had systems in place to ensure the correct management, storage and administration of medicines.
- We checked drug cupboards and fridges in the outpatient departments and therapy department. Records were mostly up to date and drugs were stored safely in accordance with the manufacturer's recommendations.
- The refrigerator in the renal outpatients department and the ophthalmology department has not been checked daily in line with local policy. There were four gaps for the renal department for December 2015. For the

Outpatients and diagnostic imaging

ophthalmology department there were no checks between 16th to 24th December 2015 and 7th to 14th January. Therefore the safety of these medicines could not be guaranteed.

- We saw that two medications for ophthalmology patients were to be stored in conditions less than 25 degrees Celsius, they had been left out on a work surface and the temperature of the room environment was unknown, therefore these medications could not be guaranteed as safe to use. We alerted the unit sister to our concerns and the medications were disposed of.
- Pharmacy support was available for advice and guidance. Members of the pharmacy team completed quarterly audits. The security of medicines storage audit carried out September 2015 in the Outpatient Department and diagnostic imaging showed them to be fully compliant.

Diagnostics and Imaging

- All controlled drugs in the department were stored and locked away appropriately.
- Radionuclides were safely and securely stored and a rigorous safety regime was evidenced at the time of the inspection.
- The department staff had a good awareness of doses of medication given to patients and there was continuing education sessions underway.
- A flow chart for patients with poor renal function undergoing scans with iodinated contrast media was in place which ensured they were not administered contrast inappropriately by checking blood results and renal impairment. The contrast media was administered using a patient group directive using guidance from a robust protocol.

Records

- Patient notes were available at clinics between January and December 2015. When notes were not available temporary notes were used and merged with the main notes. This was noted in audit results.
- The trust was in the process of becoming 'paperless' where an electronic system would be used to scan and store medical records digitally. This had been rolled out for approximately 50% of outpatient clinics. Staff were

clear which clinics had made the transformation to note less and which hadn't and needed note preparation time. Therefore this did not impact of patient appointments.

- We saw that documentation was clear and accurate. We reviewed seven sets of paper records. All but one set of notes were in chronological order, entry's in the notes were clear, legible, signed and dated by the practitioner.
- The trust told us they do not conduct any audits on the content of outpatient's notes.

Diagnostic Imaging

- We examined the maintenance records for digital imaging equipment and saw that equipment was serviced regularly and in accordance with the manufacturer's recommendations.
- The department accept a mix of paper and electronic radiology requests and these were handled well by the administration team, all paperwork relating to examinations and safety checks carried out by the radiographers at the time of the exposures were scanned into the patient's electronic record.
- All patients' records and images are stored securely on the Trust Radiology Information system (RIS) and Picture Archiving and Communication systems (PACS) Both systems were password protected and had role based only access.

Safeguarding

- The trust had a safeguarding lead and staff team. Policies and procedures were clear and available to staff on the intranet.
- All the staff we spoke with were able to describe the different forms of abuse that might take place. Nursing staff told us they understood the process for raising a safeguarding concern. Staff provided an example where a patient had made an allegation of abuse, staff described the trusts process that they followed to ensure the individual was protected from harm.
- We saw the reporting flow chart for safeguarding issues and the names of safeguarding leads were clearly displayed on the staff notice boards.
- All (100%) of outpatient staff had completed adult safeguarding level 1 and child protection level 1 and 2. The annual average attendance of children to the main outpatients department was 12% of total patients seen.

Diagnostic imaging

Outpatients and diagnostic imaging

- Adult safeguarding level one training was completed by 98% of staff, Child protection level one was completed by 93% of staff, Child protection level two was completed by 91% of staff. These were all above the trusts target of 85% compliance.

Mandatory training

- We reviewed training logs across the outpatient and diagnostics departments. We saw that although training was taken seriously and staff were encouraged to complete their training they often had to do so in their own time due to staffing shortages.
- Mandatory training included:

Adult Safeguarding Level 1, Child Safeguarding Level 1 and 2, Conflict resolution, CPR, equality and diversity, fire, infection control, information governance, local induction, manual handling inanimate loads, MCA DOLS level1, oxygen therapy, patient manual handling, slips trips and falls and VTE for nurses.

- Mandatory training compliance for the outpatient locations was 95% compliance this was above the 85% trust target.

Diagnostic Imaging

- Overall compliance for mandatory training was 92% in diagnostic imaging. This was above the trusts target of 85%, however conflict resolution training was 70% and manual handling inanimate loads was 83%.
- Staff in the ultrasound department told us they found it difficult to find time to complete mandatory training, they used to have the opportunity on audit days but often these days had been cancelled due to low staffing. Now staff often completed training in lunch breaks or in their own time.

Assessing and responding to patient risk

- Systems were in place to provide safe care for deteriorating patients in clinic areas. Staff described the process for dealing with patients who had attended an outpatient appointment but had either been taken ill or whose condition had deteriorated. They told us they would be taken to the emergency department.
- A 'grab bag' had been collated with equipment commonly needed for unwell patients that staff could utilise in these situations. It was restocked and checked after each use.

- The main outpatients department did not have any emergency call bells. This had been escalated to senior management a few weeks ago and as an interim measure a 'school bell' had been purchased so staff could use in an emergency to draw attention.
- Resuscitation trolleys were located at various locations throughout the departments. We checked these and saw that they were regularly checked to show that they were in order and ready for use.

Diagnostic Imaging

- Principles of the World Health Organisation (WHO) surgical safety checklist were not well embedded in diagnostic imaging. An audit by the department demonstrated 73% compliance to the safety check list that had been completed. Audit of WHO check list compliance was infrequent. In mammography the WHO check list was not used at all. The expectation is for this to be used 100% of the time in interventional procedures.
- The Breast unit did not use the WHO surgical safety check list when conducting invasive procedures such as biopsy.
- Due to shortages in the radiologist workforce no formal interventional radiology on call rota was in place. Out of hours, patients were sent to a London trust for interventional radiology.
- The trust employed a radiation protection advisor and medical physics experts who oversaw radiation protection and compliance with the statutory instruments Ionising Radiation Regulations 1999 (IRR) and Ionising Radiation (Medical Exposures) Regulations 2000 (IR(ME)R). These regulations ensured the safety of staff and the public (IRR) and patients (IR(ME)R whilst undergoing medical exposures.
- A number of radiation protection supervisors (RPS) were also appointed at the trust whose responsibilities were devolved from IRR but who also undertook work around radiation protection for patients. The radiology department employed a lead RPS but they have not attended a recent update training course. Update training should occur every 3-5 years, the RPS had not attended a course for 10 years. There were additionally four plain imaging RPS', two fluoroscopy and two computed tomography (CT) RPS'.

Outpatients and diagnostic imaging

- The RPS was unaware of any recommendations from the most recent RPA report which would have been expected and there was no evidence of follow up within radiology from this report. This report was issued annually.

Nursing staffing

- The outpatient department had a nursing short fall of 4.16 whole time equivalents nurses, a recruitment plans were underway to address the shortages. Sickness and annual leave were covered with bank staff.
- Bank staff were well known to the department, a highly skilled and flexible workforce bank staff accounted for 10% of the nursing numbers.

Medical staffing

- Consultants and registrars attended clinics to see patients with appointments.
- However, Ophthalmology had two consultant vacancies that had been open for three years. Medical staff turnover was 47% in the last year. This was on the risk register for ophthalmology. One appointment was in the process of being filled. This had led to considerable delays in patient reviews. A solution of bringing in an outside agency to help reduce the appointment back log was being implemented.
- The respiratory services had two consultant vacancies this had also led to considerable delays in patient reviews.

Diagnostic Imaging

- The department was staffed with an imaging lead, three deputy superintendents, two advanced practitioners a mix of band five and six radiographers. The department also trained student radiographers.
- Radiography currently have a workforce shortfall of twelve posts
- Radiology nursing team were experiencing staff shortages and there was a shortfall of two nurse whole time equivalents below the required staffing levels.
- There were ten full time and 2 part time consultant radiologists employed in the department but there was a gap of an additional 10 radiologists.
- Managers said it was very hard to recruit to the trust due to its location and proximity to London. The vacancy had been advertised and locum staff were being used.

The agency staff tended to be the same personnel who were familiar with the systems and working practices at the trust. An induction pack for agency staff was evidenced and comprehensive.

- Staff shortages and sickness rates were 2% in diagnostic imaging which is below the national average of 4%.

Major incident awareness and training

- During our inspection the trust were over maximum capacity for bed spaces due to winter pressures. We observed that outpatient nurses were redeployed appropriately in order to manage capacity. Staff described how they were supported by management to do this by keeping up to date with skills needed on other wards in case this situation occurred. Radiology services formed part of the major incident planning. We saw evidence of major incident planning being discussed in diagnostic imaging safety meetings.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

For this service effective was inspected but not rated we found;

- Multidisciplinary working was evident throughout the departments with excellent interaction from therapies staff.
- Staff training and re-validation were effective, as were supervision and appraisal systems.
- There was a good understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

However:

- Sonographers were becoming deskilled in anomaly scans which in turn affected recruitment.

Evidence-based care and treatment

- We saw effective interaction between different staff groups and departments. This was evidenced in the Cardiology department where a multi-disciplinary weekly meeting took place involving a cardiologist a clinical nurse specialist, general manager and pharmacist.

Outpatients and diagnostic imaging

- The physiotherapy department had protocols in place for the more common treatments, this combined with in house training had enabled more junior staff to progress and reach high levels of competence. We saw the protocol for the post-operative physiotherapy treatment of shoulder replacement and saw that this was based on recognised good practice and guidance.
- The respiratory department took place in the national British thoracic Society audit on an annual basis.
- The respiratory service was part of the south east respiratory strategy group where learning and best practise from key topics was shared.

Diagnostic imaging

- We saw that Administration of Radioactive Substances Advisory Committee (ARSAC) guidance was followed in line with the Medicines (Administration of Radioactive Substances) Regulations 1978.
- There were lack of audits undertaken in the department especially around the requirements of IR(ME)R and the WHO checklist.
- An image quality audit was in place at the time of the inspection. Within CT and MRI there was evidence of some audit but this was not shared robustly with all staff for learning outcomes.
- Radiation protection advisor (RPA) meetings took place on a quarterly basis and included radiation protection supervisors. We saw minutes of the last meeting. The minutes were also available electronically to staff on the trusts shared drive.

Pain relief

- Patients we spoke with whose condition caused pain or discomfort, described how they had been able to discuss these symptoms. They told us they had been prescribed drugs or recommended over the counter remedies which enabled them to control their pain effectively.

Patient outcomes

- Clinical audit was evident in the physiotherapy department in regard to the effectiveness and patient outcomes for the physio direct service. The audit demonstrated a study uptake of the call system since commencing 5 weeks before our inspection. They

identified areas to improve patient experience such as an additional telephone line to reduce call waiting times and a computerised system that illustrated the number of calls waiting.

- There was good evidence of local audit within the breast unit and nuclear medicine department.

Competent staff

- All staff we spoke with informed us they had a current annual appraisal in place. Data varied slightly between different outpatient departments however it was above the trusts target of 85%. Diagnostic therapy and support services were 95.74% compliant, Musculoskeletal services 92%, Breast unit 90%, Outpatient nurses 100% and Outpatient services 100%. Staff told us that the appraisal process was good and it allowed time for detailed discussion.
- Staff were actively encouraged to develop within their roles; we saw a pathway in place to assist health care assistance to progress into qualified nurse roles.
- We saw evidence of staff development documented in supervision notes. We reviewed supervision records; all showed recent supervision meetings with clear developmental objectives.
- Information on notice boards signposted staff to additional sources of information and support.
- Department managers confirmed information regarding a network of link nurses covering a variety of subjects such as infection control and safeguarding. These specialist nurses were often asked to speak at team meetings.
- There were a number of nurse led clinics in place. For example nurse practitioners for urology and ophthalmology all of whom had undertaken additional training to increase their knowledge and skills.
- We saw comprehensive induction programmes were in place for all new staff.

Diagnostic Imaging

- Local Rules and IR(ME)R employer's procedures were in place and staff were aware of how to access them on the shared drive. These were current and within review dates.
- There was a good education programme delivered to non-medical refers to ensure that they are aware of their responsibilities under the IR(ME)R regulations and that they were working within an agreed scope of practice.

Outpatients and diagnostic imaging

- There was an innovative online radiation e-learning module available for education of referrers which laid out their responsibilities under the radiation regulations.
- Staff told us and we saw records of operator training on all equipment and competencies were maintained and assessed regularly.
- There were plans in place with fetal medicine for collaborative working with radiology for anomaly scanning however this appeared to have had a negative impact on sonographers who are becoming deskilled in this area. This in turn affected recruitment and retention of staff and the ability to attract trainees to the ultrasound department.
- All staff were trained in CT for emergency scans with senior back up when required.
- CT staff and assistants undertook CT cannulation training in order to streamline the service offered when contrast administration was required as part of an examination.
- The lead RPS has developed an e-learning module for IR(ME)R refresher training for radiographers; this was seen as a gap in radiographer's education.

Multidisciplinary working

- Multidisciplinary working was evident throughout the outpatients department. In particular the oncology, therapy services and renal service displayed excellent interaction between consultants, nurses, physiotherapists, occupational therapists, GP's and social care.
- The musculoskeletal clinical assessment and treatment service was a project set up in conjunction with the local clinical commissioning group. This offered a single point of referral from GP's. Historically referrals were not always being sent to the most appropriate practitioner but through the introduction of this pathway decisions about patient review could be made in accordance with the appropriate clinical pathway. This improved the patient experience, reduced waiting times and maximised limited resources.

Diagnostic imaging

- The lead RPS was attempting to establish meetings with the emergency department in order to educate referrers but at the time of the inspection we were informed that there has been a lack of engagement from the emergency department due to staff shortages.

Seven-day services

- Outpatients departments mostly ran clinics Monday to Friday 9am until 5pm.
- Therapy services and ophthalmology ran clinics on Saturdays with length of clinics adjusted to suit capacity.

Diagnostic Imaging

- Diagnostic imaging services were available on a 24/7 basis, this was due to their work with the emergency department and inpatient wards. However it also meant that the service was available at all times when outpatient clinics took place.
- CT and MRI offered weekend services and they had extended the working day until 9.30 pm.

Access to information

- All department protocols for diagnostic imaging were in view in the magnetic resonance imaging (MRI) and computed tomography (CT) rooms. Staff could also access information on the trust computer shared drive.
- Outpatient staff had access to patient records electronically and from their written notes. We were assured that on the rare occasion when patients written notes were not available at the time of their appointment, patients were still able to be seen as medical staff could access the required information by reviewing the electronic system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a good knowledge of the mental capacity act. They understood how to support patients and their carers or family when they attended appointments.
- There was clear guidance available for staff to follow if a patient did not have capacity to make important decisions about their health care. Documentation was available in the department which enabled staff to follow the guidance and ensured correct procedures would be followed.

Outpatients and diagnostic imaging

- We did not encounter any patients in the outpatients or diagnostic imaging services who did not have capacity. Staff described how capacity issues occasionally arose in relation to elderly patients with dementia or other memory problems, and with people with a learning disability.

Are outpatient and diagnostic imaging services caring?

Good



We have rated this service as good for caring.

Because:

- Feedback from patients and relatives was positive about the way staff treated them.
- Interactions between staff and patients were kind and friendly.
- Patients and their carers' were involved and informed and complimentary about their experiences with staff at all levels.
- They felt staff took time to explain complex information in a way they could understand.

Compassionate care

- All the patients we spoke with were positive about the care and treatment they received from the staff. We observed interactions between staff and patients and saw that they were friendly and professional. Staff smiled as they spoke and patients appeared comfortable in the presence of staff. We observed staff introducing themselves to patients as they met them for their appointments. One patient was hard of hearing; the staff member took her time and spoke slowly and clearly to the patient.
- A patient told us that staff were courteous and helpful. They talked them through treatment. During a recent oncology appointment staff were 'exceptionally good', helpful, very caring and accommodating.
- A patient told us that staff were helpful and caring but they had had issues with staff not explaining things thoroughly and left feeling unsure, they did not ask for clarification, also they never saw the same person; which could be frustrating.

- A patient told us staff were very helpful, caring and friendly. He had been coming into the hospital regularly following hip replacements. The patient experienced good care with detailed explanation of treatment and felt involved in making decisions.
- NHS Friends and Family tests showed that 91% of patients would recommend the outpatient department to a friend or family out of 5,070 responses.
- There had been no patient complaints and six patient compliments in the past six months in nuclear medicine.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt fully informed about their care and treatment.
- Ophthalmology had a relevant policy, and staff were aware of how they could accommodate patients with assistance or guide dogs.
- We observed carers being accommodated and involved with outpatient appointments.
- One patient who was being accompanied by her husband told us that they had actually emailed the patient advice and liaison service recently to say how pleased they were with the service at Southend Hospital. On that day the appointment was scheduled for 11:30 but went in early at 11:20. They said that all treatment was explained to them they were involved in decisions and found staff to be friendly. "Fantastic service all the way through."
- One patient said, "I have nothing but praise for how I have been treated, staff were always brilliant with me. I have always been fully involved and informed of my treatment, so was my husband".

Diagnostic imaging

- A member of staff described how they invited members of the local community who had learning disabilities into the department to look at the imaging equipment and to explain what it does and how it worked. If they then ever required care in the department they hoped that this would reduce their anxiety. They could also feedback on how the department could improve to accommodate those with learning difficulty.

Emotional support

Outpatients and diagnostic imaging

- If patients needed to be given bad news about their condition or general health this was generally done by the doctor in charge of the case.
- The heart and chest clinic had a counselling room set up with sofas, tissues, etc. It could be utilised as a private place to break bad news. Conversations could not be overheard from outside which ensured privacy.
- We observed one nurse accommodating a relative of a patient that was upset following a diagnosis; she took extra time and effort to support the relative and patient in a private environment.
- Where available patients and their carers or family were signposted to external organisations for support.
- Multi faith support services were available if required.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We have rated this service as requires improvement for responsive.

Because:

- There were significant access and flow issues in ophthalmology and respiratory services.
- The service had not undertaken an audit of waiting times.
- There were no paediatric facilities within diagnostic imaging.

However:

- The trust had good partnership working and excellent multidisciplinary team working.
- Learning from complaints was evident.
- The trust supported individuals with learning disabilities and dementia.

Service planning and delivery to meet the needs of local people.

- The trust had positive working relationships with community services and local GP's. Several meeting groups of multidisciplinary professionals were in place to aid seamless patient care and education.

- The renal service also held an open consultation clinic where GP's could call a renal consultant directly to discuss patient care or concerns.
- Volunteers were available to assist patients to different areas of the hospital. They were based at the main reception area of the hospital and helped patients and relatives navigate their way around the hospital clinics and use the automated booking in system.
- A patient surveys in relation to satisfaction had been completed within the Heart and chest clinics. The survey was completed in December 2015 of the 199 patients, 140 patients rated the care as excellent, 46 patients rated the care as very good and 13 patients rated their care as good.

Access and flow

- Referral to treatment times were better than the England average at 96%. The NHS target is that 95% of patients should be seen within 18 weeks of referral.
- A patient experience survey published May 2015 showed that for waiting times for outpatient clinics and planned admissions the trust scored 8.8 out of 10 based on the responses of 372 patients. This score was about the same compared to most other trusts.
- The trust had a lower proportion of patients waiting over six weeks for diagnostic test results than the England average.
- Ophthalmology had 17,880 patients waiting for follow up appointments and respiratory service had 2-3,000 patients waiting for follow up. The service management team could not tell us the exact figure at the time of our inspection. This meant patients needed a follow up appointment but there was no capacity to allocate one at the time. Outpatient management gave an example of some patients that were expecting to have a six month wait actually waiting for 18 months. We saw that this long wait caused serious patient harm. Both departments had conducted 'virtual clinics' where doctors telephoned patients and conducted a triage assessment to decide the urgency of their appointment or if the patient could be discharged without follow up. Following this assessment patients were allocated appointments according to urgency.
- A private company had been contracted to work on-site to provide 5000 glaucoma diagnostic appointments and 2500 general and retina appointments for ophthalmology over a 12 month period commencing in April 2016.

Outpatients and diagnostic imaging

- The rehabilitation service including the musculoskeletal physiotherapists had a better than average referral to treatment time, urgent physiotherapy referrals was often seen within a week.
- Patients were seen quicker than the national average for the cancer referral pathway indicators with 95.2% of patient being seen within two weeks compared to a national average of 94.7%
- On average over the six months preceding our inspection 7% percent of patients did not attend (DNA) their appointment. This was the same as the national average.
- Patients who DNA were given alternative appointments. After the third failed appointment they would be removed from the list and advised that they needed to re-visit their GP.
- The cancelling of outpatient clinics was in the trusts escalation policy for capacity. This meant that when the hospital was very busy outpatient clinics were cancelled to allow staff to be allocated to different areas to ease patient flow. From 1st October 2015 to 31st December, 2015 3,830 clinics had been cancelled out of a possible 33,055 which was 11.6%. This is above the England average of 7%.
- Reception staff said if an appointment had to be cancelled they would telephone the patient, apologise and give the reason why. They would then rebook the appointment and send the appointment out in the post. If they were unable to contact the patient and they arrived for the clinic they would follow the same procedure except they would allocate an appointment and give it to the patient there and then. A comment card would also be given to provide patient feedback.
- Diagnostic imaging services rarely cancelled appointments, when they did this was due to equipment breakdown.
- We found that the signage to the various outpatient departments was unclear in places. The geographical layout of the departments was not easy to follow.
- We did not observe long queues at the reception desk; we saw that when more than a few patients were waiting to be assisted another member of staff was called to help.
- Patients were kept informed when appointments were running late and the reason why (for example why some patients had been seen before others) and we saw this displayed in action on an electronic and on wipe boards.
- We asked the trust for their analysis of waiting times. They advised that this information was not yet captured in the main outpatients department but systems were being developed which would enable the analysis to be done in future.

Diagnostic imaging

- The imaging department were productive despite staff shortages with short wait times for diagnostic procedures. Breaches were below the national average and at the time of the inspection there were no imaging waiting lists over six weeks and the majority of inpatients were being seen within 24 hours.
- At the time of the inspection there were no issues with report waiting times and no backlog of reporting.
- The department employed three reporting radiographers to undertake image reporting to alleviate some of the radiologist workload for appendicular plain film work.
- Urgent GP referrals were seen on the day of referral.
- During the working day radiographers have access to a “hot” reporting service where all urgent images were reported immediately.
- Out of hours, the CT department outsource justification and reporting of CT scans to a third party who were on call from 11pm- 7am; however at times report times were over one hour for urgent scans.
- The department were proud of the service they provided for stroke patients requiring CT head scanning with the trust having a 20 minute door to treatment time which was a significant better than the national average of 60 minutes.
- There was a good process for flagging with referrers including GP’s unexpected or urgent findings.
- Appointment times for access to MRI were one week and waiting times within the department were low.
- At the time of the inspection however a 90 minute wait for an x-ray was seen and this was attributed to X-ray equipment that had broken down.
- Administration staff had good knowledge and visibility of vetting and justification by the radiologists enabling appropriate and streamlined booking of appointments.

Outpatients and diagnostic imaging

- There was a good discharging process for patients, three times a day a bed meeting took place within the trust and this was attended by the senior CT radiographer. If a patient was required to undergo a scan prior to discharge the radiographer was bleeped and the patient was brought to the department.
- Children undergoing scans that required sedation or general anaesthetic had rapid access to the service with support from paediatric nursing team.
- There was provision of rapid access to DVT (deep vein thrombosis) scanning for patients admitted through the surgical assessment unit.

Meeting people's individual needs

- If individuals with learning disabilities were identified by the outpatient department they would have a flag put on the medical record signalling that they may need additional help. Staff were able to give example of how adaptations had been made to clinics in order to accommodate individuals with learning needs. These adaptations included appointments at the start or end of the day to reduce the chance of delayed appointments, longer clinic appointment times and the use of rooms with more space. Staff said they would also liaise with the trusts learning development specialist nurse if they needed additional help or support.
- Therapy staff explained that patients with dementia or those who required close support from their carers were able to have their carer present during the sessions.
- Dementia champions worked across all the outpatient and diagnostic departments. Their role included assisting other staff to support patients and carers and to raise understanding.
- Patient information in the ophthalmology unit was printed on yellow paper to make it easier for those with visual impairment to read.
- Easy read material was available for children and those with learning disabilities.
- Patients who required hospital transport were booked into early appointments to ensure patients could be transported back home before the transport service closed for the evening.
- Interpretation services were available, initially through a telephone service, but face to face services could be

arranged if advance notice were given. The oncology service said they always used a face to face interpreter for the first appointment and when communicating bad news.

- Patient information sheets were available and could be translated into other languages if required.
- British Sign Language (BSL) interpreters were also available and could be booked for consultations between patients and clinical staff.
- The trust also advertised a virtual 'application' for smart phones which was available to download for trust information such as directions, car parking and visiting times.
- The main reception area called 'outpatient sub wait' was well lit. We saw that there was adequate seating for patients and their relatives or carers. Extra fold up chairs were available when required. A water dispenser was available, however in the ophthalmology clinic they had not restocked the plastic cups.
- Magazines and books were available to read or purchase. Money from donated books was put back into the outpatient department to buy new equipment.
- There were adequate toilet facilities in the main outpatient area. In the urology outpatient area both toilets were out of order; this had been reported to estates. The nearest toilets were a short walk away and were signposted.
- The main outpatients waiting area and x-ray department had a computerised visual display unit which indicated to patients their expected waiting time and how many delays had occurred that day.
- The patient information board in the main outpatient waiting areas were large and visible. The information boards contained useful information such as support groups available for various conditions, explanation of different staff uniforms and 'Doctor Who' which was an initiative to inform patient about the background and speciality of consultants working in the department.
- The ophthalmology outpatients, main outpatients and musculoskeletal outpatients had white boards or electronic screens which displayed estimated time delays for each clinic.
- In the ophthalmology clinic we observed a patient in a wide wheelchair struggling to fit the wheelchair through the door into the treatment area; staff assisted the patient with access.

Diagnostic imaging

Outpatients and diagnostic imaging

- Radiology patients who were known to have diabetes were given early appointments to reduce their waiting.
- There was no paediatric waiting or play area available and a lack of paediatric information leaflets available.
- Bariatric patients could not be accommodated at the trust for MRI scans and were sent to other trusts.
- Gowns and dressing gowns were in plentiful supply and available in a variety of sizes.
- Privacy and dignity were compromised in the MRI department waiting and changing area due to mixed sex accommodation.
- In the same department there is only one toilet for males, females and staff members that opened directly onto the corridor.
- Patients have to walk past others waiting for scans once changed into gowns.
- Patients stated that the hospital was a good place to be treated.

Learning from complaints and concerns

- All staff we spoke with were able to describe the process they would follow if a patient wished to complain. We were told that complaints were often diffused by local resolution and referral to PALS if necessary.
- There were 19 formal complaints made in regard to diagnostic imaging service in the previous 12 months.
- Between 1st February 2015 and 31st January 2016 there were 468 complaints that related to outpatient departments. This included women's and children services and external providers. The highest numbers of complaints were 110 complaints for the surgical division. These were mostly due to delays in ophthalmology follow up appointments. The second highest complaints were for the Musculoskeletal physiotherapy department, this was due to delays in physiotherapy waiting times before the Physio Direct initiative was implemented. There were 19 complaints made about radiology services in the same period.
- Information was available to assist people if they wished to make a formal complaint, including references to the system on the trust website. We saw information leaflets displayed in every department that we visited.
- We saw evidence displayed on staff notice boards in the main outpatient departments that information and learning from complaints was communicated to staff.

Are outpatient and diagnostic imaging services well-led?

Requires improvement



We have rated this service as requires improvement for well led.

Because:

- There were significant delays in follow up patient appointments in two specialities, these delays had resulted in patient harm.
- Joint meetings across all outpatients department and diagnostic imaging were not held therefore shared learning was lost.
- Many items of diagnostic imaging equipment were past their due replacement date; there was not a robust plan in place to address this.

However we also saw that:

- Staff we spoke to were aware of the trusts vision statement and understood their role within the organisation.
- There was good staff moral despite staff shortages in diagnostic imaging.
- Staff felt valued and innovation was evident.

Vision and strategy for this service

- Staff we spoke to were aware of the trusts vision statement and understood their role within the organisation and how they contributed to the trusts vision and strategy. Staff at all levels were keen to show and explain their work.
- A number of departments including ophthalmology, rehabilitation service and the respiratory service had detailed development plans for restructuring of the clinical environment. Staff were keen and to show us the plans. They said they felt involved in the design of their new departments.

Governance, risk management and quality measurement

Outpatients and diagnostic imaging

- Outpatients and diagnostic imaging were split between three different directorates. Joint sharing of information and incidents between the directorates did not occur. Management from some services identified the lack of opportunity for shared learning.
- On an audit application form it was noted that there was lack of audit across outpatients as it did not have its own directorate.
- We saw that risk register for Outpatient department indicated risk to the main outpatient department only. The risk for the delay in ophthalmology follow up appointments were detailed on the surgery risk register and the delays in respiratory follow up patients were detailed on the medical risk register. This lacked oversight. Individual risks were scored correctly with appropriate dates for review.
- There were systems in place to enable department managers to identify and respond to issues affecting the service. Regular team meetings took place within each outpatient department and within in diagnostic imaging. Staff were able to raise concerns or receive feedback or updates.
- We discussed the delay in the review of 17,880 ophthalmology patients with senior management and directorate leads. Although they were aware of the problem they didn't have a detailed insight of the plan to resolve the patient backlog and the risk assessment process to reduce the chance of further serious incidents relating to sight loss. OP management said the ophthalmology team were in control and they had confidence in them. Learning from this incident did not appear to have been shared with other services that were also experiencing long delays in patient reviews such as the respiratory outpatient department.
- A private company has been contracted to work on-site to provide 5000 glaucoma diagnostic appointments and 2500 general and retina appointments for ophthalmology over a 12 month period commencing in April 2016.

Diagnostic Imaging

- Although the need to replace imaging equipment was readily recognised and an area of ongoing concern by diagnostic imaging, the department managed despite regularly escalating their concerns to directorate management. They told us that they felt ignored by trust management. We saw a Service Configuration Strategy

(version 5) dated October 2015. The report detailed that 8 major pieces as diagnostic equipment needed replacement. The strategy did not identify how or when this equipment would be replaced.

- There were plans in place for an £8 million reconfiguration of CT and MRI services where management believed equipment issues would be addressed.
- Senior management were aware of significant staff shortages in diagnostic imaging. A detailed analysis and report was under taken in October 2015 into the recruitment and retention issues within diagnostic imaging. All exit interviews were analysed and common themes drawn. These were:
 - Remuneration was better at other NHS Trusts and private providers, locally and in London,
 - working environment (no natural light or air flow)
 - lack development opportunity's.
- In response the department had a recruitment strategy in place to attract diagnostic imaging clinicians to the area this included a 10% pay increase and development opportunities.

Leadership of service

- Staff told us that local managers were supportive of their work, understood their issues and represented their needs.
- All departments demonstrated effective team working and good morale.
- Therapy department staff told us they felt well supported by line managers and always knew who was available if there was a problem. They described regular team meetings and an annual look back meeting to review what had been achieved over the past year, discuss forward planning, review referral rates, waiting lists and the patient satisfaction survey. We saw minutes of these meetings and plans for future meetings in the diary.
- The therapy department had staff listening events where concerns and ideas could be escalated via a staff representative in a non-confrontational way.
- We spoke with the senior nurse at the urology unit. She described clear staff management procedures and expressed her pride in the team working and positive patient feedback.

Outpatients and diagnostic imaging

- The main outpatients department described a visit from the chief executive and other board members. They believed that the senior management of the trust now understood what they did.
- We met with several senior staff they were enthusiastic and proud of what their staff had achieved, they displayed understanding and appeared competent in their roles.
- Many of the staff we spoke with were able to name members of the hospital board. Staff told us that board members made periodic visits to their area. Staff were familiar with the chief executive as she had been involved in their induction process.

Diagnostic imaging

- There was excellent support from the associate director and there was a good relationship with the executive team.
- Staff felt that in response to concerns raised with the estates department; they felt that when estate faults were reported that nothing was ever done. We were provided with the example of broken air conditioning and a cracked floor in nuclear medicine
- Staff felt that the lead radiologist was very supportive but they said that manpower shortages make the role difficult and pressured at times.
- We saw that there was good communication amongst radiology consultants with monthly meetings.
- There was a well-supported programme for radiologist trainees.
- Radiographers attended monthly staff meetings with educational talks included.
- The administration team were well managed outside of radiology by the administration management team. They were not involved with imaging meetings but there was a good input and feedback between the two.
- There were regular superintendent meetings and minutes of all meetings were evidenced including an 'action tracker'.

Culture within the service

- There was an open culture where staff were happy to raise issues and challenge practice.
- Many of the staff we spoke with had worked at the trust for a long period of time, they felt ownership of the

service they had a good working relationship with other staff including management. Staff believed that not only did they help the patients but also that they also contributed to the trust

- Staff of all disciplines were proud of their work and keen to explain how they worked and how this affected their patients.
- Outpatient health care assistant were supported in development and the manager discussed that several health care assistants had been supported by the trust to become registered nurses.

Diagnostic imaging

- Staff in diagnostic imaging regularly worked overtime or additional hours to staff extra clinics to aid capacity for appointments. Time back was given or staff received payment.
- Staff morale appeared high despite ongoing pressures
- Management were supportive and staff felt that the department was well run and cohesive.
- The radiology management were proud of staff and colleagues who work well under pressure.
- There was good clinical leadership as evidenced by open communication and encouragement to work collaboratively.
- Staff felt involved in decision making and they were made aware of departmental and Trust issues and discussions.
- One member of staff we spoke to praised the management of radiology for supporting them through the assistant practitioner programme through to being a qualified radiographer.

Public and staff engagement

- All clinical and medical staff in outpatient department and diagnostic Imaging had individual email accounts and these were used to circulate messages and alerts. Screen savers on computers also communicated 'messages of the week'.
- The MSK service has a listening group for staff, this forum enabled staff to speak up about issues or concern they had or ways to improve the service they worked for.
- Audiology and ophthalmology had hospital working groups which included patient representatives to improve the services.
- The outpatient department had a 'Patient Ambassador' group. Members of staff would bring patient feedback to

Outpatients and diagnostic imaging

the group and they would discuss how services could be improved. Extra fold away seating for the main outpatients sub waiting area had been as a result of this group along with an additional water cooler for refreshments. Dignity briefs had also been provided for patients undergoing intimate examinations.

Innovation, improvement and sustainability

- The renal department had received negative feedback about the amount of time patients needed to wait for transport to the hospital. Therefore staff reviewed current arrangements and discussed how these could be improved. By grouping patients together by geographical locations and offering them appointments on the same day the waiting times were dramatically reduced and patient satisfaction increased. By grouping patient together for transport a saving £183,000 was made.
- The physiotherapy service historically had a long waiting time for appointments of around 16 weeks. Staff were asked by management how they thought they could improve the service and reduce waiting times.

Two band seven members of staff suggested a new approach which they named - Physio Direct. This was a new physiotherapy assessment, advice and triage service. It has replaced the paper and Choose and Book referral systems for adult musculoskeletal patients. It was introduced to provide fast and easy access to physiotherapy assessment and advice, reducing patient wait times, reduces 'did not attend' (DNA) rates and missed appointments. It promoted patient empowerment and self-management. The staff members developed, implemented and continue to audit and improve the service. Non urgent referrals were now four weeks wait and urgent referrals were seen within a week.

Diagnostic imaging

- It was noted that an exemplary system was in place for capturing radiology discrepancies and learning arising from them which has been designed and implemented by a Trust radiologist. It captured all discrepancies in a friendly and efficient manner and is seen as an excellent tool for learning

Outstanding practice and areas for improvement

Outstanding practice

In Medical Services:

- The alarm used by the renal unit for high risk patients to alert staff of presence of moisture (that may be blood loss) during dialysis.
- The renal unit used a new standardised taping technique (chevron) to secure needles during dialysis to prevent dislodgement of the needle which can result in considerable blood loss.
- The hospital had received an innovation award for the seven-day transient ischaemic attack (TIA) clinic that GPs could access electronically. The system assessed patient risk and gave priority of appointments in order to improve timeliness of medical intervention for TIA patients.
- The trust provided emergency treatment (thrombolysing or clot-busting and thrombolectomy or clot retrieval), 24 hours a day, seven days a week for stroke patients.

In Surgery:

- The Early Rehabilitation and Nursing Team (ERAN) supporting the early discharge of patients following primary hip and knee surgery with recovery in their own homes.
- Consultant led Emergency Surgical Ambulatory Care ensured that patients with certain conditions were seen and treated quickly and reduced the number of inpatient admissions

In Critical Care:

We saw several examples of outstanding practice in CCU and ARCU, including:

- Use of the 'All about me' document.
- Levels of planning, governance and staff engagement and satisfaction on CCU.
- Introduction and ongoing rollout of an electronic, wireless patient observation and escalation trigger system.
- The 'Calls for Concern' service, allowing patients and relatives direct access to the CCORT following discharge home.
- The proactive, enthusiastic management team on CCU and ARCU.

In Maternity and Gynaecology:

- The number of specialist clinics available to meet the needs of the population using the service.

In OPD:

- Physio Direct was a new physiotherapy assessment, advice and triage service. It was introduced to provide fast and easy access to physiotherapy assessment and advice, reducing patient wait times, reduces 'did not attend' (DNA) rates and missed appointments. It promoted patient empowerment and self-management..

Diagnostic imaging

- An exemplary system was in place for capturing radiology discrepancies and learning arising from them which has been designed and implemented by a Trust radiologist. It captured all discrepancies in a friendly and efficient manner and is seen as an excellent tool for learning.

Areas for improvement

Action the hospital MUST take to improve

Trust wide Services MUST:

- The duty of candour regulation were not being met, there was a lack of records to demonstrate that the regulations were within root cause analysis investigations. We saw that letters did not always have an apology within it.

- The trust must improve the response rates of FFT.

Emergency Department Services MUST:

- Improve the response rates of FFT.
- Improve the security arrangements to ensure that staff and patients are protected.

Outstanding practice and areas for improvement

Medical Services MUST:

- There must be sufficient and appropriate staff available to provide care and treatment for patients.
- The trust must review the arrangements and effectiveness of morbidity and mortality meetings.
- A daily record is made of the temperature of medicine storage rooms and for medicine refrigerators to ensure that medicines were stored within safe temperature ranges.
- A review of the safe and effective use of two medicine prescribing systems is undertaken.
- Patient records must be fully and appropriately completed.
- The trust must ensure that all staff have the required and identified level of 'both adult and children's safeguarding training.
- The use of whiteboards/ handovers in public place that include confidential patient information should stop.
- Ward staff must all be aware of procedures to review patients who are 'outliers' and when required able to escalate any concerns.
- Staff must have appropriate and suitable training opportunities to develop their practice and knowledge.

Surgery MUST:

- The trust must ensure that governance systems with pharmaceutical oversight are in place to ensure that patients are protected from the risk of harm resulting from medication errors on the wards.
- The trust must ensure that there is clinical input into decisions to cancel operations.

Critical Care MUST:

- The trust must take action to ensure sufficient numbers of suitably qualified and experienced nurses are deployed on ARCU to meet standard 1.2.2 of the Faculty of Intensive Care Medicine's Core Standards for Intensive Care Units.

CYP MUST:

- Review and improve the robustness of complete, comprehensive, legible, chronological hard copy notes for children and young people. - Regulation 17 (2c)

- Ensure that there is an emergency plan for all children's and young people's areas, and that regular training is completed for awareness and preparation. – Regulation 12 (2e)s
- Develop and introduce a robust system for holding discussions with patients or their families where appropriate, in relation to consent and ensuring that this is documented appropriately within the patient notes. – Regulation 11 (1)
- Ensure that staff are adhering to the trust's infection control policies in terms of hand sanitisation. – Regulation 12 (2 h)
- Ensure that staff are sufficiently trained to be able to correctly severity grade clinical incidents, providing timely duty of candour where necessary. – Regulation 12 (2b)

EoLC MUST:

- The trust must take action to ensure mortuary facilities are secure and suitable for the purpose for which they are being used.
- The trust must take action to ensure all mortuary equipment in use is safe for use and capable of effective cleansing.
- The trust must take action to ensure sufficient numbers of suitably qualified, competent, skilled and experienced nurses are available at all times on wards caring for palliative and end of life patients and there are sufficient end of life care consultants available to the trust.
- The trust must take action to ensure that risks presented by the flexible use of beds in specialist wards caring for palliative and end of life patients are managed to avoid patients missing regular treatments or being displaced to wards without the skilled staff to care for them.
- The trust must take action to ensure all DNACPR Orders state whether the patient had the capacity to make decisions.
- The trust must take action to ensure deceased patient's need for dignity and the reasonable expectations of relatives are met by the environment of the mortuary.

Outstanding practice and areas for improvement

- The trust must take action to ensure it improves the quality and safety of palliative and EoLC services by identifying all risks and mitigating all identified risks in a timely way.

OPD MUST:

- The trust must take action to ensure that learning from serious incidents in ophthalmology is shared with all outpatient departments.
- The trust must take action to ensure that the backlog patients waiting for follow up appointments in ophthalmology and respiratory services are managed in a timely manner.
- The trust must take action to improve compliance of the WHO checklist in diagnostic imaging.

Action the hospital SHOULD take to improve

Medical Services SHOULD:

- Staff should receive training in the principle of duty of candour and procedures that relate to it.
- A review of the environment on the AMU should be undertaken to ensure that there is sufficient space to safely access and exit the ward.
- Care pathways are in place for endoscopy procedures.
- The competencies required of staff to work in AMU staff should be reviewed.

Surgery SHOULD:

- Full implementation of the electronic prescribing system should be expedited across all wards to reduce delays in the dispensing of medications and to increase safety through the removal of the dual prescribing system in place at the time of inspection.
- Encourage and act on feedback via the NHS FFT to ensure that the service is achieving the average national percentage of 95% for those who would recommend the service.
- When surgical operations are cancelled and a patient is not treated within 28 days of the cancellation, the trust should investigate the causes and implement actions to address them.

Critical Care SHOULD:

- The trust should ensure data from ARCU is submitted to the Intensive Care National Audit and Research Centre (ICNARC) or similar national audits.

Maternity and Gynaecology SHOULD:

- The trust should review medical presence on the labour ward to meet best practice recommendations.
- The trust should improve attendance at mandatory training.
- The trust should have a maternity and gynaecology strategy.
- The trust should store medical records securely and are not accessible to the public.
- The trust should inform the people using the service how to complain.
- The trust should review and reduce the amount of operations that are cancelled.
- The trust should display maternity outcomes for staff to see.
- The trust should improve the completion of risk assessments on the gynaecology ward.
- The trust should review the gynaecology ward handovers.
- The trust should ensure patients are not identifiable on boards that are in view of the public.

CYP SHOULD:

Ensure that bathroom cleaning schedules are adhered to, in order to promote health and well-being. – Regulation 12 (2h)

- The service must be able to assure itself that all reasonable steps are being taken to minimise paediatric waiting lists, ensuring there is a robust and fair system implemented for trust decision changes to patient appointments. -
- Provide assurance that children's and young people's staff members are all familiar with both Gillick competence and Fraser guidelines. – Regulation 11, (1, 3)
- Be able to provide assurance that having surgical adult patients located within the children's ward for recovery purposes does not cause a safety issue for children on the unit. - Regulation 12 (2b)

EoLC SHOULD:

- The trust should consider improving assessment of the spiritual needs of patients, relatives or friends.
- The trust should ensure end of life patients can be discharged quickly to their preferred place of death.

Outstanding practice and areas for improvement

- The trust should ensure the practice of 'flipping' areas of specialist wards to care for general medical patients when the hospital is under pressure is put under review.
- Arrangements for attendance by a consultant haematologist to the weekly multidisciplinary palliative care meetings should be reviewed.

OPD SHOULD:

- The trust should take action to improve the levels of medical staffing in respiratory and ophthalmology services.
- The trust should take action to improve the level of radiographer and radiologist staffing levels.
- The trust should take action to ensure equipment in the diagnostic imaging service equipment is replaced in a timely manner.
- The trust should improve uptake of audit within the departments of outpatients and diagnostic imaging.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>For Medicine, Critical Care and EoL</p> <p>Regulation 18(1) 18 Staffing</p> <p>Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.</p> <p>In that:</p> <p>There were insufficient numbers of nursing staff on all medical wards which compromised patient safety.</p> <p>Insufficient numbers of nurses were planned and deployed on ARCU to meet standard 1.2.2 of the Faculty of Intensive Care Medicine's Core Standards for Intensive Care Units.</p> <p>There were insufficient nurses on duty on the Princess Anne ward to support 28 medical patients including some patients with end of life care.</p> <p>There were insufficient palliative/end of life care consultants working for the trust.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>For Surgery and Emergency Department:</p> <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>12(2)(b) doing all that is reasonably practicable to mitigate any such risks</p>

Requirement notices

In that:

There was no ward-based pharmaceutical oversight for MSK or surgical wards. Prescription charts were not reviewed or checked by a pharmacist.

Within ED staff and patients were put at risk with the current arrangements for security.

Regulated activity

Diagnostic and screening procedures
Nursing care
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

For EoLC:

15 Premises and Equipment

1. All premise and equipment used by the service provider must be-
1. Clean,
2. Secure,
3. Suitable for the purpose for which they are being used,
4. Properly maintained

In that:

Mortuary facilities were not all secure and suitable for the purpose for which they were being used.

Not all mortuary equipment in use was safe for use and capable of effective cleansing.

Water was flowing into the tunnel connecting the main hospital building to the mortuary body store room and the lift to the mortuary premises, used for transporting deceased patients.

One mortuary store room could be accessed only by a footpath open to general public use.

The security and night surveillance arrangements for the mortuary facilities were inadequate.

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>For Trust wide, ED and EoLC:</p> <p>(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.</p> <p>(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to:</p> <p>(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);</p> <p>(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;</p> <p>(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;</p> <p>In that:</p> <p>Friends and family response rates were low across the trust; ED was an area of note. The trust would benefit from gaining feedback from patients using the services to make improvements.</p> <p>Some risks to patient safety posed by flexible bed/ward use arrangements were not identified and risks identified as posed by the mortuary arrangements were not all mitigated in a timely way to protect patients, staff and the reputation of the hospital</p> <p>and</p> <p>Not all DNACPR Orders recorded whether the patient had the capacity to make decisions.</p>

Requirement notices

Regulated activity

Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Trust wide

Treatment for disease, disorder and injury

Diagnostics and screening

Surgery

Nursing care

20 Duty Of candour

20.— (1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(3) The notification to be given under paragraph (2)(a) must—

(a) be given in person by one or more representatives of the registered person,

(b) provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the

incident as at the date of the notification,

(c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

(d) include an apology, and

(e) be recorded in a written record which is kept securely by the registered person.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided under paragraph (3)(b),

Requirement notices

(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),

(c) the results of any further enquiries into the incident, and

(d) an apology.

In that:

The trust were not able to demonstrate the records of conversations that took place. There was a lack of evidence of apologies in writing. The letters lacked detail of the incident and what the responsible person knew at the time.

There was no evidence of sharing the outcome of the investigation with a follow-up letter containing another apology.