

Basildon and Thurrock University Hospitals NHS
Foundation Trust

Basildon University Hospital

Quality Report

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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

Good



Critical care

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Basildon and Thurrock University Hospitals NHS Foundation Trust serves a population of around 405,000 in south west Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point. The trust also provides services across south Essex. The trust provides an extensive range of acute medical services at Basildon University Hospital, which includes The Essex Cardiothoracic Centre and Orsett Hospital as well as x-ray and blood testing facilities at the St Andrew's Centre in Billericay. The trust employs more than 4,000 staff and has more than 10,000 public members. The trust became one of the first 10 NHS foundation trusts in April 2004.

The trust was placed into special measures following reviews by Sir Bruce Keogh June 2013 following concerns around quality of care and high mortality. The Care Quality Commission undertook a comprehensive inspection of the trust in March 2014 and rated the trust as Good. Following this inspection the Commission recommended to Monitor that the trust could come out of special measures.

We returned to inspect on 17th and 18th March 2015 and inspected those key questions where the service had been rated as requiring improvement which are reported in a separate report. We did not undertake a full comprehensive inspection. We undertook an inspection of the critical care service during this inspection due to concerns received about the leadership and responsiveness of the service.

In 2014 we inspected the critical care unit at Basildon University Hospitals NHS Foundation Trust and found significant improvements to the care delivered to the population. At this time we rated the unit as Good. When we returned in 2015 we found this service had concerns relating safety with staffing shortages within the critical care outreach team, areas for improvement within the effectiveness of the service, responsiveness on patient pathways and the pace at which change had been implemented. The rating for this service overall has changed from 'Good' to 'Requires Improvement'.

Our key findings were as follows:

- The critical care outreach team had been depleted through maternity leave and resignation and the trust had commissioned a review prior to our inspection.
- There were also significant delays on occasions in discharging patients from critical care unit which impacted on the responsiveness of the service. The trust had commissioned a report into delayed transfers of care within the hospital.
- The pace of change within the critical care, although improving, required further work to ensure that patients received a timely service.
- Patient outcomes as recorded by the Intensive Care National Audit and Research Centre were poor in four out of the seven areas reviewed.
- The strategy for the critical care unit was discussed by the senior management group during our inspection.

We identified the following areas of poor practice where the trust needs to make improvements:

The trust should:

- Continue to work and improve on the skill mix and staffing levels throughout the hospital particularly in the critical care service.
- Review staffing and management structures for the critical care outreach service to ensure that an appropriate number of outreach staff are on duty for each shift.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Critical care

Requires improvement

Rating



Why have we given this rating?

In 2015 we only inspected the general critical care and outreach services at Basildon Hospital. We inspected due to concerns raised to us by patients and their families.

We found that staffing in the outreach team was depleted at the time of our inspection, however the trust were aware of this and a review was being carried out. There was a lack of morbidity and mortality meetings occurring within the critical care unit to learn lessons to improve safe care.

We found that the effectiveness of the service required some improvement to ensure good outcomes for patients. The number of nurses with nationally recognised training was below the national benchmark at 29%. We found that DNACPR decisions were increasingly undertaken with patients or their nearest family although some further work was required to ensure that this was embedded and enacted for every patient.

The service required some improvement so that it was responsive to the needs of patients. We saw evidence of delayed admissions and discharges and significant numbers of discharges occurring overnight which is neither beneficial for patients nor responsive to their needs. We saw that two external reports had been undertaken, some actions had been taken and were yet to be embedded; other actions were still to be enacted.

We saw that there was some inertia in making improvements to the service. A senior leadership development programme was underway by the trust through an external advisor. Whilst this work had begun in April 2014 the critical care team were in the early stages of developing a chronic obstructive pulmonary disease pathway as part of their leadership development. Whilst staff felt supported there was a lack of understanding of the vision for the service at the time of our inspection. We rated this aspect of the service as requiring improvement.

Basildon University Hospital

Detailed findings

Services we looked at

Critical care;

Detailed findings

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Background to Basildon University Hospital

Basildon and Thurrock University Hospitals NHS Foundation Trust serves a population of around 405,000 in south west Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point. The trust also provides services across south Essex. The trust provides an extensive range of acute medical services at Basildon University Hospital, which includes The Essex Cardiothoracic Centre and Orsett Hospital as well as x-ray

and blood testing facilities at the St Andrew's Centre in Billericay. The trust employs more than 4,000 staff and has more than 10,000 public members. The trust was awarded the status of Associate Teaching Hospital by the Royal Free University College London Medical School in 1997 and in 2002, the Secretary of State for Health conferred University Hospital status. The trust became one of the first 10 NHS foundation trusts in April 2004.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, Head of Hospital Inspection, Care Quality Commission

The team included five CQC inspectors and three specialists in critical care, surgery and midwifery

How we carried out this inspection

We carried out this inspection in to the critical care unit following concerns raised with us from relatives of patients who had used the service. We included it as a part of our focused review to follow up main services that required improvement from our comprehensive

inspection in 2014. A specialist and two CQC inspectors undertook a review of the service through speaking with staff, patients and relatives using the service. We also had a formal interview with senior management responsible for this service.

Facts and data about Basildon University Hospital

Basildon and Thurrock University Hospitals NHS Foundation Trust primarily provides services for 405,000 people living in south-west Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point.

It provides an extensive range of acute healthcare services at Basildon and Orsett Hospitals, plus x-ray and blood testing facilities at the St Andrew's Centre in Billericay. It also provides dermatology services across the whole of south Essex.

Detailed findings

The Essex Cardiothoracic Centre (CTC) is also part of the trust, providing a full range of tertiary cardiothoracic services for the whole county and further afield.

With a budget of more than £288million, last year the trust treated 77,500 inpatients and day patients, provided nearly 300,000 outpatient appointments and attended to 103,000 patients in accident and emergency.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Critical care

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

Information about the service

The critical care service at Basildon and Thurrock University Hospitals NHS Trust has 14 beds, of which 11 are funded, to provide general intensive care. These are intensive therapy unit (ITU) and high dependency beds (HDU) beds which deliver care to patients of with serious life-threatening illness and for patients who are too ill to be cared for on a general ward. A critical care outreach team assists in the management of critically ill patients on wards across the hospital.

We inspected the intensive therapy unit in March 2015 as we were aware of a number of concerns around the leadership of the department and in particular the discussion of do not attempt cardio respiratory resuscitation decisions. We spoke with eight members of staff and two relatives and one patient. We did not review the cardiothoracic centre at this inspection.

Summary of findings

In 2015 we only inspected the general critical care and outreach services at Basildon Hospital. We inspected due to concerns raised to us by patients and their families.

We found that staffing in the outreach team was depleted at the time of our inspection, however the trust were aware of this and a review was being carried out. There was a lack of morbidity and mortality meetings occurring within the critical care unit to learn lessons to improve safe care.

We found that the effectiveness of the service required some improvement to ensure good outcomes for patients. The number of nurses with nationally recognised training was below the national benchmark at 29%. We found that DNACPR decisions were increasingly undertaken with patients or their nearest family although some further work was required to ensure that this was embedded and enacted for every patient.

The service required some improvement so that it was responsive to the needs of patients. We saw evidence of delayed admissions and discharges and significant numbers of discharges occurring overnight which is neither beneficial for patients nor responsive to their needs. We saw that two external reports had been undertaken, some actions had been taken and were yet to be embedded; other actions were still to be enacted.

Critical care

We saw that there was some inertia in making improvements to the service. A senior leadership development programme was underway by the trust through an external advisor. Whilst this work had begun in April 2014 the critical care team were in the early stages of developing a chronic obstructive pulmonary disease pathway as part of their leadership development. Whilst staff felt supported there was a lack of understanding of the vision for the service at the time of our inspection. We rated this aspect of the service as requiring improvement.

Are critical care services safe?

Requires improvement 

The service requires improvements to be made to ensure that patients are protected from the risk of avoidable harm. These include improvements in the availability of the outreach team to support and direct care for patients not in the unit but who require a higher level of care. Whilst the number of staff in this team was in line with the minimum staffing levels for the service as identified by the trust the team were reported to spend long periods of time with unwell patients depleting their advice and support of others. The unit did not currently undertake morbidity and mortality meetings which would review care provided and lead to improvements in the service.

Incidents

- No never events were reported in the unit in the previous 12 months.
- Staff were aware of incident reporting procedures and the lessons learnt from incidents were disseminated amongst the team through team meetings and bulletins.
- Mortality and Morbidity is a standing agenda item on the Two at the Top meetings however we reviewed five sets of minutes and could not see that a review of patients' mortality was documented. Critical care medical staff are invited to mortality meetings held by the specialities when a patient has a cardiac arrest within the critical care unit. Serious incidents are reported at this meeting and discussed with actions to be taken recorded.
- Staff were aware of their duty of candour responsibilities.
- Patients' relatives reported that they were informed about decisions made about their relatives. However we had two concerns raised with us that this had not been undertaken effectively within the previous months of the inspection. Staff recognised that this was an area for improvement and had plans in place to address this.

Safety thermometer

- We saw that information on the safety thermometer was available to staff and those visiting in the main corridor of the unit.

Critical care

- We saw that the unit was performing broadly in line with expectations in these areas. The unit had reported two pressure sores in the last month.

Cleanliness, infection control and hygiene

- The unit was visibly clean.
- Staff were compliant with the bare below elbows policy of the trust and hand gel was available and used by all staff entering and working in the unit.

Environment and equipment

- We saw that some equipment was stored in the unused bed spaces. We were aware that when phase two of the build is completed that staff will have space to store currently unused equipment in the department.
- The resuscitation equipment was checked daily; there was a record which stated the time and individual who had undertaken this check.

Medicines

- CCU had one medication incident in February 2015 and three medication incidents in March 2015. Staff were aware of these and had plans in place to address these.
- We examined the medicines management on the unit in respect of the care of two patients and found that the medicines had been administered safely.
- Medicines were stored correctly and securely throughout. All medicines, including intravenous fluids, were stored in locked clean utility areas and access was restricted.

Records

- Risk assessments were undertaken and provided individualised care. Patient records contained information of the review and management plans for individual patients.
- The six records of care examined were hand written and personalised the patient. However the care plans format was not all consistent.
- Notes were in a logical and easy to follow order so that the most recent information and treatment plan were readily available to staff working on the unit.
- In ICU paper records were still in use, entries in the notes were dated, timed and signed by staff. We reviewed six notes and found them to be completed.

Safeguarding

- Staff were aware of the issues around safeguarding.

- There is a trust wide safeguarding team which the staff on Critical Care areas refer any patients for discussion.
- Staff confirmed that they had received safeguarding awareness training and confirmed actions that would be undertaken to keep people safe. Staff were aware of their safeguarding responsibilities.

Mandatory training

- Mandatory training is reported via an excel spreadsheet to the department. We reviewed this and this showed that most staff had attended all mandatory training. The staff who had not attended were flagged within the system and the practice development nurse was aware of who needed to attend.
- 51 out of 52 staff had attended resuscitation training, 58 out of 65 staff had attended dementia training and all staff had attended intermediate life support training where identified that this was required.

Assessing and responding to patient risk

- Due to the nature of the provision of care patients who may have been deteriorating were responded to in a timely manner.
- Staff utilised an early warning system and escalated appropriately.
- The outreach team had been depleted in staff numbers since September 2014. There was only currently one outreach nurse available to support patients who were not in the critical care areas of the trust on shift during the day and at night. There had previously been two nurses on each shift. The trust were in the process of reviewing this service at the time of our inspection.
- We were informed of an incident, which had been reported on the Ulysses system, where the outreach staff member was required to provide care to an unwell patient who had deteriorated on the acute respiratory unit and required intensive care. Due to bed availability within intensive care the critical care nurse was required to stay and provide safe care to the patient for 10 hours until a bed became available. This meant that the outreach nurse was not available to staff for guidance or support during this time.
- Staff in other areas of the hospital valued their support and advice on patients; however they could spend long periods of time with one patient which meant that others were not seen in a timely manner.

Nursing staffing

Critical care

- The staffing on the unit is calculated on the number of beds available and the potential patient acuity. Agency and bank staff are used to cover any gaps in staffing. Similarly when the dependency of patients changes other staff with the suitable skills knowledge and experience are relocated to the critical care unit to assist to care for these patients. Bank and agency staff are used to cover any gaps in staffing these staff receive a good induction to the area.
- There was always a senior nurse identified as the lead for the critical care unit.
- There were sufficient number of staff to maintain the national guidance on staffing a critical care unit.
- Handovers occur at the bedside of the patient and the nurse in charge also hands over to the incoming nurse in charge at the nurses station.
- The unit displays the number of registered staff and unregistered staff on duty for the day in the main area of the unit. During our inspection we saw that this matched the staff available on the unit.
- In 2014 the hospital had a critical care outreach team which included nine nurses (not all full time) and they currently had one vacancy. However in 2015 we found that this team had been depleted and there was only sufficient staff to have one nurse on per shift. We found that whilst there were plans to have a complement of 10 nurses that two staff were on maternity leave and two had left the service. This meant that the service was now supported by six nurses. Occasionally at night there was no outreach cover and support was provided by the site nurse and medical staff. The trust had recently completed a review of the critical care outreach team and a number of recommendations had been made as a result of this review. From 1 April 2015 the service was established to a level providing increased cover during the day.

Medical staffing

- Historically the unit has been led by anaesthetists with support from primary physicians. This led to any consultant admitting to the unit and maintaining decision making about the patient. In November 2014 the East of England Critical Care Operational Delivery Network reported that there were “inadequate medical resources within the unit and the structures of these resources appeared to be secondary to the needs of the anaesthetic department rather than focused on the needs of critical care.” The trust state that since October

2014 the critical care unit has moved to a new consultant rota where the same consultant stays in the unit from 8am to 8pm to provide consistency and continuity. There are arrangements for the consultant on call to be contacted via telephone or bleep immediately.

- The trust has adopted the closed unit approach where only those in charge of the critical care area could admit to the unit. The trust has five appointed intensivists but outstanding vacancies in this area providing challenges to the fully intensivist led service.
- The unit currently works openly with the patient being cared for predominantly by the anaesthetic team with support from the intensivists. The primary physician either medical or surgical also maintained input into the care of the patient. The trust informed us that they plan to change the unit to an entirely intensivist led unit.
- Junior doctors are rostered to cover the unit on an ad-hoc basis and are available to nursing staff within the unit.

Major incident awareness and training

- The trust had a major incident plan in place. Staff confirmed verbally that they were aware of the major incident plan and were able to find the information quickly. The policy was available on the intranet.

Are critical care services effective?

Requires improvement 

We found that the effectiveness of the service required improvement as appropriate care bundles were not always in place or utilised. Compliance with care bundles is monitored monthly however further compliance in respect of antimicrobial care bundle is required to improve the service received by patients. The number of staff having undertaken appropriate accredited training in critical care nursing was not in line with national guidance. However the trust had mitigated this to some degree by putting in place a competency framework for nursing staff. We found that the communication between medical staff required improvement to ensure the best outcome for the patient. We found that DNACPR decisions were increasingly undertaken with patients or their nearest family although some further work was required to ensure that this was embedded and enacted for every patient.

Critical care

Evidence-based care and treatment

- The unit reported through the ICNARC process and stated that they reviewed the outcomes of these measurements to improve services for patients.
- The East of England Critical Care Operational Delivery Network stated in their report that care bundles were in place for ventilated patients and in relation to “saving lives.” The trust has a number of care bundles in place under the saving lives programme including; hand hygiene, central line and peripheral catheter insertion and ongoing care, urinary catheter care, reducing the risk of C difficile and cleaning and decontamination. However during our inspection we found only one care bundle in place in relation to ventilated patients in respect of ventilation acquired pneumonia.
- Sepsis bundles were not being completed appropriately on patients for the risk or management or early signs of sepsis. Audits received from the trust show that in respect of the antimicrobial care bundle the unit was only achieving 20% of all elements completed in February and March 2015.

Nutrition and hydration

- Patients who were unable to eat or drink received nasogastric feeding within 24 hours of their admission to ICU and HDU.
- The assessment, implementation and management of appropriate nutrition support for patients was led by the Consultant in collaboration with the MDT. Dietetic advice was sought when required.

Pain relief

- Patients’ pain was scored as part of the early warning system in place, which is not standard practice.
- Patients who had epidural for post-operative pain relief were nursed on the critical care unit despite there being a trust wide pain service. The Trust pain service is available 9-5 Monday to Friday. Out of Hours, pain management is via the on-call anaesthetic teams.

Patient outcomes

- The standardised mortality for the unit was on average slightly higher than the expected rate of 1.0 but within the 95% confidence interval. In Q4 in 2014 the mortality ratio was 1.09 which had decreased from 1.21 in Q4 in 2013. There has been a year on year improvement in the figures on mortality.

- Readmission rates were above the Clinical Reference Group indicator suggesting that more patients are readmitted to the critical care areas in this trust than in others in England. This trust rates as the highest for readmissions within 48 hours in England.

Competent staff

- 29% of staff had received training in critical care however the national guidelines for critical care set the minimum number of trained nurses to be 50%. The trust had mitigated this risk by introducing a competency framework for nursing staff. Staff had competency packs which were signed off within a given timeframe. Where these were not achieved remedial action was taken with these staff.
- There was an appropriate supervision and appraisal system in place and staff felt supported.
- All medical staff had achieved revalidation.

Multidisciplinary working

- Decision making and communication between doctors involved in the patients care was at times contradictory. This led to nursing staff having numerous conversations in order to plan patients nursing care alongside medical orders.
- Staff we spoke with told us allied healthcare professionals supported patients’ recovery because there was access to physiotherapy, speech and language therapists and dietetic services. We observed them on the unit attending patients’ needs during the inspection.
- We saw that other allied health care professionals, such as physiotherapists, were involved in the review of patients and that they were available on the unit to provide support to patients.
- The outreach team ideally saw patients discharged from the unit within 24 hours although this had become increasingly difficult in the recent months due to the shortage of outreach nurses on shift.

Seven-day services

- Services aligned to the critical unit were available seven days a week.
- Critical care outreach services were available seven days per week.

Consent and Mental Capacity Act

Critical care

- The staff, whilst acknowledging that the trust wide mental capacity act forms for assessing a patients mental capacity was in place, stated that they do not currently use these forms. The trust policy states that when undertaking a formal assessment under the Mental Capacity Act the trust uses the Southend, Essex and Thurrock capacity Assessment form.
- Prior to this inspection we received concerns about the completion of do not attempt cardio pulmonary resuscitation orders (DNACPR) on the unit where families and patients had not been involved in decisions regarding end of life care.
- We reviewed 2 DNACPR forms on the unit and found that one form was not fully completed having the section on discussion with the patient not completed. Therefore we could not be assured that this discussion had taken place.

Are critical care services caring?

Good



Patients and relatives stated that the care they received on the unit was good and that they were involved in decision making. We found that the patients' dignity was respected through use of curtains and through active interventions to ensure that patients remained covered. Support was available as required by patients and their relatives.

Compassionate care

- We saw that the critical care areas were clean and well organised and that patients looked comfortable.
- Relatives of people who were being cared for on the units told us that the staff were very professional and nothing was too much trouble.
- Staff respected patients' privacy and dignity. For example, we saw staff pulling curtains around patients' beds while caring for their needs. This demonstrated that staff acted appropriately to maintain patient's privacy.
- Most patients were aware of their care and treatment and described their clinical care as very good or excellent.
- We found that staff were caring and compassionate on the critical care units and we saw staff providing care in a sensitive and dignified manner.

Understanding and involvement of patients and those close to them

- The nature of the care provided in a critical care unit meant that patients cannot always be involved in decisions about their care. However, whenever possible the views and preferences of patients were taken into account.
- Patients and relatives attending the unit felt that they were kept informed of decisions being made around their care needs. However we were aware that there had been some cases in recent months where this had not been the case. We spoke with staff about this and they were able to describe improvements that had been made to support patients and their relatives.

Emotional support

- People we spoke with about the care on the critical care unit told us they were kept informed by staff and were told about any changes in their relative's condition.
- There was a chaplaincy service available for patients and relatives requiring this support.

Are critical care services responsive?

Requires improvement



The service was not as responsive to the needs of patients. The trust had the worst out of hours discharge of patients from the critical care unit. People frequently were not able to access services in a timely way for treatment. Patients were kept waiting on the ward above four hours for admission to the unit as there was limited capacity. We saw that two external reports had been undertaken. Some actions had been taken such as the review of readmissions and the adoption of the closed unit but many were yet to be enacted or embedded. Patient and relative feedback was generally positive, however we heard from two complainants who felt that they were not taken seriously. The staff escalated these complaints and the trust senior team has offered to work with one of these complainants to improve services.

Service planning and delivery to meet the needs of local people

- The Critical Care Operational Delivery Network for the East of England undertook a peer review visit in

Critical care

November 2014. They reported that the occupancy and expectation of need suggested that there was an inadequate supply of these facilities at the hospital. This was corroborated through our inspection with data showing that patients were waiting over four hours to be transferred to the unit. In addition we saw evidence that there were 31 delays in discharge in February 2015 from the unit, which were equivalent to 46 extra days spent in the ITU.

- The unit was moved to a new location in April 2013. Although demand and capacity was increasing the bed numbers commissioned in the unit were not increased. The unit has 14 beds of which 11 were funded. This low number impacted the wards in terms of transfers into and out of the unit and also required a higher level dependency care for patients on wards where intensive care is required.
- We spoke with the chief executive, medical director and deputy director of governance who informed us that they had planned to review the capacity and flow within the service. The trust had commissioned a task and finish group reviewing all hospital transfers out of hours. This reviewed the number of hospital patients transferred out of hours and suggested ways in which improvements could be made. Whilst impacting on the availability of beds within the hospital for discharge of critical care patients this report was not specific to the critical care unit.

Meeting people's individual needs

- Patient's individual needs were met and where extra support was required staff on the unit were able to access nurse specialists in learning disabilities, safeguarding and dementia care.
- We were provided with examples of cultural based care on the unit where staff shared their knowledge of beliefs or conditions to support patient care.

Access and flow

- There were significantly high numbers of patient transfers to wards overnight. In February 2015 there were 11 patients transferred out of the unit between 10pm and 7am. The ICNARC report shows that this is a longer term issue. This means that whilst these patients are no longer deemed to be in need of critical care services they are being transferred to ward areas at a time when medical and nursing staff are not as plentiful as in daylight hours.

- Delayed discharges were high which reflected that bed flow management within the trust was under strain. This was confirmed by staff locally who said that patients' discharge out of the unit was often delayed due to waiting for an available bed on the wards.
- There were significantly more discharges to ward areas out of hours than at other hospitals (30%), the national average is approximately 8%.
- Staff attended bed management meetings to make sure patients were placed in the right area for their clinical needs. It also responded by reviewing patients who staff were concerned about on other wards. In 2015 we were not assured that systems were in place so staff could respond appropriately to patients' needs, particularly for patients whose condition was deteriorating in a timely manner.

Learning from complaints and concerns

- There was evidence of some complaints where staff on the unit did not engage with patients and relatives as early as they might.
- There was a system in place to disseminate the learning from complaints and concerns which occurred through team meetings and bulletins.
- Action plans were in place but further work was required to ensure that complaints added to improvements within the unit.

Are critical care services well-led?

Requires improvement 

Improvements are required to ensure that information flows in a timely manner to staff working within the critical care unit. There were governance structures in place to review some aspects of performance of the critical care unit, however these were not well attended by staff working on the unit. Minutes were available for all staff to read to ensure that they were informed of the issues and actions taken at this meeting however we found that many staff were unclear of the governance arrangements within the unit. A number of initiatives to improve the service were about to commence following our inspection such as the Critical Care Delivery Group however these were yet to be embedded.

Vision and strategy for this service

Critical care

- Staff we spoke with understood the trust vision.
- The strategy for the critical care unit was taken to the Senior Management Group meeting on 18 March 2015. There was limited evidence that this strategy was known amongst the staff of the critical care unit.

Governance, risk management and quality measurement

- Risks to the service were discussed at the “Two at the top” meetings. The top three risks were identified as being the delay in admissions, discharges and transfers.
- Local audits such as number of falls, pressure ulcers, infections, medicines, complaints and patient involvement are being undertaken.
- There were local team meetings though we were informed that these were not carried out recently due to staff shortages on the unit. Staff could attend or read the minutes of the Two at the Top meetings which outline the performance and learning points for the unit. Attendance of staff at the Two at the Top meetings by staff on the unit was at times poor and the trust were reviewing actions to improve attendance by staff at this meeting.
- The trust had recently had two external reviews. The East of England Critical Care Operational Delivery Network undertook a review in November 2014 and found a number of areas lacking including: occupancy and expectations of the unit in relation to the general public and demand. The policy of admission to the unit, inadequacy of medical staff within the unit and general rostering of medical staff to cover the unit, and the lack of nursing staff trained in critical care. The trust has an action plan based on the recommendations and action was currently underway. However some of the actions will not be in place until August 2016 due to recruitment and financial issues.
- The Clinical Commissioning Group undertook a quality review in January 2015 which found that there were no concerns about the care of patients on the critical care unit. However it reiterated the earlier report that medical staffing was an area that required improvement. It also raised questions as to the ownership of the patient whilst in the unit in respect of decisions made about the patient. The CCG also raised issues with capacity.

Leadership of service

- There had been no changes to the senior team since our previous inspection in 2014. However turnover within the critical care unit in March 2015 was 19%. This increased the need for senior staff to support junior staff. The nurse consultant and the practice development nurse had introduced a competency based framework to ensure that staff meet the standards required for delivery of care in this specialised area.
- Staff within the unit were a cohesive team and found support from their leaders and each other.
- Medical leadership currently undergoing a planned change. It was found through a recent external review that the level of cover did not allow for sufficient time to plan the leadership of the service.

Culture within the service

- There was a culture which encouraged staff to do the best for their patients and staff felt supported to raise concerns. However some staff felt that the trust had not responded in a timely manner to concerns being raised regarding the critical care outreach team. The trust provided evidence that they were aware of the coming shortfalls in staffing and had plans in place to address these shortly after our inspection.

Public and staff engagement

- Nursing staff held meetings at which issues were raised and staff were encouraged to comment on issues within the unit.
- The patient experience group undertake ad hoc walk around to obtain feedback from patients and relatives using the unit.
- Following a complaint, the trust had asked the complainant to assist the trust with service development.

Innovation, improvement and sustainability

- We found that there was learning occurring from incidents reported including recent issues with DNACPR but that these were yet to be embedded. We found that improvements and innovation were at times slow to enact. However the formation of the Critical Care Delivery Group which had its inaugural meeting following our inspection may ensure that issues are addressed in a timely manner.
- In April 2014 the trust secured the services of Professor Richard Bohmer to lead a senior clinical leadership

Critical care

programme. The leadership team in critical care supporting the development of a Chronic Obstructive Pulmonary Disease pathway as part of their leadership development.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- Assess, monitor and take action to improve the quality and safety of services provided within the critical care unit. The trust must take note of reports about the care and provision of services to ensure that services are safe, effective and responsive to the needs of patients.

Action the hospital **SHOULD** take to improve

- Continue to work and improve on the skill mix and staffing levels throughout the hospital particularly in the critical care service.
- Review staffing and management structures for the critical care outreach service to ensure that an appropriate number of outreach staff are on duty for each shift.