

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: 9 and 10 February 2017

Date of publication: 18/05/2017

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

Urgent and emergency services	Good 
Medical care (including older people's care)	Requires improvement 
Surgery	Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

Southend University Hospital NHS FT is part of the Essex 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.

We undertook a short announced focused inspection at Southend Hospital on 9 and 10 February 2017 in response to concerns raised to CQC. We found that the trust is under significant capacity pressures and all the risks we saw were known to the senior management team. Actions were in place to deal with most of these issues. We have not rated this inspection in line with our current guidance. However, we will return to Southend Hospital to review actions taken in line with the current improvement plan and the issues raised within the report.

We found:

- There were shortages of medical and nursing staff but that the trust was managing the risks associated with these shortages. However, continued focus needs to be kept on ensuring that the service has sufficient staff to ensure patient safety.
- Mandatory and safeguarding training was not always undertaken in line with the trusts target.
- Staff had a good understanding of incident reporting procedures and received feedback on incidents reported.
- Staff worked together to meet patients' individual needs. Staff gave us examples of coordinating care to meet the needs of patients with learning disabilities and told us about actions they took to improve the experience of patients living with dementia.
- Leaders were visible and approachable. There were opportunities for leaders to engage with staff at ward level and listen to their concerns.
- Some wards reported issues with outliers being seen by the correct team. I am aware that there is a buddying system being discussed and this will assist this issue.
- There were no named pharmacists for surgery. Reconciliation of medicines was not done in a timely manner. An example was found that in February only 10% of admissions had had their medication reconciled within 24 hours.
- The stroke unit staff were unclear if they still operated as a HASU. They told inspectors that they did at times. Senior staff told us that there was no HASU.
- At times in the stroke ward nurse to patient ratios was 13:1 and in Benfleet the ratio was 3 to 4: 25 patients.
- There was conflicting information about the BAMS unit medical staffing. We were told by staff that they had put forward a plan for changes but that these had been dismissed. However the medical director appeared unaware of this plan during his interview.
- There are challenges within the consultant body which impact upon the patient experience and capacity of the hospital. There was little evidence of a plan in place to address these. However impacts were seen through the lack of specialist nurse and capacity issues within outpatients.
- There were concerns around the extension to SAU which was behind doors so sight of these patients was limited. We also found that there were approximately 12 patients to one toilet in this area.
- There was a disconnect between the senior management team and the workforce and a lack of appetite to change. Staff felt that they were not always supported to change and that change took a long time.
- There were several established systems to ensure good clinical governance and monitor performance, clinical governance, mortality, and morbidity and infection control.
- Patient record keeping was of a very good standard, allergies, national early warning scores (NEWS) and paediatric early warning scores (PEWS) were all clearly documented within the Emergency Department.

We saw several areas of outstanding practice including:

- There was a stroke emergency phone, which provided direct contact between the emergency department and the stroke ward.

Summary of findings

- Surgeons are undertaking innovative surgery for stroke patients during which they remove the blood clot to ease pressure on the brain. This reduces the symptoms that stroke patients' experience.
- Ambulatory wound unit on Balmoral ward taking referrals from community, podiatry, GP's as well as wound care for discharged patients. Focused on early intervention and admission avoidance.
- The musculoskeletal team had created a Trauma Assessment Centre (TAC) within the ED as an extension of the fracture clinic, where patients were streamed directly to be seen for treatment.

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

Importantly, the trust should:

- The hospital should ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced consultant medical staff to meet the needs of patients in the medical service.
- The hospital should ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced junior medical staff available on BAMS to meet the needs of patients.
- The hospital should ensure there are sufficient numbers of suitably qualified competent, skilled and experienced nursing staff available in the medical and surgical services to meet the needs of patients.
- The hospital should ensure that there are processes in place to make sure that medical outliers are reviewed by their speciality team in a timely way.
- The hospital should ensure that staff complete mandatory and safeguarding adults and children training in line with trust targets.
- The hospital should ensure staff are trained in the recognition and management of sepsis to the appropriate level in line with trust targets.
- The hospital should ensure all fridge temperatures for the storage of medication are recorded and acted upon in line with trust guidance.
- The hospital should ensure that male and female patients are not accommodated in the same bay on the stroke unit.

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?

We found:

- The emergency department (ED) staff raised concerns about the ability to lock down the major trauma and resus areas efficiently in an emergency. The security of the department was on the ED risk register.
- There was no controlled access on any of the adult ED areas. This meant the department was not safe from a security or major incident perspective, as anyone could enter the department at any time. We noted on several occasions patients and visitors entering the department who were lost or looking for other departments.
- At the time of our inspection, data supplied by the trust showed staff achieved 80% compliance with safeguarding adults' level one training and 73% with level two. Staff achieved 92% compliance with child safeguarding level one, 88% compliance with level two, and 75% compliance with level three.
- At the time of our inspection, data supplied by the trust showed overall staff compliance with mandatory training was 77% and 84% with local induction.
- Blunt abdominal trauma (BAT) is a common reason for patients attending ED. Focused assessment with sonography for trauma (FAST), is a valuable diagnostic that can often facilitate a timely diagnosis for patients with BAT. FAST was not always available in the ED. This issue was on the ED risk register due to concerns regarding the ability to diagnose life-threatening conditions quickly.
- Between February 2016 and January 2017, the trust declared 2,418 black breaches. These were most prevalent between September 2016 and December 2016, ranging between 248 and 349 per month respectively. Black breaches are occasions where handovers from ambulance arrival to offloading the patient to the ED took longer than 60 minutes.

Summary of findings

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the ED. Data supplied by the trust showed that in November 2016, the trust achieved 77%. The trust achieved 73.1% in December 2016, and 81.4% in January 2017, all below the 95% target. However, during our inspection we observed the trust achieving 100% on the 10 February 2017, 98.4% on the 9 February 2017, and a reported 93.1% on 8 February 2017.
- Data supplied by the trust showed the percentage of patients waiting between four, and 12 hours from the decision to admit, until being admitted was 1.7% in November 2016, 1.5% in December 2016, and 0.8% in January 2017. This was lower than the England average, which ranged between 12% and 9% for the same period and showed an improvement in performance by the trust over the three-month period.
- Staff raised concerns regarding access to mental health services for children entering the department. Staff gave examples of children waiting for extended periods for assessment and support, often overnight, due to the restricted access to specialist mental health support.
- Staff we spoke with said that the senior management team lacked visibility in the department, even during exceptionally busy periods or significant times of need.
- Since our last inspection, issues remained regarding collaboration with other specialities within the hospital.

However:

- Staff knew how to report incidents and deal with complaints and there was a learning culture within the ED.
- Since our last inspection, the trust had installed a controlled access system in the paediatrics area to restrict any unauthorised access to clinical areas.
- We found that overall medicines were stored securely. Controlled Drugs were stored following safe and good guidance procedures.

Summary of findings

- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- We reviewed 18 patient records and found all risk assessments were completed, allergies, national early warning scores (NEWS) and paediatric early warning scores (PEWS) were all clearly documented.
- At the time of our inspection, we found no significant concerns regarding staffing the ED, the trust took appropriate action to cover any shortfalls and recruitment was proactive and ongoing to fill any unfilled posts.
- There were several established systems to ensure good clinical governance and monitor performance, clinical governance, mortality, and morbidity and infection control.
- The ED had a specific risk register for its service. Senior staff monitor the risks identified, and take appropriate action to mitigate any impact on patients and staff.
- The ED had a clear management structure and there was good leadership.
- Staff spoke very highly of the leadership and management provided by the clinical lead, associate director, and matrons and said they were approachable, and listened to their concerns.

Medical care (including older people's care)

Requires improvement



We found:

- There were shortages in permanent consultant staffing, particularly on Bedwell Acute Medical Service (BAMS) and in the department of medicine for the elderly (DME). Data provided by the trust showed the actual number of consultants in these specialities was consistently below the planned number from December 2016 to February 2017. The trust provided information showing that vacant posts were covered by agency doctors, however medical staff told us that agency cover was not consistently available and we saw gaps in the BAMS consultant staffing rota.

Summary of findings

- Thirteen out of the 28 staff we spoke to expressed concerns about timely consultant review and discharge of patients due to staffing shortages.
- There was a shortage of junior doctor staffing on BAMS. At the time of our inspection the planned number of junior doctors for BAMS was four and the actual number of junior doctors was two.
- Five out of nine medical staff we spoke to expressed concerns around the organisation and management of the junior doctor rota. They described it as 'poorly organised' and 'too complex'. Staff told us there could be gaps in daytime medical staffing due to the organisation of on-call duties for medical staff.
- There were shortages in nursing staffing across the medicine service due to unfilled vacancies. The whole time equivalent (WTE) establishment for registered nursing staff in the medical service in January 2017 was 374.5 and the number of nursing staff in post was 298.9. There were 75.6 WTE vacancies.
- We saw that the ratio of nurses to patients on Paglesham ward was 1:13. This was not in line with the Royal College of Nursing recommendations of one nurse providing care for no more than eight patients.
- Staff compliance with mandatory training was variable. On BAMS, staff compliance with mandatory training was 68%, which was lower than the trust target of 85%.
- Staff compliance with safeguarding training was variable. Compliance with adult safeguarding training level one and two was below the trust target on BAMS. Compliance with child safeguarding training level one and two was below the trust target in three clinical areas we visited.
- Staff compliance with sepsis training was highly variable. Training records dated 2 November 2016 showed compliance with sepsis training ranged from 26% on BAMS to 92% on the respiratory unit.
- The process for in-reach to BAMS from speciality medical teams was inconsistent. Two members of staff on BAMS told us that some medical speciality teams found in-reach difficult due to staffing and workload.

Summary of findings

- There was a high number of medical outliers. From November 2016 to January 2017, the number of outliers on medical wards ranged from 117 to 203 per month. The number of medical outliers on surgical wards ranged from 171 to 429 per month in this period. There was concern about the medical review of medical patients on other non-medical wards. Records showed that not all received a daily medical review. Staff also expressed concerns about this and stated that they felt that there was a shortage of medical consultants.
- There was a high number of bed moves after 10pm for patients in the medical service. From August 2016 to January 2017, data showed that there was an average of 352 bed moves after 10pm, per month.
- Two senior staff on Benfleet ward told us that one bay on the ward was used as a hyper acute stroke unit (HASU) and that this bay would often have male and female patients accommodated together. However, this bay was not categorised as a HASU by the trust and should not have accommodated male and female patients in the same bay. On the days of our inspection, this bay was not used as a mixed sex bay.
- Staff identified difficulties in communication between different speciality teams. One junior doctor told us about difficulties in communication between medical teams in the emergency department and BAMS. Two consultants told us there could be “friction” between different specialities and spoke of a “silo culture” which could cause difficulties when agreeing where junior doctors spent their time.

However:

- All staff had a good understanding of incident reporting procedures and received feedback on incidents reported.
- Senior managers completed detailed investigations into serious incidents and shared this learning with staff throughout the medical service.
- Clinical areas were visibly clean. Staff were compliant with bare below the elbows practices

Summary of findings

and we saw staff completing hand hygiene appropriately. Results of a trust audit of personal protective equipment dated January 2017, showed positive results.

- Staff stored medicines securely and completed twice daily checks of controlled drugs (CDs) to ensure that all stock was monitored and accounted for.
- Patient records were stored securely in lockable trolleys in staff areas.
- Staff understood their responsibilities regarding safeguarding adults and children. We asked six members of staff about safeguarding and all of them were able to tell us how they would report a safeguarding concern and what they would report.
- There was a stroke emergency phone, which provided direct contact between the emergency department and the stroke ward. This meant that the stroke consultant could be immediately alerted to any patient presenting with signs of a stroke in the emergency department. The ward manager on Benfleet ward told us the early review and transfer of patients admitted with signs of stroke worked well.
- The average referral to treatment time for admitted patients in the medical service from January 2016 to January 2017 was 98%.
- Staff worked together to meet patients' individual needs. Staff gave us examples of coordinating care to meet the needs of patients with learning disabilities and told us about actions they took to improve the experience of patients living with dementia.
- There were clear processes for sharing information with staff in the medical service. Senior staff shared information with staff through team meetings, information noticeboards and through the trust 'weekly roundup' newsletter.
- There was a positive culture within speciality teams on medical wards. Nursing staff described positive working relations with medical staff in their speciality. Junior doctors described consultants as supportive and approachable.

Summary of findings

Surgery

Good



We found:

- Nursing teams were regularly short staffed. Data provided by the hospital showed that planned versus actual staffing had dropped from 100% across the service in November 2016. We saw that in January 2017 Chalkwell surgical assessment unit (SAU) had 93.4% of their staff number of registered nurses at night and Shopland ward had 80.6% of registered nurses during the day shift. Shortfalls were covered by bank and agency staff where possible. Staff would also be allocated from other wards. Three senior nurses told us that this impacted the skill mix on the wards and that on occasion shifts would not be covered.
- Three surgical wards we visited did not have a ward based pharmacist which meant that patient medicines were not reviewed by a qualified pharmacist. This meant that there was no oversight of medications management and could lead to medication errors.
- There were a large number of medical outlier patients on surgical wards. In January 2017 there were 429 medical outliers across the surgical wards. Four nurses told us that patients were reviewed late in the day and a member of the surgical ward staff was not always present meaning that updates on the patient's treatment were not communicated effectively.
- During the period October to December 2016, 146 operations were cancelled of which 24 patients were not offered another appointment with 28 days.

However:

- Staff had a good understanding of incident reporting procedures and received feedback on incidents reported.
- Senior managers had completed detailed investigations into the recent never events and shared this learning with staff through team meetings, noticeboards and the 'weekly roundup' newsletter.
- Theatre had established five extra Saturday all day theatre lists to help manage waiting lists. These lists were flexible and could be utilised by each speciality. The emergency service

Summary of findings

ambulatory care service had been established on Chalkwell ward to support the surgical assessment unit to help prevent unnecessary admissions.

- Leaders were visible and approachable. There were opportunities for leaders to engage with staff at ward level and listen to their concerns.
 - Staff described positive working relations within their speciality teams and across the hospital as a whole.
 - Junior doctors were positive about the support they received from consultants.
 - Consultants we spoke with confirmed a positive culture of interdisciplinary working. There was regular internal multi- disciplinary team working with all teams supportive to provide the best outcome for their patients.
-

Southend University Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Southend University Hospital	13
Our inspection team	13
How we carried out this inspection	13
Facts and data about Southend University Hospital	14
Findings by main service	15

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.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: A&E Doctor, Consultant Surgeon and a consultant medical physician.

How we carried out this inspection

We undertook a short notice announced inspection on 9 and 10 February 2017. We inspected the core services where we had identified concerns. We spoke with other stakeholders in preparation for this inspection.

Detailed findings

Facts and data about Southend University Hospital

Staff:

3,714 staff – including:

- 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

- 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.

Urgent and emergency services

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

Information about the service

We conducted an announced inspection of the emergency department (ED) at Southend University Hospital NHS Foundation Trust on the 9 and 10 February 2017, due to concerns regarding the safety, responsiveness, and leadership of the service.

Between January 2016 and January 2017, the adult ED saw 85,441 patients and the paediatric ED saw 23,455 patients. During 2015/16, 26.7% of attendances resulted in admission.

The ED has continued to experience exceptional demand on its services during the last twelve months. Patients arrived at the ED by ambulance to the major trauma unit or by attending the main urgent and emergency services reception area.

The major trauma area is open 24 hours per day, seven days a week. The hospital provided triage and general practitioner (GP) services in partnership with a local GP service. The service was available from 8am to 12pm seven days a week and located in the main urgent and emergency services reception area.

The paediatric ED is open seven days a week between the hours of 8am to 9pm. Since our last inspection, the trust has installed a controlled access system in the paediatrics area to restrict any unauthorised access to clinical areas.

The ED consists of an adult major trauma unit with 16 cubicles, an adult minor trauma unit with nine cubicles, and a paediatric unit with four cubicles. A resuscitation unit with three adult bays, one paediatric bay, and a flexible bay sits alongside the major trauma area.

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.

The ED also has a mental health suite staffed by a specialist team from South Essex Partnership University NHS Foundation Trust (SEPT) working in partnership with the Southend ED.

A clinical director with dual training in adults and children's emergency care leads the ED. At the time of our inspection, this post was overseeing medicine, urgent and emergency care on an interim basis. The leadership team comprised of the clinical director, associate director, matrons, and general manager to 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.

During our inspection, we spoke with the ED clinical director, assistant director, operations manager, two matrons, a navigation nurse, eight nurses, and the infection control lead. We also spoke with three

Urgent and emergency services

emergency department assistants, two health care assistants, the GP team, four receptionists, and two administrators. As well as two domestic staff, the mental health team, three doctors, and two junior doctors.

We spoke with ten adult patients, two child patients, and ten relatives of patients. We reviewed information from comment cards, looked at 18 patient records and ten patient medication records. We reviewed performance data and additional items of evidence that were available in the department, for example the ED dashboard, notice boards, minutes of meetings and staff training data.

Summary of findings

We found:

- The emergency department (ED) staff raised concerns about the ability to lock down the major trauma and resus areas efficiently in an emergency. The security of the department was on the ED risk register.
- There was no controlled access on any of the adult ED areas. This meant the department was not safe from a security or major incident perspective, as anyone could enter the department at any time. We noted on several occasions patients and visitors entering the department who were lost or looking for other departments.
- At the time of our inspection, data supplied by the trust showed staff achieved 80% compliance with safeguarding adults' level one training and 73% with level two. Staff achieved 92% compliance with child safeguarding level one, 88% compliance with level two, and 75% compliance with level three.
- At the time of our inspection, data supplied by the trust showed overall staff compliance with mandatory training was 77% and 84% with local induction.
- Blunt abdominal trauma (BAT) is a common reason for patients attending ED. Focused assessment with sonography for trauma (FAST), is a valuable diagnostic that can often facilitate a timely diagnosis for patients with BAT. FAST was not always available in the ED. This issue was on the ED risk register due to concerns regarding the ability to diagnose life-threatening conditions quickly.
- Between February 2016 and January 2017, the trust declared 2,418 black breaches. These were most prevalent between September 2016 and December 2016, ranging between 248 and 349 per month respectively. Black breaches are occasions where handovers from ambulance arrival to offloading the patient to the ED took longer than 60 minutes.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four

Urgent and emergency services

hours of arrival in the ED. Data supplied by the trust showed that in November 2016, the trust achieved 77%. The trust achieved 73.1% in December 2016, and 81.4% in January 2017, all below the 95% target. However, during our inspection we observed the trust achieving 100% on the 10 February 2017, 98.4% on the 9 February 2017, and a reported 93.1% on 8 February 2017.

- Data supplied by the trust showed the percentage of patients waiting between four, and 12 hours from the decision to admit, until being admitted was 1.7% in November 2016, 1.5% in December 2016, and 0.8% in January 2017. This was lower than the England average, which ranged between 12% and 9% for the same period and showed an improvement in performance by the trust over the three-month period.
- Staff raised concerns regarding access to mental health services for children entering the department. Staff gave examples of children waiting for extended periods for assessment and support, often overnight, due to the restricted access to specialist mental health support.
- Staff we spoke with said that the senior management team lacked visibility in the department, even during exceptionally busy periods or significant times of need.
- Since our last inspection, issues remained regarding collaboration with other specialities within the hospital.

However:

- Staff knew how to report incidents and deal with complaints and there was a learning culture within the ED.
- Since our last inspection, the trust had installed a controlled access system in the paediatrics area to restrict any unauthorised access to clinical areas.
- We found that overall medicines were stored securely. Controlled Drugs were stored following safe and good guidance procedures.

- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- We reviewed 18 patient records and found all risk assessments were completed, allergies, national early warning scores (NEWS) and paediatric early warning scores (PEWS) were all clearly documented.
- At the time of our inspection, we found no significant concerns regarding staffing the ED, the trust took appropriate action to cover any shortfalls and recruitment was proactive and ongoing to fill any unfilled posts.
- There were several established systems to ensure good clinical governance and monitor performance, clinical governance, mortality, and morbidity and infection control.
- The ED had a specific risk register for its service. Senior staff monitor the risks identified, and take appropriate action to mitigate any impact on patients and staff.
- The ED had a clear management structure and there was good leadership.
- Staff spoke very highly of the leadership and management provided by the clinical lead, associate director, and matrons and said they were approachable, and listened to their concerns.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



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

- The emergency department (ED) staff raised concerns about the ability to lock down the major trauma and resus areas efficiently in an emergency. The security of the department was on the ED risk register.
- There was no controlled access on any of the adult ED areas. This meant the department was not safe from a security or major incident perspective, as anyone could enter the department at any time. We noted on several occasions patients and visitors entering the department who were lost or looking for other departments.
- The ED major trauma area carried out a controlled drugs audit on 20 January 2017, achieving 82% compliance. An action plan was in place to address issues, for example the use of blue pen in records, missing signatures and incomplete transactions due to quantities not recorded correctly.
- At the time of our inspection, data supplied by the trust showed overall staff compliance with mandatory training was 77% and 84% with local induction. For example, staff achieved 80% compliance with safeguarding adults' level one training and 73% with level two. Staff achieved 88% compliance with child safeguarding level two, and 75% compliance with level three.
- Blunt abdominal trauma (BAT) is a common reason for presentation to the ED. Focused assessment with sonography for trauma (FAST), is a valuable diagnostic that can often facilitate a timely diagnosis for patients with BAT. FAST was not always available in the ED. Staff raised this and it was on the ED risk register due to concerns regarding the ability to quickly diagnose life-threatening conditions.
- Not all staff were trained in the use of non-invasive ventilation (NIV), however, we were told that there was a departmental policy for NIV. This meant that if a patient with chronic obstructive pulmonary disease (COPD) arrived at the ED requiring NIV, they could not always access this immediately. Instead, the department would call for a NIV trained nurse from the respiratory department to attend the ED or the patient transferred

to a respiratory ward to receive NIV. Patients may therefore, be delayed in receiving NIV as they wait for a nurse to attend the ED or wait for a transfer to the respiratory ward. This could also contribute to patient flow issues through the department and bed blocking on the respiratory ward.

- Between February 2016 and January 2017, the trust declared 2,418 black breaches. These were most prevalent between September 2016 and December 2016, ranging between 248 and 349 per month respectively. Black breaches are occasions where handovers from ambulance arrival to offloading the patient to the ED took longer than 60 minutes.

However:

- Staff knew how to report incidents and deal with complaints and there was a learning culture within the ED.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- The cleaning audit for the ED in January 2017 showed the major and minor trauma areas 98.88% compliant with cleaning activities. The main urgent and emergency care waiting area achieved 100% compliance, all above the trust target of 95%.
- Since our last inspection, the trust has installed a controlled access system in the paediatrics area to restrict any unauthorised access to clinical areas.
- We found that overall medicines were stored securely. Controlled Drugs were stored following safe and good guidance procedures.
- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- The department had a full time practice development nurse responsible for leading and developing training to support staff skills, knowledge, and competencies.
- At the time of our inspection, we found no significant concerns regarding staffing the ED, the trust took appropriate action to cover any shortfalls and recruitment was proactive and ongoing to fill any unfilled posts.

Urgent and emergency services

- We reviewed 18 patient records and found all risk assessments were completed, allergies, national early warning scores (NEWS) and paediatric early warning scores (PEWS) were all clearly documented.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between February 2016 and February 2017, the trust reported 1,171 incidents by the urgent and emergency care department. The trust rated two of these incidents as extreme, five as high, 14 moderate, and 1,150 rated as low.
- In accordance with the Serious Incident Framework 2015, Between February 2016 and February 2017, the trust reported seven serious incidents (SIs) in urgent and emergency care meeting the reporting criteria set by NHS England. Of these, three caused low harm, two moderate and two high. The trust carried out appropriate root cause analysis of incidents and provided feedback to staff and stakeholders on the outcomes.
- The staff we spoke with knew how to report incidents on the trust electronic reporting system and stated that they received feedback from any incidents via email or from their line manager and at team meetings. Staff had access to the Southend University Hospital "Incident Round Up" newsletter, a dedicated staff newsletter to update staff on incidents and actions taken to minimise incidents in the future. We saw evidence of learning shared with staff.
- The trust held mortality and morbidity meetings specifically for adults, trauma, paediatrics, and mental health. Staff stated that they knew of learning from such analysis through team briefings, team meetings, board rounds, and emails to all staff. We saw detailed minutes of meetings from January 2017 that included learning points for each case presented.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All nursing and medical staff we spoke with knew what the duty of candour was and that it was about being open and transparent when things go wrong.

Cleanliness, infection control and hygiene

- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care.
- Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilising the hand sanitiser where appropriate. However, the infection control lead informed us that they regularly reminded consultants on the trusts 'bare below the elbow' policy, we did not observe this during inspection.
- Staff explained the protocol for patients with possible infectious disease and demonstrated they had good understanding of infection, prevention, promotion, and control in their day-to-day activities with patients. The staff also asked patients key questions on arrival at the department to establish if they posed an infection risk to other patients and staff.
- At the time of our inspection, a patient presented in the emergency department with possible *Clostridium Difficile*, also known as *C. difficile* or *C. diff*. All staff entering the patient's room took appropriate action to prevent risks to other patients and staff. This included reminding individuals to follow infection control procedures and using appropriate signage on the patient's door to remind anyone entering the room of the possible risks of infection.
- Hand sanitizer was available at the entrance to each area of the emergency department (ED). Clear signage was in place asking all staff and visitors to wash their hands and to follow the trust policy on infection prevention, protection, and control when entering or leaving wards or departmental areas.
- The ED had an abundant stock of cleaning and sanitising equipment and key guidance for staff and patients on infection prevention, protection, and control was available at all hand washing areas.

Urgent and emergency services

- Staff appropriately managed sharps bins, completed appropriate documentation, and ensured bins were well-maintained, sealed, and closed at all times.
- There was appropriate provision of cleaning materials. Housekeeping staff were visible throughout our inspection and continually engaged in cleaning activities. Staff frequently emptied waste bins during the course of the day and the environment was visibly clean.
- We spoke with a two members of the domestic team and observed their daily work regime. This included updating signage in patient bays to say they were clean and safe to use. We also saw green 'I am clean' stickers across the department stating that the equipment was clean and was safe to use. However not all departmental records in relation to the cleaning of areas were up to date at the time of our inspection.
- The unannounced paediatric cleaning audit for January 2017, showed a compliance rate of 99.6%, which was above the trust target of 95%.
- The cleaning audit for the ED in January 2017 showed the major and minor trauma areas 98.8% compliant with cleaning activities. The main urgent and emergency care waiting area achieved 100% compliance, all better than the trust target of 95%.
- Data supplied by the trust during inspection showed an 89% staff compliance with infection control training.

Environment and equipment

- The ED staff raised concerns about the ability to lock down the major trauma and resus areas efficiently in an emergency. The security of the department was on the ED risk register.
- There was no controlled access on any of the adult ED areas. This meant the department was not safe from a security or major incident perspective, as anyone could enter the department at any time. We noted on several occasions patients and visitors entering the department who were lost or looking for other departments.
- Since our last inspection, the trust had installed a controlled access system in the paediatrics area to restrict any unauthorised access to clinical areas. This

prevented any unauthorised access and we observed staff within the paediatrics area following the security protocols correctly and challenging anyone calling to enter the department.

- We examined equipment check labels to establish if staff checked equipment appropriately. In the main, we found staff checked equipment routinely.
- Staff carried out daily audits of adult resus trolley contents, the logbook was clearly accessible and daily entries documented checks carried out in line with hospital protocol.
- Patient trolleys, equipment, and curtains providing privacy appeared visibly clean throughout the department. Curtains displayed an expiry check date and we found all curtains to be within service date and in good condition.
- The department had closed circuit television in place in specific areas, for example, paediatrics, corridors and reception areas monitored by staff.
- The ED utilised signage to identify the nurse in charge, the number of staff planned and actual staff on duty. Signage was clear and enabled staff, patients and relatives to see the number of staff on duty, identify staff roles, and see who was in charge of the department.

Medicines

- We reviewed the medication records of ten patients and found all records were accurate and included allergies likely to affect the patients.
- We viewed the medication storage areas, rooms were visibly clean, staff locked medicine cupboards, and we found medicines to be in date and in a well-maintained condition.
- We found that overall medicines were stored securely including controlled drugs. The ED major trauma area carried out a controlled drugs audit on 20 January 2017, achieving 82% compliance. A subsequent action plan was in place to address issues, for example the use of blue pen in records, missing signatures and incomplete transactions due to quantities not recorded correctly.
- Staff monitored the temperature of the medicine refrigerator and recorded these daily to ensure medicines were stored within the recommended safe temperature ranges. However, the medicine refrigerator

Urgent and emergency services

was unlocked. Staff said this had been risk assessed as necessary to enable staff quick access to emergency medicines. However, the area was in an open location that meant any one entering the area could access it.

- Staff reported medicine incidents, with lessons learnt and positive action taken to prevent them happening again. We saw how medicine alerts were cascaded to all staff using e-mail and screensaver reminders. Following a medicine incident the previous year, staff told us that positive learning and action took place to prevent it happening again. Staff displayed new information about changes to medicines clearly on medicine cupboard doors.
- Although there was no regular named pharmacist visit in the ED staff told us they could contact the hospitals medicine safety officer, for any medicine information and support when needed.

Records

- We reviewed 18 patient records and saw staff completed all patient risk assessments, allergies and that national early warning scores (NEWS) and paediatric early warning scores (PEWS) were all clearly documented.
- Patients arriving at the department had their initial details transferred onto an electronic record system by clerks, but sometimes this was paper based. Some staff said there were issues between the paper based and electronic recording system. Staff said the two systems did not always work efficiently. This meant that staff did not always accurately record the time taken for a patient to be triaged or to see a doctor. However, the trust were monitoring this closely and seeking to improve outcomes in this area as part of its governance processes.

Safeguarding

- There were clear processes and procedures in place for safeguarding adults and children in the ED. There were policies in place available to staff accessible through the trust's intranet system. Staff we spoke with knew how to recognise abuse and make a referral to the safeguarding leads for adults and children. Safeguarding referral guidance was available next to workstations and in staff information folders.
- Staff placed a red alert tag onto any child's records to show the child had a social worker and either, a child

protection plan or a children in need plan was in place or the child was on the looked after children register. This enabled staff to identify any child likely to be at higher risk of abuse when they reviewed the child's records when entering the department.

- Guidance was available to staff on recognising and reporting domestic violence and female genital mutilation. The ED had a lead member of staff for supporting staff awareness and offering guidance on domestic violence. Notice boards and posters showed details from the National Guidance for Domestic Violence, Safer Places, and Domestic Abuse Support Services specific to Essex and Hertfordshire.
- Posters offering guidance on child sexual exploitation were throughout the ED, along with posters giving the contact details for the local rape crisis centre.
- At the time of our inspection, data supplied by the trust showed staff achieved 80% compliance with safeguarding adults' level one training and 73% with level two.
- At the time of our inspection, data supplied by the trust showed staff achieved 92% compliance with child safeguarding level one. Staff achieved 88% compliance with child safeguarding level two, and 75% compliance with level three.
- At the time of our inspection, data supplied by the trust showed ED reception staff achieved 100% compliance in child safeguarding at level one.

Mandatory training

- The department had a full time practice development nurse responsible for leading and developing training to support staff skills, knowledge, and competencies.
- Staff we spoke with said the trust was proactive in offering training. However, sometimes due to staffing levels or shift patterns, they could not always attend face-to-face training. One member of staff told us how they complete their own direct online training, referred to by staff as 'I Learn'. This gave staff instant online access to their own individual training record from any computer or workstation on wheels. The record gave the staff a percentage completion rate against the trust training target, offered time scales for training updates and other training available to staff.

Urgent and emergency services

- Online training was one of the key methods of training used by the trust for its staff team. Staff we spoke with liked the opportunity to access this training and felt that online learning enabled them to learn at their own pace and access training to suit their needs.
- Training data supplied by the trust during inspection showed that 67% staff compliance with conflict resolution training, 74% were compliant with cardiopulmonary resuscitation (CPR) and 67% compliant with patient manual handling.
- Training data supplied by the trust during inspection showed staff achieved an 80% compliance with Mental Capacity Act training at level one, and 73% compliance at level two.
- Training data supplied by the trust during inspection showed 70% of staff met compliance with falls training, 66% were compliant with fire training, and 52% compliant with PREVENT training. PREVENT training is part of the Governments strategy to counter terrorism and extremism in the UK.
- Training data supplied by the trust during inspection showed staff achieved 85% compliance with equality and diversity training, and 87% compliance with manual handling of inanimate loads.
- At the time of our inspection, data supplied by the trust showed overall staff compliance with mandatory training was 77% and 84% with local induction.

Assessing and responding to patient risk

- We reviewed 18 patient records and found all risk assessments were completed, allergies, national early warning scores (NEWS) and paediatric early warning scores (PEWS) were all clearly documented.
- Data seen during inspection showed the trust carried out a retrospective audit of 34 patient records between August 2016 and October 2016, which showed 59% of patients, had appropriate antibiotics prescribed. This was an improvement on the January 2016 audit, which showed 28% of patients, had appropriate antibiotics prescribed.
- During the same audit, the trust identified 53% of patients had a CURB-65 documented. This was an improvement on the January 2016 audit, which showed

12% of patients had a CURB-65 documented. CURB-65, also known as the CURB criteria, is a clinical prediction rule for predicting mortality in community-acquired pneumonia and infection of any site.

- Nursing and medical staff undertook rapid assessments of patient conditions admitted by ambulance and other patients as required. Patient treatment bays were close to the ambulance entrance and staffed by senior nurses and medical staff to undertake the patient assessment and complete diagnostic tests as required.
- The trust had a rapid assessment triage (RAT) in accordance with the Royal College of Emergency Medicine guidance. The RAT is an assessment of patients that should occur within 15 minutes of arrival at the ED. The RAT operated 24 hours a day, seven days a week. Staffing in this area was dependent on need but always included a nurse in charge and mix of nursing and emergency department assistants.
- The RAT team mobilised to deal with any ambulance queueing issues or where patients may be waiting on trolleys during times of peak flow and demand, to try to minimise the impact of delays within the ED. The nurse in charge allocated a nurse to the trolley queue at peak times and a Hospital Ambulance Liaison Officer (HALO) would be called in from the local ambulance trust, to ensure the safety of patients who may be waiting on trolleys or in corridors.
- We observed five patients arriving by ambulance on trolleys to the ambulance bay. Nurses saw and assessed all these patients in less than 15 minutes.
- We observed that patients on emergency trolleys always had the safety sides elevated when required. This meant that elderly, frail patients or those with lowered levels of consciousness were cared for safely and protected from falls.
- The ED staff utilised a treatment escalation plan and sepsis-screening tool for adults. The sepsis pathway had clear guidance for staff to follow including how to identify high risk factors that could severely affect a patient's wellbeing. The sepsis guidance document was in line with NICE (National Institute for Health and Care Excellence) guideline - sepsis recognition, diagnosis and early management (NG51).

Urgent and emergency services

- Blunt abdominal trauma (BAT) is a common reason for presentation to the ED. Focused assessment with sonography for trauma (FAST), is a valuable diagnostic that can often facilitate a timely diagnosis for patients with BAT. FAST was not always available in the ED. Staff raised this and it was on the ED risk register due to concerns regarding the ability to quickly diagnose life-threatening conditions.
- Not all staff were trained in the use of non-invasive ventilation (NIV), however, we were told that there was a departmental policy for NIV. This meant that if a patient with chronic obstructive pulmonary disease (COPD) arrived at the ED requiring NIV, they could not always access this immediately. Instead, the department would call for a NIV trained nurse from the respiratory department to attend the ED or the patient transferred to a respiratory ward to receive NIV. Patients may therefore, be delayed in receiving NIV as they wait for a nurse to attend the ED or wait for a transfer to the respiratory ward. This could also contribute to patient flow issues through the department and bed blocking on the respiratory ward.
- Patient records contained documentation of the sepsis pathway. This meant staff treated patients with sepsis according to an agreed protocol based on national guidance.
- We reviewed ED compliance in relation to sepsis screening between July 2016 and December 2016. The department achieved 75% compliance in July 2016. This fell to 62% in August 2016, but improved to 80% in September 2016. Compliance improved to 90% in October 2016 and 100% in November 2016. However, compliance fell again to 90% in December 2016.
- Between February 2016 and January 2017, the trust declared 2,418 black breaches. These were most prevalent between September 2016 and December 2016, ranging between 248 and 349 per month respectively. Black breaches are occasions where handovers from ambulance arrival to offloading the patient to the ED took longer than 60 minutes.
- At the time of our inspection, we found no significant concerns regarding staffing the ED. The trust took appropriate action to cover any shortfalls and recruitment was proactive and ongoing to fill any unfilled posts.
- Nursing staff work in core teams and follow a four-week rolling rota. They worked two weeks of nights, two weeks of days, a set rota that gives staff two weekends off in the month. Shifts start at 8am to 9pm for long days and 8.45pm to 8.15am for a night shift. Each matron leads a staff team and provides staff supervision, appraisal, and delegated staff duties within the ED on a day-to-day basis.
- At the time of our inspection, the establishment on a day shift consisted of 11 registered nurses (RN) This consisted of two trained in paediatrics, and four emergency department assistants (EDA). The night shift establishment consisted of ten RN including a paediatric nurse and three EDA's. The department was four RN down during our inspection, due to sickness absence and vacancies. However, the managers proactively sought fill any gaps in the staff rota with existing ED staff wherever possible.
- The ED had four whole time equivalent RN vacancies within its establishment. The department covered these with ED staff pulling in additional shifts wherever possible. The ED had a standard operating procedure (SOP) to guide staff on how to escalate concerns regarding staffing levels.
- Recruitment for the RN posts had been running for six weeks, and the trust are actively seeking to recruit to the posts, including recruitment fairs and adverts in the professional nursing magazines.
- We observed the nursing handover was comprehensive and focused on key issues. Issues covered included patient care and treatment, staffing levels, patient flow and any safety issues likely to be of concern.
- The department had an appropriate skills mix within the staff team. The rotation of staff on a daily basis combined with the opportunity of staff rotation across the department, encouraged teamwork and increased the skills and competencies of staff.
- The paediatric department was fully staffed at the time of our inspection and had no vacancies. The

Nursing staffing

Urgent and emergency services

department usually had two RN's on duty at any time. This included one paediatric trained nurse and at least one with emergency paediatric life support (EPLS) training. The department would also have an emergency department assistant (EDA) on duty to support staff throughout during the same period.

- Between November 2016 and January 2017, there were two RN on duty to open the paediatric ED between 8am and 9pm, which is the right staffing ratio for that area. We identified only one occasion during this period, a night shift on the 18th November 16, when the ED did not have an emergency paediatric life support (EPLS) trained RN on duty.

Medical staffing

- A lead clinical consultant led the ED. At the time of our inspection, this role was also taking on the clinical director role for medicine across the hospital.
- We reviewed the consultant rota for the ED and noted very few gaps in consultant cover. Where there were gaps in the consultant rota. These were entirely due to unplanned sickness absence and local locums readily filled the gaps. Medical staff worked on a rota system, which provided medical cover to the wards 24 hours a day, 7 days per week.
- We spoke with a consultant who told us they felt departmental staffing was appropriate and that the department had very few issues with medical staffing.
- The ED always had a minimum of one consultant present in the department between 8am and 10pm and on-call at all other times. Occasionally this figure could be as high as three dependent on the shift rota and needs of the department. Junior doctors, ranging from foundation year to middle grade, supported the consultants within the shift rota.
- A paediatric consultant was readily available to support the ED, 24hours a day, and seven days per week.

Major incident awareness and training

- The trust had a major incident plan (often referred to as MAJAX) and business continuity plan in place. Staff we spoke with knew of the plan and when the reasons why and when it would be implemented.

- The storerooms for major incident equipment were of a good standard. They were visibly clean and well organised. Equipment labels showed that equipment was routinely checked that it as was in date and ready for deployment in a major incident.
- Staff told us of a recent major incident where the hospital was subject to a diesel spillage from tanks on the roof of the hospital. The department had responded well to the incident and the incident managed with as little disruption to patients and staff as possible.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



Are urgent and emergency services caring?

Good



Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Good



We have rated this service as Good for the responsive domain. We found:

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the ED. The trust was showing an improvement in performance since January 2017 at 80-98%
- Data supplied by the trust showed the percentage of patients waiting between four, and 12 hours from the decision to admit, until being admitted was improving. The trusts was performing at 08% in January 2017 which was lower than the England average, which was 9% for the same period. The trust showed an improvement in performance over the three-month period.

Urgent and emergency services

- The trust was showing an improvement in performance against the targets for ambulance handovers over 15 minutes, but no greater than 30 minutes. However, in January 2017 the number had increased slightly.
- The trust three monthly figures for ambulance handovers over 30 minutes, but no greater than 60 minutes was not consistently improving. This was due to an increase in the December 2016 figure. However by January 2017 the trust saw a further fall in the numbers of patients waiting. This pattern was mirrored within the category of ambulance handovers over 60 minutes.
- The ED employed a full time member of staff in a flow navigator role who specifically worked with a third party provider of services.
- The ED had access to dementia support from the hospital dementia practitioners. Specialist nurses were available to support staff and offer guidance. The trust used the “This Is Me” booklet, designed to capture the needs of patients living with dementia.
- Staff and patients accessed toys and games. These helped support children who may be in distress due to pain or confidence issues when waiting to for assessment or treatment.
- The emergency department (ED) had access to translation services for patients whose first language was not English. They also had access to sign language services for patients or relatives that may be deaf or hard of hearing.
- The ED had access to dementia support from the hospital dementia practitioners. They were available to support staff and offer guidance with using the “This Is Me” booklet. This is designed to capture the needs of patients living with dementia. There was clear advice for patients and relatives on how to access additional support for patients with dementia or Alzheimer’s disease.
- Patients could access the memory clinic on Mondays, Wednesdays, and Fridays to aid their coping with memory loss.
- Staff also utilised twiddle muff comforters, which were crocheted by staff and given to patients with dementia to provide sensory stimulation and reduce distress.
- Staff and patients accessed toys and games to help support children who may be in distress due to pain or confidence issues when waiting to for assessment or treatment.

However:

- Staff raised concerns regarding access to mental health services for children entering the department. Staff gave examples of children waiting for extended periods for assessment and support, often overnight, due to the restricted access to specialist mental health support. We did not get assurance that children with mental health issues were having their needs met in a timely and appropriate way, and this issue was on the ED risk register.
- The trust had a learning disability nurse, contact details for the service were available throughout the ED. Posters included the named nurse, their contact details and pictorial symbols to guide people on how to access the service.
- Staff raised concerns regarding access to mental health services for children entering the department. Staff gave examples of children waiting for extended periods for assessment and support, often overnight, due to the restricted access to specialist mental health support. We did not get assurance that children with mental health issues were having their needs met in a timely and appropriate way, and this issue was not on the ED risk register.

Service planning and delivery to meet the needs of local people

- During our inspection, we found little in relation to service planning for the local community. Staff we spoke with agreed that due to capacity and workloads much of their focus had been on maintaining a safe service and environment for the patients. As a result, the team inwardly focused and external developments had been limited.

Meeting people’s individual needs

Access and flow

- The ED employed a full time member of staff in a flow navigator role. This role specifically worked with teams to encourage patient flow and access to treatment.
- Waiting times to triage and treatment via the GP service were affecting flow through the ED. Staff we spoke with

Urgent and emergency services

gave examples of patients waiting extended periods and variable performance when redirecting patients to alternative services. The trust was proactively seeking to develop this area of its service to improve flow and reduce patient waiting times.

- The clinical director explained the department was in the process of redesigning patient pathways to minimise unnecessary referrals to medicine and reduce the potential for bed blocking or the risk of delayed transfers out of the department.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred, or discharged within four hours of arrival in the ED. Data supplied by the trust showed that in November 2016, the trust achieved 77%. The trust achieved 73.1% in December 2016, and 81.4% in January 2017, all below the 95% target. However, during our inspection we observed the trust achieving 100% on the 10 February 2017, 98.4% on the 9 February 2017, and a reported 93.1% on 8 February 2017.
- Data supplied by the trust showed the percentage of patients waiting between four, and 12 hours from the decision to admit, until being admitted was 1.7% in November 2016, 1.5% in December 2016, and 0.8% in January 2017. This was lower than the England average, which ranged between 12% and 9% for the same period and showed an improvement in performance by the trust over the three-month period.
- Data supplied by the trust showed that during November 2016 one patient waited more than 12 hours from the decision to admit, until being admitted. During December 2016, this figure increased to two and was two again in January 2017.
- During November 2016, the national median total time in the ED for admitted patients was two hours and 31 minutes. Data supplied by the trust showed that in November 2016, total time in the ED for admitted patients was four hours and 42 minutes. This was significantly above the national figure. In December 2016, the national median total time was two hours and 35 minutes. Data from the trust for December 2016 showed the total time in the ED for admitted patients was five hours. This was again substantially higher than the national figure.
- Between November 2016 and January 2017, the unplanned re-attendance rate within seven days for any condition within the ED was 6.7%. This was higher than the England standard of 5%. The unplanned re-attendance rate within seven days for the same condition within the ED was 2.3%. This figure does not attract an England standard.
- Data supplied by the trust showed that in November 2016, the median percentage of patients leaving the trust urgent and emergency care services before being seen was 1.3%. This increased to 2.4% in December 2016 showing a fall in performance. However, this percentage fell to 1.2% in January 2017 showing an improvement on the previous month's performance.
- In November 2016, data supplied by the trust showed 756 ambulance handovers were over 15 minutes, but no greater than 30 minutes. This figure fell to 729 in December 2016, showing improved performance. However, this figure increased to 797 in January 2017 showing a reduction against the previous month's performance.
- Data supplied by the trust showed in November 2016, 372 ambulance handovers were over 30 minutes, but no greater than 60 minutes. This figure increased to 446 in December 2016, showing a fall in performance. However, this figure reduced to 311 in January 2017 showing improvement on the previous month's performance.
- In November 2016, data supplied by the trust showed 285 ambulance handovers were over 60 minutes. This figure increased to 349 in December 2016, showing a fall in performance. However, this figure reduced to 191 in January 2017, showing improvement on the previous month's performance.
- If patients waited longer than four hours in the ED, staff implemented hourly care rounds to monitor the patient wellbeing. If the wait increases to six hours staff will try to admit the patient to a hospital bed and if a bed is not available staff complete an incident report.
- We spoke with four staff from the East of England Ambulance Service who commented on the responsiveness of the ED staff, and their focus on patient risk. One member of staff explained that if flow through the hospital was challenging or patients queued, a senior nurse or doctor would triage a patient

Urgent and emergency services

on the ambulance if the patient's condition had worsened. Ambulance staff said that Southend Emergency Department was always the friendliest and most caring department they used when delivering patients. They told us staff always went the extra mile for their patients when handing over, especially during busy periods where patients had to wait longer due to capacity issues inside the hospital.

Are urgent and emergency services well-led?

Good



We have rated this service as Good for the well-led domain. We found:

- There were several established systems to ensure good clinical governance and monitor performance, clinical governance, mortality, and morbidity and infection control.
- The emergency department (ED) had a specific risk register for its service. Senior staff monitor the risks identified, and take appropriate action to mitigate any impact on patients and staff.
- The trust had recently appointed a further matron to the ED with a specific remit to lead on clinical governance as a substantive part of their role. This meant that the ED had a member of their leadership team responsible for monitoring and reporting on governance issues that specifically related to the ED.
- The ED had a clear management structure and there was good leadership.
- Staff spoke very highly of the local leadership including the clinical lead, associate director and matrons and said that these staff were approachable, and listened to their concerns.
- All patients we spoke with acknowledged a caring and positive culture within the ED and were happy with their experience of care and treatment despite the delays they may have experienced.
- The musculoskeletal team had created a Trauma Assessment Centre (TAC) within the ED as an extension of the fracture clinic, where staff streamed patients directly to receive treatment.

However:

- Staff we spoke with said that the trust senior leadership team lacked visibility in the department, even during exceptionally busy periods or significant times of need.
- Since our last inspection, issues remained regarding collaboration with other specialities within the hospital.

Leadership of service

- The ED had a clear management structure consisting of a clinical director, associate director, matrons, and operations manager. The newly appointed matron had a specific role regarding clinical governance within the ED. They were looking forward to taking ownership of the new role and sharing responsibilities amongst the staff team.
- There was good leadership of the ED. Departmental managers were visible, as was the clinical lead, with clear levels of accountability and control over operations. Staff knew who was in charge at any time and how to escalate any concerns regarding the management of the department, for example staffing levels, patient safety, or security.
- Staff we spoke with said the matrons were supportive, offering significant support during busy periods and always willing to help when needed, actively checking on staff and patient wellbeing throughout the day.
- Staff meetings happened every two weeks, this enabled staff to learn from incidents, discuss complaints and concerns, look at best practice guidance and be clear on roles and responsibilities.
- Staff spoke very highly of the leadership and management provided by the clinical lead, associate director, and matrons and they were approachable, and listened to their concerns.
- Staff we spoke with said that the trust senior management team lacked visibility in the department, even during exceptionally busy periods or significant times of need.

Vision and strategy for this service

- Senior staff focused on the here and now in terms of leading and managing the department. This was due to the significant pressures on the department from

Urgent and emergency services

capacity and flow. At the time of our inspection, there were a number of confidential business cases before the trust board for consideration. These were to improve performance within the emergency department (ED).

Governance, risk management and quality measurement

- There were several established systems to ensure good clinical governance and monitor performance.
- The trust had recently appointed a further matron to the ED with a specific remit to lead on clinical governance as a substantive part of their role. This meant that the ED had a member of their leadership team responsible for monitoring and reporting on governance issues that specifically related to the ED.
- The clinical governance meeting happened fortnightly with key staff. This included the matrons, and the associate director, amongst others and details of the meeting and minutes circulated to staff. Each meeting produced action points as required. We saw that these shared with the teams in flexible ways, by email and daily briefing meetings to ensure continual improvement to quality of the service.
- The ED had a specific risk register for its service, which identified risks to the service. This included a 'RAG rating' of the level of risk, controls put in place to manage the risk and timelines for review. The risks identified included:
 - Inadequate capacity of ED with resultant reduction in patient safety
 - Risk of patients with mental health needs absconding or deteriorating whilst waiting for an assessment
 - Inability to lockdown the ED in the event of a major incident
 - Risk of patients not receiving timely transfer to tertiary care due to the lack of a transfer policy
 - Risk to patients if assessment within 15 minutes is delayed
- Senior staff monitor the risks identified and take appropriate action to mitigate any impact on patients and staff. At the time of our inspection, the ED was going through a significant period of change to improve on capacity and flow issues. Actions included the

relocation of the acute medical assessment unit and the development of a larger ambulatory care unit to enable the hospital to see, treat, and discharge patients more efficiently.

- The trust held 'Safe at Southend' meetings each morning at 8am where staff from various specialities met to discuss safety issues, flow and capacity

Culture within the service

- Since our last inspection, issues remained regarding collaboration with other specialities within the hospital. Staff gave specific examples of difficult working relationships with the medicine, surgery, and paediatric department teams who would often not support patient admissions within their specialism. Some staff did praise the surgery team however, who had specially supported the ED during high demand or capacity issues.
- However, we spoke with a consultant who described an improving view of relationships about referring ED patients to specialities as the department now operate a one-way referral system.
- Senior staff we spoke with knew of their responsibilities in relation to the Duty of Candour.
- All patients we spoke with acknowledged a caring and positive culture within the ED and were happy with their experience of care and treatment despite the delays they may have experienced.
- All nursing staff and emergency department assistants we spoke with told us they felt the ED was a supportive and interesting place to work. We saw staff interacted in a supportive way within the department to ensure safety and efficiency for patient care and that there was a positive and calm feeling within the team, even during very busy periods.
- Junior doctors told us that the ED was a good place to work, they felt valued by their colleagues, and that they had opportunities to learn and grow in professional confidence. Junior doctors spoke of a culture of good supervision and opportunities for personal development. Staff plan working rotas six months in advance, and staff felt that leave was well managed and allocated on a fair basis.

Urgent and emergency services

- All the reception staff team were welcoming and friendly, this placed the patients at ease when entering the department. The reception staff team focused on a patient centred culture, offering advice and guidance to support patients appropriately to ensure they accessed the correct services.

Staff engagement







- The ED staff had access to departmental meeting minutes and attended regular meetings to discuss performance and share ideas or concerns with the managerial team. We saw detailed comprehensive team meeting minutes from January 2017 that contained detailed feedback to staff on incidents and departmental activities.
- Notice boards within the department shared key information to enable staff to see the latest developments within the department, performance targets, data, access to training and professional updates and patient outcomes.

- Staff suggestion boxes were prominent within the ED. This enabled staff to post suggestions on any issues in relation to the ED department, for example how to improve the service, staffing issues, or general suggestions on the service. Staff we spoke with said they had used these and received feedback during team meetings on issues they had raised for consideration.

Innovation, improvement and sustainability

- The ED had created a Trauma Assessment Centre (TAC) as an extension of the fracture clinic, where patients were streamed directly to be seen for treatment rather than being seen in the ED and then again in the fracture clinic. Staff we spoke with on this development and saw the benefits this had on reliving pressures in the ED and supporting patients.

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

We completed a responsive inspection of the medical service at Southend University Hospital NHS Trust on 9 February and 10 February 2017. This inspection was in response to information of concern about the safety, responsiveness and leadership of the service.

The medical service includes a medical admissions unit (Bedwell Acute Medical Service), 14 speciality wards including stroke, respiratory, cardiology, renal, diabetes, gastroenterology, elderly care, haematology and oncology and a discharge lounge, which provides a waiting area for patients ready to leave the hospital. Wards are open 24 hours a day, seven days a week. The discharge lounge is open daily from 9am to 7pm. There were 37,834 admissions to the medical service from 01 January 2016 to 31 January 2017.

Our inspection team looked at the pathway taken by patients admitted to the hospital with an acute medical condition. We visited the Bedwell Acute Medical Service (BAMS), four speciality medical wards including the acute stroke ward (Benfleet ward), rehabilitation ward (Paglesham ward), respiratory ward (Westcliff ward) and elderly care ward (Princess Anne ward), and the discharge lounge. We also visited a surgical ward (Southbourne ward) where there was a high number of outlying medical patients.

We spoke to 28 staff, including four ward managers, three consultants, six junior doctors, ten nurses, three allied health professionals and two support staff. We spoke to six patients and two relatives of patients. We observed a

medical handover, a safety briefing and looked at 14 patient care records. We also looked at equipment, information displayed in the department and reviewed information including meeting minutes, action plans and staff training data.

Medical care (including older people's care)

Summary of findings

We found:

- There were shortages in permanent consultant staffing, particularly on Bedwell Acute Medical Service (BAMS) and in the department of medicine for the elderly (DME). Data provided by the trust showed the actual number of consultants in these specialities was consistently below the planned number from December 2016 to February 2017. The trust provided information showing that vacant posts were covered by agency doctors, however medical staff told us that agency cover was not consistently available and we saw gaps in the BAMS consultant staffing rota.
- Thirteen out of the 28 staff we spoke to expressed concerns about timely consultant review and discharge of patients due to staffing shortages.
- There was a shortage of junior doctor staffing on BAMS. At the time of our inspection the planned number of junior doctors for BAMS was four and the actual number of junior doctors was two.
- Five out of nine medical staff we spoke to expressed concerns around the organisation and management of the junior doctor rota. They described it as 'poorly organised' and 'too complex'. Staff told us there could be gaps in daytime medical staffing due to the organisation of on-call duties for medical staff.
- There were shortages in nursing staffing across the medicine service due to unfilled vacancies. The whole time equivalent (WTE) establishment for registered nursing staff in the medical service in January 2017 was 374.5 and the number of nursing staff in post was 298.9. There were 75.6 WTE vacancies.
- We saw that the ratio of nurses to patients on Paglesham ward was 1:13. This was not in line with the Royal College of Nursing recommendations of one nurse providing care for no more than eight patients.
- Staff compliance with mandatory training was variable. On BAMS, staff compliance with mandatory training was 68%, which was lower than the trust target of 85%.
- Staff compliance with safeguarding training was variable. Compliance with adult safeguarding training level one and two was below the trust target on BAMS. Compliance with child safeguarding training level one and two was below the trust target in three clinical areas we visited.
- Staff compliance with sepsis training was highly variable. Training records dated 2 November 2016 showed compliance with sepsis training ranged from 26% on BAMS to 92% on the respiratory unit.
- The process for in-reach to BAMS from speciality medical teams was inconsistent. Two members of staff on BAMS told us that some medical speciality teams found in-reach difficult due to staffing and workload.
- There was a high number of medical outliers. From November 2016 to January 2017 the number of outliers on medical wards ranged from 117 to 203 per month. The number of medical outliers on surgical wards ranged from 171 to 429 per month in this period. There was concern about the medical review of medical patients on other non-medical wards. Records showed that not all received a daily medical review. Staff also expressed concerns about this and stated that they felt that there was a shortage of medical consultants.
- There was a high number of bed moves after 10pm for patients in the medical service. Data showed that there was a monthly average of 352 bed moves after 10pm from August 2016 to January 2017.
- Two senior staff on Benfleet ward told us that one bay on the ward was used as a hyper acute stroke unit (HASU) and that this bay would often have male and female patients accommodated together. However, this bay was not categorised as a HASU by the trust and should not have accommodated male and female patients in the same bay. On the days of our inspection, this bay was not used as a mixed sex bay.

Medical care (including older people's care)

- Staff identified difficulties in communication between different speciality teams. One junior doctor told us about difficulties in communication between medical teams in the emergency department and BAMS. Two consultants told us there could be “friction” between different specialities and spoke of a “silo culture” which could cause difficulties when agreeing where junior doctors spent their time.

However:

- All staff had a good understanding of incident reporting procedures and received feedback on incidents reported.
 - Senior managers completed detailed investigations into serious incidents and shared this learning with staff throughout the medical service.
 - Clinical areas were visibly clean. Staff were compliant with bare below the elbows practices and we saw staff completing hand hygiene appropriately. Results of a trust audit of personal protective equipment dated January 2017, showed positive results.
 - Staff stored medicines securely and completed twice daily checks of controlled drugs (CDs) to ensure that all stock was monitored and accounted for.
 - Patient records were stored securely in lockable trolleys in clinical areas.
 - Staff understood their responsibilities regarding safeguarding adults and children. We asked six members of staff about safeguarding and all of them were able to tell us how they would report a safeguarding concern and what they would report.
 - There was a stroke emergency phone, which provided direct contact between the emergency department and the stroke ward. This meant that the stroke consultant could be immediately alerted to any patient presenting with signs of a stroke in the emergency department. The ward manager on Benfleet ward told us the early review and transfer of patients admitted with signs of stroke worked well.
 - The average referral to treatment time for admitted patients in the medical service from January 2016 to January 2017 was 98%.
- Staff worked together to meet patients' individual needs. Staff gave us examples of coordinating care to meet the needs of patients with learning disabilities and told us about actions they took to improve the experience of patients living with dementia.
 - There were clear processes for sharing information with staff in the medical service. Senior staff shared information with staff through team meetings, information noticeboards and through the trust 'weekly roundup' newsletter.
 - There was a positive culture within speciality teams on medical wards. Nursing staff described positive working relations with medical staff in their speciality. Junior doctors described consultants as supportive and approachable.

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. We found:

- There were shortages in permanent consultant staffing, particularly on Bedwell Acute Medical Service (BAMS) and in the department of medicine for the elderly (DME). In February 2017, the planned number of permanent consultants in BAMS was 10.5 and the actual number was 4.5. From December 2016 to February 2017, the planned number of permanent consultants on DME was 8.7 and the actual number was 4.7. The trust provided information showing that vacant posts were covered by agency doctors, however medical staff told us that agency cover was not consistently available and we saw gaps in the BAMS consultant staffing rota.
- Thirteen out of the 28 staff we spoke to expressed concerns about timely consultant review and discharge of patients due to staffing shortages.
- There was a shortage of junior doctors on BAMS. We saw data to show that from November 2016 to February 2017, the planned number of junior doctors for BAMS was four. The actual number of junior doctors was three in November 2016 and two from December 2016 to February 2017.
- Five out of nine medical staff we spoke to expressed concerns around the organisation and management of the junior doctor rota, describing it as 'poorly organised' and 'too complex'. Staff told us there could be gaps in daytime medical staffing due to the organisation of on-call duties for medical staff.
- There were shortages in nursing staffing due to unfilled vacancies. The whole time equivalent (WTE) establishment for registered nursing staff in the medical service in January 2017 was 374.5 and the number of nursing staff in post was 298.9. There were 75.6 WTE vacancies.
- The ratio of nurses to patients on Paglesham ward was 1:13. This was not in line with the Royal College of Nursing recommendations of one nurse providing care for no more than eight patients.

- Staff compliance with mandatory training was variable. On BAMS, staff compliance with mandatory training was 68%, which was lower than the trust target of 85%.
- Staff compliance with safeguarding training was variable. Compliance with adult safeguarding training level one and two was below the trust target on BAMS. Compliance with child safeguarding training level one and two was below the trust target in three clinical areas we visited.
- Staff compliance with sepsis training was highly variable. Training records dated 2 November 2016 showed compliance with sepsis training ranged from 26% on BAMS to 92% on the respiratory unit.

However:

- Staff had a good understanding of incident reporting procedures and received feedback on incidents reported.
- Senior managers completed detailed investigations into serious incidents and shared this learning with staff through team meetings, noticeboards and the 'weekly roundup' newsletter.
- Clinical areas were visibly clean. Staff were compliant with bare below the elbows practices and completed hand hygiene appropriately. Results of an audit of personal protective equipment dated January 2017 showed positive results, with 90% compliance on Eleanor Hobbs ward and 100% compliance for the eight other medical wards audited at this time. We did not see a target for compliance included in this audit.
- Staff stored medicines securely and completed twice daily checks of controlled drugs (CDs) to ensure that all stock was monitored and accounted for.
- Records were stored securely in lockable trolleys in staff areas.
- Staff understood their responsibilities in terms of safeguarding adults and children. We asked six members of staff about safeguarding and all of them were able to tell us how they would report a safeguarding concern and what they would report.

Incidents

- There were no never events in the medical service from December 2015 to November 2016. Never events are

Medical care (including older people's care)

serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- The trust reported 45 serious incidents (SIs) in the medical service from February 2016 to February 2017. Senior staff completed detailed investigations into serious incidents. We reviewed investigations into two serious incidents. The investigations included analysis of the root cause of the incident, lessons learned, arrangements for sharing learning and documentation of compliance with duty of candour requirements.
- Staff at all levels of seniority understood how to report incidents using the trust electronic incident reporting database. We asked nine staff about incident reporting and all of them were able to describe what they would report and how.
- Staff knew their responsibilities in relation to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Senior staff shared learning from incidents with their teams. The ward manager on Benfleet ward told us that learning from incidents was displayed on a safety noticeboard and was discussed with staff at monthly team meetings. We saw three sets of team meeting minutes dated from 22 September 2016 to 30 January 2017, which showed discussion of incidents. Two staff on Benfleet ward confirmed that learning from incidents was shared with them at team meetings.
- We saw documentation of an incident investigation on Bedwell Acute Medical Service (BAMS). The investigation included analysis of the incident and clear actions related to improvements in nursing documentation. The ward manager told us that learning from this incident and required actions would be shared with ward staff at the next team meeting.

- There was a hospital-wide weekly roundup newsletter, which included learning from incidents. We saw an example of this newsletter dated 27 January 2017. This included details of investigations into incidents and actions taken to prevent similar incidents in the future.
- We saw minutes from a cardiology morbidity and mortality meeting dated 23 January 2017, which included discussion of patient case presentations, recommendations and actions including escalation of issues to be discussed at the next governance meeting.

Safety thermometer

- Staff collected information for the NHS safety thermometer, although this was not displayed on the wards we visited. The NHS safety thermometer is a national initiative and local improvement tool for measuring, monitoring, and analysing harm free care. Staff reported the number of falls, catheter-related urinary tract infections (CUTIs) and cases of venous thromboembolism (VTE) on a monthly basis.
- Results from the NHS safety thermometer showed that on Westcliff ward there were no catheter-acquired urinary tract infections (CUTIs), no new pressure ulcers, no cases of venous thromboembolism (VTE) and an average of 0.15 falls with harm per month from January 2016 to January 2017. On Princess Anne ward, there was an average of 0.62 CUTIs per month, 0.15 falls with harm, no new pressure ulcers and one case of VTE in this period.

Cleanliness, infection control and hygiene

- All clinical areas we visited were visibly clean. We saw staff completing hand hygiene before and after contact with patients. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.
- Clinical staff were bare below the elbows and wore uniforms in line with trust policy. Staff wore appropriate personal protective equipment when treating patients. Results of an audit of personal protective equipment dated January 2017 showed positive results with 90%

Medical care (including older people's care)

compliance on Eleanor Hobbs ward and 100% compliance for the eight other medical wards audited at this time. We did not see a target for compliance included in this audit.

- Results of cleaning audits were positive. Results for February 2017 were displayed at the entrance to each ward we visited. On Princess Anne ward compliance was 98%, on Benfleet ward 98.3%, on Paglesham ward 97.6%, on Rochford ward, 100% and on Westcliff ward, 91%.
- Training records provided by the trust showed 90% compliance with infection control training for staff in the medical service. This was above the trust target of 85%.
- We checked the cleanliness of 12 pieces of equipment on the medical wards. All the equipment we checked was visibly clean and labelled with green 'I am clean' stickers appropriately dated to indicate when the equipment was last cleaned.
- There were no cases of MRSA within 48 hours of admission from April to December 2016, in the medical service. There were 14 cases of Clostridium difficile in the medical service in this period. We did not see any goals set by the service in terms of managing infection rates.

Environment and equipment

- Resuscitation equipment was visibly clean and was stored in an accessible location on all the wards we visited.
- On Bedwell Acute Medical Service (BAMS) we reviewed records of safety checks for resuscitation equipment from 9 December 2016 to 9 February 2017. We saw that there were three days when daily safety checks had not been completed. We raised this with the ward manager at the time of inspection. We looked at records of safety checks for resuscitation equipment on Benfleet ward, Princess Anne ward and Westcliff ward dated from 1 December 2016 to 9 February 2017. The records showed that staff completed daily checks.
- We looked at seven pieces of electrical equipment on medical wards and found all pieces of equipment had been electrical safety tested. Each piece of equipment was within the stated date for its next review.

Medicines

- Staff stored medicines securely. Controlled drugs (CDs) were stored behind two locked doors and staff locked medication trolleys when not in use.
- Medicines incidents were reported and we saw evidence of lessons learnt and positive action taken to prevent them happening again.
- Staff checked the stock of CDs twice a day to ensure that all stock was monitored and accounted for. We looked at the CD register on BAMS and Princess Anne ward. We checked the recorded balance of four CDs compared to the stock and found that the values matched.
- We checked the expiry dates on a selection of medications on BAMS, Princess Anne ward, Westcliff ward and Benfleet ward including four CDs, six bags of fluid and seven other medications. All the medications we checked were in date, except for one pack of adrenaline on BAMS. We raised this with the ward manager at the time of our inspection and they disposed of the medication immediately.
- We looked at records of temperature checks for refrigerators where medications were stored. Records dated from 1 February 2017 to 9 February 2017 on Benfleet ward and Princess Anne ward showed that staff had completed daily checks. On Benfleet ward all recorded temperatures were within the stated range. However, on Princess Anne ward there were two days where the maximum temperature exceeded the stated range. This meant that medications requiring storage at a certain temperature may not have been stored appropriately. We raised this with senior staff at the time of our inspection, who assured us they would take action.
- On BAMS, in January 2017 there were 19 out of 31 days where the maximum temperature was recorded as above the required range. There was no documentation of the reason for this or any action taken. We raised this with senior ward staff at the time of our inspection, who assured us they would take action.

Records

- The trust used paper records and staff kept records securely in lockable trolleys within staff areas on each ward.
- We reviewed 14 patient care records. Records contained documentation of risk assessments. Ten out of the 14

Medical care (including older people's care)

records we looked at contained fully completed risk assessments, including falls risk assessment, moving and handling assessment, Waterlow score (a tool for assessing the risk of developing a pressure sore) and SUNS (Southend University Hospital Nutrition Screening). Four of the records we saw had one or more risk assessment not completed.

- All of the records we reviewed were signed and dated by staff and legible.

Safeguarding

- Staff completed safeguarding training as part of their mandatory training. However, staff compliance with safeguarding training was variable. The trust set a target of 95% for compliance with child safeguarding level one and a target of 85% for compliance with child safeguarding level two and adult safeguarding training (levels one and two). We saw that these targets were not being met on some of the wards we visited.
- On BAMS staff compliance with adult safeguarding level one training was 68% and compliance with adult safeguarding level two training was 59%, both of which were below the trust target of 85%. We did not see any action plans to address this. Compliance with adult safeguarding training level one and two was above target for the stroke unit, respiratory unit and Princess Anne ward.
- Compliance with child safeguarding training was below target for three of the clinical areas we visited. On BAMS, staff compliance with child safeguarding level one was 74% and compliance with child safeguarding level two was 38%. On the stroke unit staff compliance with child safeguarding level one was 68% and compliance with child safeguarding level two was 68%. On the respiratory unit staff compliance with child safeguarding level one was 91% and compliance with child safeguarding level two was 60%.
- Staff understood their responsibilities in terms of safeguarding adults and children. We asked six members of staff about safeguarding and all of them were able to tell us how they would report a safeguarding concern and what they would report.

- There were policies in place regarding safeguarding of adults and children, including guidance on identifying domestic violence and female genital mutilation. Staff could access these policies through the hospital intranet system.
- There was a designated safeguarding lead within the hospital. Staff were able to identify who the lead was and how they would contact them.

Mandatory training

- Staff compliance with mandatory training was variable. The trust target for mandatory training compliance was 85%. Data provided by the trust showed overall compliance with mandatory training in February 2017 on BAMS was 68%, compliance on the stroke unit was 87%, on the respiratory unit 90% and on Princess Anne ward 98%. Data showed compliance with mandatory training for medical staff working in stroke was 64% and for medical staff working in DME was 76%.
- Staff compliance with sepsis training was highly variable. Training records dated 2 November 2016 showed compliance with sepsis training ranged from 26% on BAMS to 92% on the respiratory unit.
- Staff told us that it could be difficult to access training due to cancellation of training sessions and staffing pressures. Senior staff on Benfleet ward and BAMS told us that training was often cancelled and a junior member of staff on Benfleet ward said "It's hard to get time off the ward." A member of staff on Westcliff ward said "I tend to do mandatory training at home because of staffing." Two junior doctors we spoke to also expressed concerns about missing teaching sessions due to their workload.
- A member of staff on Westcliff ward was positive about opportunities for speciality specific training and told us how the trust supported them to do an acute respiratory course at a local university.

Assessing and responding to patient risk

- Staff used the national early warning score (NEWS) to identify deteriorating patients. NEWS is a nationally standardised assessment of illness severity and determines the need for escalation based on a range of patient observations.

Medical care (including older people's care)

- Results of an audit of NEWS documentation for January 2017 showed mixed results. Four out of the eight wards audited scored 100% on all six areas of documentation. However, four wards fell below the required standard for two areas of documentation and one ward fell below the required standard for three areas of documentation.
 - Nursing staff escalated information about deteriorating patients appropriately. Nursing staff completing patient observations on hand held computers (nerve centre pads). The nerve centre provided the ward manager and matron an overview of patients and provided continuity between nurses and shifts.
 - Where patients had scored as being at risk on NEWS the nerve centre would automatically notify the outreach team, which helped staff respond rapidly and appropriately. We observed nursing staff handing over information to medical staff in relation to patient observations and NEWS scores on Princess Anne ward.
 - We reviewed 14 patient records and found that in 10 records all appropriate risk assessments were completed. Risk assessments included pressure risk assessments, national early warning scores (NEWS), allergies and falls assessments. Records showed that patients had clear plans for escalation documented.
 - Staff in the medical service monitored performance on completion of risk assessments. A dashboard was displayed on each ward we visited. This included information about compliance with documentation of risk assessments, such as falls assessments. Each area was given a red/amber/green (RAG) rating to indicate performance against targets. This meant that senior staff could monitor and identify areas for improvement in risk assessment documentation.
 - Staff expressed concerns about risks caused by consultant staffing shortages on BAMS. One consultant gave us an example of an incident where a patient had deteriorated due to a lack of timely consultant review. On BAMS, we saw that one patient admitted at 3pm on 8 February 2017 had not been reviewed by a consultant when we visited the ward at 9am on 9 February 2017. This was not in line with the London Quality Standards, which state that unplanned medical admissions should be seen and assessed by a relevant consultant within 12 hours of admission. We asked the ward manager about this and they told us the delay in review was due to consultant staffing shortages.
 - We saw evidence of senior leaders responding to staff concerns about patient safety. For example, we observed a "Safe at Southend" meeting, which was a daily open forum where staff could raise any concerns with senior leaders.
 - There was a critical care outreach team, who supported staff with management of deteriorating patients on the ward. Staff on BAMS told us that this team were very supportive.
 - There was a designated sepsis champion on BAMS to support ward staff to manage patients with sepsis. We saw information displayed for staff about the sepsis champion.
 - Patient records contained documentation of a sepsis pathway, which was completed appropriately. This meant that patients with sepsis were treated according to an agreed protocol based on national guidance.
- ## Nursing staffing
- Senior staff used the 'Safer Nursing Care Tool' to determine nurse staffing levels for the medical service. The Safer Nursing Care Tool is an evidence based tool that allows nurses to assess patient acuity and dependency and to use this to inform the number of staff needed.
 - The whole time equivalent (WTE) establishment for registered nursing staff in the medical service in January 2017 was 374.5 and the number of nursing staff in post was 298.9. There were 75.6 WTE vacancies.
 - Staffing data provided by the trust for January 2017, confirmed a high number of vacancies for registered nursing staff on medical wards. For example, on BAMS there were 14.4 WTE vacancies, on the respiratory unit (Westcliff and Rochford wards) there were 11.4 WTE vacancies and on the stroke unit (Benfleet and Paglesham wards) there were 13.2 WTE vacancies.
 - The WTE establishment for healthcare assistants in the medical service in January 2017 was 241.7 and the number of healthcare assistants in post was 228.1. There were 13.6 WTE vacancies.

Medical care (including older people's care)

- Planned versus actual nursing staff numbers were displayed on the wards we visited. On Rochford, Westcliff, Benfleet and Paglesham wards the actual number of nursing staff did not meet the planned number. The trust used agency nurses to supplement the nursing team where possible. On Princess Anne ward and BAMS the planned number of staff was equal to the actual number of staff on the day of our inspection.
- On the second day of our inspection, the registered nurse to patient ratio on Paglesham ward was 1:13. This was not in line with Royal College of Nursing recommendations that one nurse should care for no more than eight patients. Senior staff confirmed that this ratio of staff on Paglesham ward was a regular occurrence due to nursing staff vacancies. We saw documentation of an upcoming recruitment day on 25 February 2017 to increase recruitment to vacant nursing posts.
- Some medical wards used a high percentage of agency staff. Data for January 2017 showed 35.4% agency usage on Princess Anne ward, 32.7% on the respiratory unit (Westcliff and Rochford wards) and 41.2% on the stroke unit (Benfleet and Paglesham wards).
- Agency staff received an induction. A member of staff on Princess Anne ward told us that they had gone through a checklist for induction on their first day working in the hospital and said they had been given time to become orientated to the ward.
- Senior ward staff were aware of staffing shortages and escalated this information to senior managers appropriately. Staffing shortages were identified using a 'red flag' system and a daily staffing update was sent to matrons and the site coordinator so that staff could be allocated appropriately. The ward manager on Benfleet ward told us that staffing was reviewed a week in advance so that unfilled shifts could be filled where possible.
- Sickness absence rates for the medical service ranged from 3.42% to 6.91%.
- Nursing staff completed a handover of information between each shift, which included discussion of patient care, staffing issues and any patient safety issues.

Medical staffing

- A clinical lead consultant for the emergency department was also taking on the role of clinical lead for medicine across the hospital at the time of our inspection.
- Medical staff worked on a rota system, which provided medical cover to the wards 24 hours a day, 7 days per week.
- There were shortages in permanent consultant staffing in medical specialities. We saw data to show that from December 2016 to February 2017, the actual number of permanent consultants on BAMS was consistently below the planned number. In February 2017, the planned number of permanent consultants in BAMS was 10.5 and the actual number was 4.5, covering a seven day rota from 8am-10pm weekdays and from 8am-8pm at weekends. The trust provided information showing that vacant posts were covered by agency doctors, however medical staff told us that agency cover was not consistently available and we saw gaps in the BAMS consultant staffing rota.
- We reviewed the consultant rota for BAMS for January 2017 and saw that there were several unfilled consultant shifts. There were also seven shifts marked as 'extra', indicating that these had been covered by consultants in addition to their normal shifts. Senior medical staff on BAMS told us that they were concerned about consultant staffing levels. Two doctors from other specialities also expressed concerns about consultant staffing on BAMS. The medical director told us that there were plans in place for addressing this however, these were subject to change.
- Data for the department of medicine for the elderly (DME) showed that the actual number of permanent consultants was consistently below the planned number. From December 2016 to February 2017, the planned number of permanent consultants was 8.7 and the actual number was 4.7. The trust provided information showing that vacant posts were covered by agency doctors. However, three junior doctors and two senior nurses we spoke to expressed concerns about consultant staffing on DME. One junior doctor said consultants were "beyond flat out." We raised concerns about consultant staffing with senior leaders at the time of our inspection.

Medical care (including older people's care)

- There was a shortage of junior doctors on BAMS. Data provided by the trust showed that from November 2016 to February 2017, the planned number of junior doctors for BAMS was four. The actual number of junior doctors was three in November 2016 and two from December 2016 to February 2017. A junior doctor on BAMS told us it was “very busy” and “a struggle to cover the ward”.
- Three junior doctors and two consultants expressed concerns about organisation of the medical rota, stating that it was “poorly organised” and “too complex.” Staff told us there could be gaps in daytime medical staffing due to the organisation of on-call duties for medical staff. Senior staff knew these concerns and assured us that they had begun work to review management of the junior doctor rota.
- A medical handover took place every morning, 7 days a week. We observed this handover and saw that it was well-organised and included discussion of clinical incidents, unexpected deaths, intensive care admissions, unwell patients and scans and investigations requiring urgent review. The handover meeting also included a review of medical staffing gaps and agreed redistribution of doctors.
- There were daily board rounds on speciality medical wards, which included multidisciplinary discussion of each patient's medical care and plans for discharge.
- A senior nurse on BAMS told us a doctor trained in ALS (advanced life support) was available at all times on BAMS. Data provided by the trust showed 47 staff in the medical service had recorded ALS competencies.

Major incident awareness and training

- The trust had a major incident plan (known as MAJAX) and business continuity plan in place. There were clear escalation procedures in place for managing staffing pressures and capacity. Staff understood their responsibilities in relation to these procedures.

Are medical care services effective?

Good

Are medical care services caring?

Good

Are medical care services responsive?

Requires improvement

We have rated this service as Requires Improvement for the responsive domain. We found:

- There was a high number of medical outliers (patients under the care of a medical speciality consultant but placed on other medical wards or surgical wards due to a shortage of bed space). From November 2016 to January 2017 the number of outliers on medical wards ranged from 117 to 203 per month. The number of medical outliers on surgical wards ranged from 171 to 429 per month in this period. Patient records showed that the frequency of medical review for these patients was variable. For example, we reviewed records for eight medical outliers and found that three of these patients had not received daily medical review.
- Five medical staff and three nursing staff we spoke to expressed concerns around the management of medical outliers due to consultant staffing shortages and organisation of the junior doctor rota. Nursing staff expressed concerns around communication from medical teams about the management of medical outliers.
- There was a high number of bed moves after 10pm for patients in the medical service. Data showed 384 bed moves after 10pm in August 2016, 359 in September 2016, 297 in October 2016, 394 in November 2016, 319 in December 2016 and 356 in January 2017.
- Staff described variability in the processes for in-reach to BAMS. Two members of staff on BAMS told us that some medical speciality teams found in-reach difficult due to staffing and workload.
- Two senior staff on Benfleet ward told us that one bay on the ward was used as a hyper acute stroke unit (HASU) and that this bay would often have male and female patients accommodated together. However, this

Medical care (including older people's care)

bay was not categorised as a HASU by the trust and so should not have accommodated male and female patients in the same bay. On the days of our inspection, this bay was not used as a mixed sex bay.

However:

- There was a stroke emergency phone, which provided direct contact between the emergency department and the stroke ward. This meant that the stroke consultant could be immediately alerted to any patient presenting with signs of a stroke in the emergency department. The ward manager on Benfleet ward told us that the early review and transfer of patients admitted with signs of stroke worked well.
- The average referral to treatment time for admitted patients in the medical service from January 2016 to January 2017 was 98%.
- Staff worked together to meet patients' individual needs. Staff gave us examples of coordinating care to meet the needs of patients with learning disabilities and told us about actions they took to improve the experience of patients living with dementia.

Service planning and delivery to meet the needs of local people

- Staff identified that the location of Bedwell Acute Medical Service (BAMS) was not ideal for taking patients to x-ray. The ward manager on BAMS told us that it took 45 minutes to transport a patient to and from x-ray due to the location of the ward. This meant that staffing on the ward could be impacted when staff took patients to x-ray. In response to this, BAMS was moved to a location closer to x-ray on the second day of our inspection.
- Senior staff on Princess Anne ward had identified visitors and staff may be frustrated if staff were busy completing care tasks at times when visitors asked for updates on patients. In response to this, staff told us about a plan to introduce a 'question time' session, which would be ring-fenced time set aside for answering the questions of relatives and carers. This was not in place at the time of our inspection.

Access and flow

- Patients were admitted to the medical wards directly from the emergency department or from BAMS. BAMS accepted referrals from the emergency department or from GPs.
- Staff expressed concerns about delays in the daily post-take ward round on BAMS. The post-take ward round started at 8am each day. A consultant told us that ward rounds on BAMS usually finished at 10.30am if the ward was fully staffed, but could go on until 6pm if medical staffing was not complete. A junior doctor confirmed that there was a delay in senior review of patients when consultant shifts were not filled.
- The process for in-reach to BAMS from speciality medical teams was inconsistent. Staff used a 'red top referral' form to identify patients on BAMS who needed review by a speciality team. Staff told us that some speciality teams would use this, while others would visit the ward to identify patients for review or would communicate via specialist nurses. Two members of staff on BAMS told us that some medical speciality teams found in-reach difficult due to medical staffing problems and increased workload.
- Data showed the average length of stay for patients on BAMS from 1 August 2016 to 31 January 2017 ranged from 11 hours 58 minutes to 13 hours. This was within the planned length of stay of 24 hours.
- The average length of stay for patients was 4.7 days from November 2015 to October 2016. This was in line with the England average of 5 days.
- The average bed occupancy for the medical service from 1 August 2016 to 31 January 2017 was 93.6%. Research shows that if bed occupancy is over 85%, the quality of patient care can be affected.
- From 1 August 2016 to 31 January 2017, the average number of bed moves on medical wards per patient admission was two and the maximum number of bed moves ranged from nine in September 2016 to 18 in October 2016. In this period, the number of patients that moved beds three or more times during their admission ranged from 231 in September 2016 to 317 in January 2017. There was a high number of bed moves after 10pm. Data showed 384 bed moves after 10pm in August 2016, 359 in September 2016, 297 in October

Medical care (including older people's care)

2016, 394 in November 2016, 319 in December 2016 and 356 in January 2017. The frequent movement of patients between wards meant that continuity of care could have been affected.

- The number of medical outliers on medical wards was 117 in November 2016, 151 in December 2016 and 203 in January 2017. The number of medical outliers on surgical wards was 171 in November 2016, 281 in December 2016 and 429 in January 2017. Medical outliers are patients under the care of a medical consultant but placed on other wards due to a shortage of bed space. Staff told us that there was often a high number of medical outliers spread across medical and surgical wards. For example, two nurses on Southbourne ward (a surgical ward) told us there had been times when 20 out of the 30 patients on the ward were medical outliers.
- Five medical staff and three nursing staff told us that timely medical review of medical outliers was a problem. A senior member of staff on Benfleet ward stated that a lot of 'chasing' of medical specialities was required to ensure review of outlying patients and stated that patients often were not reviewed until 3 to 4pm.
- We observed staff on Southbourne ward discussing medical review of outliers on the day of our inspection. Three out of seven outlying patients had not been reviewed by 2pm. The medical team had contacted the ward sister to advise that the patients would be reviewed at 4pm. This meant that if any of the patients were fit for discharge, they would be unlikely to be discharged home that day due to the timing of their medical review.
- Patient records confirmed that the frequency of medical review for outlying patients was variable. We saw records for eight medical outliers and found that three of these patients had not received daily medical review.
- Staff on medical speciality wards raised concerns around timely medical review of patients. A senior member of staff on Princess Anne ward told us that ward round could be late due to the consultant visiting patients on outlying wards first. This meant that nursing staff sometimes did not get an update on patients' readiness for discharge until the afternoon. A nurse on Westcliff ward also told us that patient flow was affected

by medical staffing. Staff told us that the day before our inspection, there was only one junior doctor on the ward. There was no consultant on the ward and the registrar was unable to review patients until 4pm due to working in clinic. This meant that even though some patients were fit to go home, their discharge was delayed until the following day.

- Medical patients went to the discharge lounge prior to discharge. A nurse there told us that communication with the wards was variable. The trust had a set criteria for which patients were suitable to go to the discharge lounge.
- A doctor on BAMS told us that there was a large backlog of discharge summaries due to workload pressures on medical staff. We saw that this issue was included in the medicine risk register and actions were in place to improve this.
- Data from August 2016 to January 2017 showed the percentage of bed days lost due to delayed transfers of care ranged from 4.25% to 6.85%. This was worse than the trust target of 3.5%.
- Discharge coordinators followed up patients with medical teams on a daily basis and liaised with families and social care agencies to facilitate discharge. The discharge coordinators had information on patients whose discharge was delayed and told us they worked closely with social workers and ward nurses to ensure that discharge processes were followed. Four staff told us that a lack of care provision in the community could delay patient discharges.
- There was a stroke emergency phone, which provided direct contact between the emergency department and the stroke ward. This meant that the stroke consultant could be immediately alerted to any patient presenting with signs of a stroke in the emergency department. The ward manager on Benfleet ward told us that the early review and transfer of patients admitted with signs of stroke worked well.
- We saw an electronic record of all patients admitted with an acute medical condition in the last 24 hours. This allowed staff on BAMS to track which patients had been clerked and reviewed by a doctor.

Medical care (including older people's care)

- The average referral to treatment time for admitted patients in the medical service from January 2016 to January 2017 was 98%. This meant that 98% of patients received treatment within 18 weeks of referral.
- There were daily board rounds on medical wards, where staff discussed patients' management plans and arrangements for discharge.
- The clinical site manager collated the number of outlying patients on a daily basis. We saw a standard operating procedure and risk assessment for medical outliers. This meant that there was oversight of the number and location of medical outliers.

Meeting people's individual needs

- Two senior staff on Benfleet ward told us that one bay on the ward was used as a hyper acute stroke unit (HASU) and that this bay would often have male and female patients accommodated together. However, this bay was not categorised as a HASU by the trust and so should not have accommodated male and female patients in the same bay. On the days of our inspection, this bay was not used as a mixed sex bay. We raised this issue with senior staff at the time of our inspection and they confirmed that there was no HASU at the trust.
- There were specialist nurses in place to support the care of patients with complex needs. They included a specialist falls nurse, a learning disability nurse and a dementia lead nurse.
- We spoke to the learning disability nurse who told us that any patient with a learning disability was 'flagged' on the hospital computer system. This meant that the specialist nurse was aware of any patient with a learning disability admitted to the hospital and could provide appropriate support.
- The learning disability specialist nurse gave us an example of how teams worked together to meet the needs of patients with learning disabilities. For example, they told us how they worked with a patient and their family to coordinate care so that the patient could receive an element of medical care that they were anxious about while under a general anaesthetic for a surgical procedure they required. This meant that the patient received the medical care they needed while reducing the patient's anxiety.
- Staff were focused on meeting patients' individual needs. A health care assistant on Benfleet ward said "It's just finding out their individual needs – the small things." Staff told us how they had arranged for some knitting supplies to be provided for a patient with a learning disability who enjoyed this activity.
- All six patients we spoke to were positive about staff meeting their individual needs. One patient said they felt reassured as staff talked them through tests and procedures and another commented staff had treated them with "dignity and care".
- We saw staff offering a patient and his family a birthday cake to celebrate the patient's 90th birthday. The patient's family described the care given as "faultless".
- Patients living with dementia were identified using a 'forget-me-not' symbol on the patient board. This meant that staff could easily identify patients who may have complex needs due to dementia. Staff told us that 'This is me' booklets were used to give staff information on the needs and preferences of patients living with dementia. We saw these booklets in use on Benfleet ward. We saw dementia support boards on Paglesham ward and BAMS, which included information for relatives and carers on initiatives to support patients living with dementia.
- Staff told us about activities they provided for patients living with dementia. On Benfleet ward, we saw 'twiddlemuff' comforters, which were crocheted by staff and given to patients with dementia to provide sensory stimulation and reduce distress. The ward dementia lead and the ward manager told us about fundraising they had completed to provide activities for patients who were living with dementia.
- We saw a newsletter called "The Daily Sparkle" which was given to patients to encourage engagement, orientation and reminiscence. This was a daily newsletter, which included the day's date and features titled "On this day" and "Do you remember."
- Staff were offered training in supporting patients living with dementia, although this was not mandatory. Training available included topics such as understanding dementia, challenging stigma, myths and stereotypes and supporting people to live well with

Medical care (including older people's care)

dementia. We saw training records documenting individual staff attendance at training, although no percentage compliance or target for training compliance was included.

- We asked two members of staff about translation services and both told us that translation services were available for patients who did not speak or understand English.
- There was a named discharge coordinator for each ward. Staff on Westcliff ward and Benfleet ward told us they contacted the discharge coordinator to request assistance with discharge planning for patients with complex needs.
- The 'home from hospital team' helped patients with complex needs to settle back into their homes after discharge from hospital. This team supported patients by taking equipment to the patient's home, ensuring that heating and hot water was turned on and helping patients to make a meal when they returned home.

Are medical care services well-led?

Good



We have rated this service as Good for the well led domain. We found:

- Leaders were visible and approachable. Senior leaders took steps to engage with staff at ward level and listen to their concerns, for example through daily 'Safer at Southend' meetings.
- There were clear governance processes for sharing information with staff in the medical service. Senior staff shared information with staff through team meetings, information noticeboards and through the 'weekly roundup' newsletter.
- There were processes in place for escalating information to senior leaders. For example, ward managers used a 'red flag' system to identify staffing concerns and escalated their concerns to matrons and coordinators on a daily basis.
- We saw the risk register for the medical service, which identified risks to the service and included a 'RAG rating' of the level of risk, controls put in place to manage the

risk and timelines for review. Nursing and medical staff shortages were included on the risk register. This was in line with the concerns identified by staff we spoke to on the medical wards.

- Staff described positive working relations within their speciality teams. Junior doctors were positive about the support received from consultants.

However:

- Some staff on Bedwell Acute Medical Service did not always feel that their vision for the service was acted upon or incorporated into service plans or that their concerns around consultant staffing were listened to by senior leaders.
- Staff identified difficulties in communication between different speciality teams. One junior doctor told us about difficulties in communication between medical teams in the emergency department and BAMS. Two consultants told us there could be "friction" between different specialities and described a "silo culture."

Leadership of service

- The medical service was led by the clinical director. The role of clinical director for medicine was being filled by the lead clinical consultant for the emergency department at the time of our inspection.
- Staff were generally positive about visibility of senior leaders. Two nursing staff told us that the managing director and the medical director were "very visible and approachable". A consultant told us that the executive team were working very hard to improve the medical service.
- Staff were positive about local leadership at ward level. Ward managers were supportive of staff and communicated information to staff. We saw that ward managers were visible and approachable on the wards we visited.

Vision and strategy for this service

- On Bedwell Acute Medical Service (BAMS), senior medical staff had a vision for the service. However, they told us that they did not always feel that their ideas were acted upon or incorporated into service plans or that their concerns around consultant staffing were listened to by senior leaders. The BAMS service had been through several changes in the 18 months before

Medical care (including older people's care)

our inspection. Two senior staff told us there was “aspiration” to improve the service, however they felt some changes implemented were without adequate planning or consultation of staff.

- We saw evidence of executive level staff responding to the concerns of staff around service planning for BAMS. For example, staff told us that a meeting between all doctors and the medical director had recently taken place to discuss concerns.
- Medical and nursing staff were consistent in their ideas about strategies that would improve the service. Staff told us that increasing consultant staffing and focusing on ‘the front door’ would improve access and flow in the medical service.

Governance, risk management and quality measurement

- There were clear processes for sharing information with staff in the medical service. Senior staff shared information with staff through team meetings, information noticeboards and through the ‘weekly roundup’ newsletter. We saw three sets of team meeting minutes for Benfleet and Paglesham wards dated from 22 September 2016 to 30 January 2017. These showed that incidents, complaints, compliments and staff training were standing items on the agenda.
- There were processes in place for staff to escalate information to senior managers. For example, a “Safe at Southend” meeting took place every day and provided an open forum for staff to escalate safety concerns to senior managers. We observed this meeting and saw that there was attendance from around 50 staff members and there was discussion of issues including bed state, patient flow, ward moves and plans for improving the system for managing outlying patients.
- Ward managers understood and implemented processes for escalating staffing concerns. This meant that senior staff had oversight of staffing issues and could allocate available nursing staff to areas of greatest need. We saw evidence of senior staff taking action to increase staffing, for example through recruitment days.
- We saw the risk register for the medical service, which identified risks to the service and included a ‘RAG rating’ of the level of risk, controls put in place to manage the

risk and timelines for review. Nursing and medical staff shortages were included on the risk register. This was in line with the concerns identified by staff we spoke to on the medical wards.

- Local risks for wards within the medical service were recorded and monitored. We saw the risk registers for the stroke unit and BAMS, which identified risks around nursing staffing and skill mix. The risk registers included a ‘RAG rating’ of the level of risk and timelines for review.
- Staff meeting minutes showed evidence of actions taken to manage risk. For example, minutes from a team meeting on Benfleet ward on 30 January 2017, showed evidence of a speaker attending the meeting to discuss changes to an insulin regime. The ward manager told us that following this meeting, the new protocol was sent to staff and staff confirmed they had read it by signing a register.
- We saw a quality dashboard displayed at the entrance to each ward. This contained information on performance against quality indicators and used a ‘RAG rating’ system to indicate the wards performance against quality markers.

Culture within the service

- There was a positive culture within speciality teams on medical wards. Nursing staff described positive working relations with medical staff in their speciality. One member of staff on Princess Anne ward told us “we have good relations with medical staff and consultants,” a nurse on Westcliff ward said “teamwork is good” and a nurse on Benfleet ward said “The medical team here are really good, approachable.”
- Junior doctors were positive about the support they received from consultants, despite shortages in consultant staffing. We asked four junior doctors about support from consultants and all of them were positive about this. One junior doctor said they had “good support from consultants” and another said they were “well-supported by consultants.”
- We asked three therapy staff about multidisciplinary working and all three staff were positive about this. Therapy staff told us that other members of the multidisciplinary team listened to them.
- Senior staff on Benfleet and Paglesham ward focused on building a positive culture among staff. For example,

Medical care (including older people's care)

the ward manager on Benfleet ward told us about a training session they had organised with a 'National Patient Champion' who came to talk to staff to boost morale and identify actions for improving communication between staff. We saw team meeting minutes to document this session and the ward manager told us about actions that had come from this training. A junior member of staff on Benfleet ward told us they had attended a focus group about staff culture, which had made them feel more appreciated.

- Senior staff understood their responsibilities in relation to duty of candour.
- Staff identified difficulties in communication between different speciality teams. One junior doctor told us about difficulties in communication between medical teams in the emergency department and BAMS. Two consultants told us there could be "friction" between different specialities and spoke of a "silo culture" which could cause difficulties when agreeing where junior doctors spent their time.
- Three nursing staff told us that communication with medical teams for outlying patients on their wards was not always good. Nursing staff gave us examples relating to a lack of direct communication between medical teams and ward nursing staff when medical teams came to review their outlying patients.
- A healthcare assistant on Benfleet ward told us "staff shortages are stressful" and another healthcare assistant said, "staffing is too much of a pressure."







Staff engagement

- We saw evidence of senior staff taking steps to engage with staff about plans for the service. One member of staff told us about a BAMS restructuring group with junior doctor representation. Another doctor told us that a meeting had been organised between all doctors and the medical director following feedback from an outside organisation. They said this was "productive" and the medical director took on board issues and concerns from medical staff.
- One junior doctor told us about a junior doctor communication group, which met every two weeks with the medical director and managing director.
- Daily "Safe at Southend" meetings took place, where staff could raise concerns around patient safety. One junior doctor told us that "things brought up [in this meeting] are acted upon."
- Monthly staff meetings took place on medical wards. However, on two wards we visited staff told us that recent meetings had been cancelled due to staffing. This meant that local leaders may have missed opportunities to engage with staff.

Innovation, improvement and sustainability

- Staff told us that quality improvement meetings occurred every six to eight weeks. Quality improvement projects were presented and reviewed at these meetings. This meant that staff had a forum to suggest improvements to the service.

Surgery

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

Information about the service

We completed a responsive inspection of the surgical service at Southend University Hospital NHS Trust on 9 February and 10 February 2017. This inspection was in response to information of concern about the safety, responsiveness and leadership of the service.

Our inspection team primarily looked at the pathway taken by patients admitted to the hospital with an acute condition. We visited the Chalkwell surgical assessment unit, four speciality surgical wards including Shopland and Hockley (orthopaedic), Balmoral (vascular) and Stambridge (surgical and surgical high dependency unit). We also visited J Alfred Lee ward (theatre recovery), theatres and the elective admissions unit.

We spoke to 29 members of staff, including four ward managers, four consultants, three junior doctors, eleven nurses, two health care assistants, two operating department practitioner and three support staff. We spoke to five patients. We observed a theatre safety briefing and looked at eight patient care records. We also looked at equipment, information displayed in the department and reviewed information including meeting minutes, action plans and staff training data.

Summary of findings

We found:

- Nursing teams were regularly short staffed. Data provided by the hospital showed that planned versus actual staffing had dropped from 100% across the service in November 2016. We saw that in January 2017 Chalkwell surgical assessment unit (SAU) had 93.4% of their staff number of registered nurses at night and Shopland ward had 80.6% of registered nurses during the day shift. Shortfalls were covered by bank and agency staff where possible. Staff would also be allocated from other wards. Three senior nurses told us that this impacted the skill mix on the wards and that on occasion shifts would not be covered.
- Three surgical wards we visited did not have a ward based pharmacist which meant that patient medicines were not reviewed by a qualified pharmacist. This meant that there was no oversight of medications management and could lead to medication errors.
- There were a large number of medical outlier patients on surgical wards. In January 2017 there were 429 medical outliers across the surgical wards. Four nurses told us that patients were reviewed late in the day and a member of the surgical ward staff was not always present meaning that updates on the patient's treatment were not communicated effectively.

Surgery

- During the period October to December 2016, 146 operations were cancelled of which 24 patients were not offered another appointment with 28 days.

However:

- Staff had a good understanding of incident reporting procedures and received feedback on incidents reported.
- Senior managers had completed detailed investigations into the recent never events and shared this learning with staff through team meetings, noticeboards and the 'weekly roundup' newsletter.
- Theatre had established five extra Saturday all day theatre lists to help manage waiting lists. These lists were flexible and could be utilised by each speciality. The emergency service ambulatory care service had been established on Chalkwell ward to support the surgical assessment unit to help prevent unnecessary admissions.
- Leaders were visible and approachable. There were opportunities for leaders to engage with staff at ward level and listen to their concerns.
- Staff described positive working relations within their speciality teams and across the hospital as a whole.
- Junior doctors were positive about the support they received from consultants.
- Consultants we spoke with confirmed a positive culture of interdisciplinary working. There was regular internal multi- disciplinary team working with all teams supportive to provide the best outcome for their patients.

Are surgery services safe?

Requires improvement



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

- Three surgical wards we visited did not have a ward based pharmacist which meant that patient medicines were not reviewed by a qualified pharmacist. This meant that there was no oversight of medications management and could lead to medication errors.
- Nursing teams were regularly short staffed. Data provided by the hospital showed that planned versus actual staffing had dropped from 100% across the service in November 2016. We saw that in January 2017 Chalkwell surgical assessment unit (SAU) had 93.4% of their staff number of registered nurses at night and Shopland ward had 80.6% of registered nurses during the day shift.
- Staff compliance with sepsis training was variable. Training records from November 2016 for example showed that on Chalkwell SAU 93% of staff had received training whereas on Balmoral ward only 10% of staff had been trained.
- The electronic prescribing system did not include a visual reminder or any form of automatic reminder for clinical staff to review prescribed antibiotics after 72 hours. This potentially could lead to antibiotics being administered for longer than the prescribed course.

However:

- Staff had a good understanding of incident reporting procedures and received feedback on incidents reported.
- Senior managers had completed detailed investigations into the recent never events and shared this learning with staff through team meetings, noticeboards and the 'weekly roundup' newsletter.
- Staff stored medicines securely and completed twice daily checks of controlled drugs (CDs) to ensure that all stock was monitored and accounted for.
- We found good compliance with the World Health Organisation (WHO) 'five steps to safer surgery' checklist, designed to reduce the number of surgical errors and enhance patient safety during the perioperative phase of care.

Surgery

Incidents

- There were two recent never events in surgery, (in October 2016 and January 2017). The first involved the implant of a wrong component during knee replacement surgery. The second was the retention of a swab tag which was discovered when the patient was returned to surgery after post-operative complications. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- We reviewed the root cause analysis for the never event in October 2016 and found evidence of learning which was shared among the surgery teams. We saw that there was a robust action plan involving a change of practice. Staff we spoke with in theatre were aware of the never event and the changes in practice had been implemented.
- Theatre staff told us that there was an immediate response following the retention of a swab tag in January 2017. An immediate action plan was put in place. The incident was discussed at the team meeting the following day and procedure was implemented for tag checks to be included in swab counts. The incident was discussed at the 'Safe at Southend' meeting led by the executive team.
- Staff told us that there was an open culture and they were encouraged to report incidents via the electronic datix system. All 12 members of staff we asked were able to explain how they would report an incident. They told us that they could request email notification with the outcome of an investigation and any changes that had been implemented. A healthcare assistant (HCA) on Hockley ward gave an example of an incident that was reported about low staffing levels impacting on patient safety. This was investigated and an extra HCA had been put onto the day and night shift. .
- Learning from incidents were shared with staff via emails and team meetings. We reviewed four sets of meeting minutes which confirmed this. For example in the theatre clinical governance meeting minutes and saw that serious incidents and action plans were a standard agenda item. Minutes from a governance meeting held on 7th February 2017 showed that the never event involving the retention of a swab tag and the immediate action plan was discussed. A nurse on Chalkwell surgical assessment unit (SAU) told us that learning sessions with reflection on incidents were run by the ward manager.
- Staff were encouraged to attend "Safe at Southend" meeting held daily at 8am where learning from incidents were shared. However due to staff shortages we were told that it was not always possible to release staff from each clinical area to attend. The surgical directorate ran monthly drop in sessions where incidents were discussed and learning shared.
- We saw safety notices on the ward and in staff areas, including a safety board in the theatre corridor and infection control and adult safeguarding information.
- Morbidity and mortality meetings took place which included discussion of patient case presentations, recommendations and actions including escalation of issues to be discussed at the next governance meeting. We saw evidence of this in governance meeting minutes.
- Staff were aware of duty of candour which states that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff told us that a patient would be informed by a senior member of the staff. A form was completed with details of the discussion which was kept in the patient's notes.

Safety thermometer

- Staff collected information for the NHS safety thermometer, although this was not displayed on the wards we visited. The NHS safety thermometer is a national initiative and local improvement tool for measuring, monitoring, and analysing harm free care. Staff reported the number of falls, catheter-related urinary tract infections (CUTIs) and cases of venous thromboembolism (VTE) on a monthly basis.
- Results from the NHS safety thermometer showed that on Stambridge ward there were an average of 0.3 catheter-acquired urinary tract infections (CUTIs) per month from January 2016 to January 2017, 8 new pressure ulcers, 0.1 cases of venous thromboembolism (VTE) and an average of 0.3 falls with harm. On Balmoral ward there was an average of 0.4 CUTIs per month, no falls with harm, one new pressure ulcer and no cases of VTE in this period.

Surgery

- We spoke to a nurse on Stambridge ward who told us how new pressure ulcers were recorded and treated. The incident would be reported to a senior staff member and reported on datix. Medical photographs would be taken and the patient would be put on a pressure ulcer care pathway. This would be explained to the patient.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean including storage rooms and dirty utilities.
- The trust had a robust infection control policy in place for example the policy for the prevention and control practice in the operating department. The policy was up to date and in line with best practice guidelines. Staff we spoke to were aware of the policies and were able to access them via the trust intranet.
- Hand sanitiser was available at the entrance to each ward and clear signage was in place asking all staff and visitors to wash their hands and to follow the trust policy on infection prevention, protection, and control when entering or leaving wards or clinical areas. We saw staff use the hand sanitising gel.
- Staff adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment such as gloves and aprons during care. Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilising the hand sanitizer where appropriate. However we observed a healthcare assistant on Chalkwell ward reviewing a patient's notes whilst wearing gloves which is not best practice.
- We saw green 'I am clean' stickers across the service stating that the equipment was clean and was safe to use. However on Stambridge ward we saw that there were no "I am clean stickers" on and HDU IV stand and trolley, PEG feed stand and a bed. Inconsistency with stickers meant it was unclear which equipment was clean and ready for use.
- Training records provided by the trust showed 93% compliance with infection control training for staff in the surgical service. This was above the trust target of 85%.
- We spoke with a member of the domestic team and discussed their daily work regime. They told us that they

took pride in their work and if a member of their family were on the ward they would expect them to be in a clean environment. They were currently undertaking British Institute of Cleaning Science (BICSc) training.

- Sharps bins were appropriately managed across the service. Staff completed appropriate documentation and ensured bins were well maintained and closed in most areas we visited. However the sharps bin on the sepsis trolley on SAU was open and we saw that it was full. We brought this to the attention of a nurse at the time of inspection and it was closed, disposed of and replaced appropriately.
- There were systems in place for sterilising reusable flexible laryngoscopes which provided emergency cover for incidences where patients were difficult to intubate. Two scopes were processed and ready for use and disposable scopes were available should the need arise.
- We saw records in theatres showing daily cleaning of surfaces and equipment were fully completed for February 2017.

Environment and equipment

- Emergency resuscitation equipment was available in theatres with records in place that demonstrated daily checks were completed for January 2017 up to the date of our inspection.
- There was a system in place for full tracking and traceability of loan equipment in theatre. This meant equipment was obtained, processed appropriately and ready for use.
- We checked 12 pieces of equipment and found that all but one had been serviced in line with the manufacturer's safety requirements with the exception of one cardiac monitor on Stambridge ward.
- We checked the resus trolley in all areas we visited and found that daily checks had been carried out in January 2017 and equipment was in date with the exception of Chalkwell SAU where we found a syringe that was past expiration date. We brought it to the attention of the nurse in charge and it was replaced.
- We found that there were gaps in the daily checks of the sepsis trolley on Chalkwell ward. Checks were not done on seven days in November 2016 and four days in January 2017. We raised this with senior staff at the time of inspection and were assured checks would be completed.

Surgery

- Theatre staff told us that there had been an extended delay in the repair of the buzzers in theatre one, two and eight. This was reported and was on the risk register but they had been broken for over a month. The situation had been mitigated by the use of temporary buzzers.
- There was a nominated senior member of staff as laser protection supervisor (LPS). The consumables and instruments on the ENT laser trolley were in date and the laser log was completed appropriately. However not all documentation had been updated; local rules were not dated, there were no details of laser trained staff and the latest audit was not present in folder. We raised this with the senior team and were provided with details of the last laser audit on 9 June 2016, details of update training for the LPS in November 2016 and a training course for staff. The senior team acknowledged that the recording of information could improve.
- The overflow ward on the surgical assessment ward only had one bathroom for 12 patients. Staff had raised this issue to management and it was on the risk register. However staff told us that only male patients were allocated to this bay and patients were made aware of the situation.
- Due to the overflow ward being established by partitioning off the area from another ward there were no permanent bed alarms. A temporary bedside alarm system had been set up connected to the nurses station in the surgical assessment unit. Therefore patients were able to alert the nurses if they required assistance.

Medicines

- The hospital used an electronic prescribing system, which improved the overall processes for prescribing, ordering, administration and recording of medicines. This meant that medicines could be ordered online direct from pharmacy. This helped to reduce the waiting time for medicines and ensured clinical staff had access to patients' prescribed medicines at all times.
- The electronic prescribing system which replaced paper medicine did not include a visual reminder or any form of automatic reminder for clinical staff to review prescribed antibiotics after 72 hours. This potentially could lead to antibiotics being administered for longer than the prescribed course.
- Patient allergies were recorded in the patient notes we reviewed.
- We reviewed the controlled drugs in theatre five and on Stambridge and Chalkwell SAU. We found that daily

morning and afternoon checks were completed. Medication checked was within expiry date and stock levels matched records. We saw that daily fridge and storage room temperature checks were completed and recorded in the areas we inspected from January 2017 to the date of our inspection which meant that medications that needed to be kept within a defined temperature range were stored appropriately.

- Learning from medicine incidents was shared on the ward with lessons learnt. Recent medicine safety bulletins and alerts were displayed on medicine door cupboards.
- Medicines were stored securely in locked cupboards on Chalkwell SAU, Stambridge ward and Balmoral ward. There were no doors to the medication storage rooms, however all IV fluids, needles and sharps were stored in locked cupboards. On Shopland ward medicines were stored safely and securely in a new purpose designed treatment room. We were told that there were plans to build similar treatment rooms on Stambridge and Balmoral ward. We saw that work had been started for a new treatment room on Chalkwell SAU. Keys for the medication cupboards were held by the nurse in charge on the ward.
- On Stambridge ward a ward based clinical pharmacist service had been reinstated since the previous inspection. Patients' prescription charts were regularly checked and reviewed by a pharmacist to ensure the safe prescribing of medicines. However there were no ward pharmacists allocated to the Chalkwell surgical assessment unit, Balmoral wards or Shopland ward. This meant that patients' prescribed medicines were not always reviewed or checked by a pharmacist.

Records

- We reviewed eight patient records. All records included consultant assessment, venous thromboembolism (VTE) assessment and nutritional needs, details of the patient's admission, risk assessments, pre and post – surgery treatment plans and records of multidisciplinary therapies provided.
- We looked at preoperative records, including completed preoperative assessment forms. Records were legible, accurate and up to date.
- The trust used paper records and staff kept records securely in lockable trolleys within staff areas on each ward we visited.

Surgery

- All of the records we reviewed were signed and dated by staff and legible.

Safeguarding

- There were clear processes and procedures in place for safeguarding adults and children. Policies were in place and were available for staff to access through the trust's intranet system. Staff we spoke with knew how to recognise abuse and make a safeguarding referral. Safeguarding referral guidance was available on staff notice boards and in staff information folders.
- Safeguarding was included in mandatory training, up to level two for both adults and children. Data provided by the hospital showed that 93% of surgical staff were up to date with their safeguarding training.
- There was a designated safeguarding lead within the hospital. Staff were able to identify who the lead was and how they would contact them.

Mandatory training

- Mandatory 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. Subjects included infection control, fire, falls prevention, information governance, conflict resolution, patient manual handling, equality and diversity, safeguarding, mental capacity act and deprivation of liberty.
- Staff we spoke with said the trust was supportive in offering training, but due to staffing levels and shift patterns they were not always able to attend training sessions or access training on line. Staff had instant online access to their own individual training record from any computer or workstation. The record gave an overview of completion against the trust training target, time scales for training updates and training opportunities available to staff.
- The mandatory training rate for staff in theatre was 85% meeting the trust target. The mandatory training rate for staff on the surgical wards was 84%, just below the trust target. The ward manager on Stambridge ward confirmed their mandatory training was at 92%. However they told us that they struggle to get staff to attend the conflict resolution course as it is a four hour face to face course and it was difficult to allocate staff time due to the demand on the rota.

Assessing and responding to patient risk

- The National Early Warning Score tool (NEWS) which assesses whether a patient's condition is deteriorating was used in all the surgical wards we visited. 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 at risk following observations.
- Nurses completed observations and NEWS scores on hand held computers (nurses centre pads). The nerve centre provided the ward manager and matron over view of patients and provided continuity between nurses and shifts.
- Where patients had scored as being at risk on NEWS the nerve centre would automatically notify the outreach team, which helped staff respond rapidly and appropriately.
- The world health organisation (WHO) five steps to safer surgery checklist was utilised and audited in all theatres. A local observational audit was undertaken by senior staff within theatres five times a month as a quality assurance measure. All aspects of the five steps were audited including team briefing, sign in, time out, sign out and debrief.
- During our observations in theatres we found good compliance with the World Health Organisation (WHO) 'five steps to safer surgery' checklist, designed to reduce the number of surgical errors and enhance patient safety during the perioperative phase of care.
- 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. Staff monitored performance on completion of risk assessments. A dashboard was displayed on most wards we visited. This included information about compliance with documentation of risk assessments, such as falls assessments. Each area was given a red/amber/green (RAG) rating to indicate performance against targets. We saw on Stambridge ward that VTE risk assessments had been below the trust target and an action plan had been developed and implemented to improve compliance.
- Staff had received sepsis training although training rates were variable across the service. For example on Chalkwell SAU 93% of staff had received training whereas on Balmoral ward only 10% of staff had been trained.

Surgery

- Four senior staff members expressed concerns around response from medical doctors to attend medical outliers on the wards. Outliers relate to patients who were situated away from the speciality they should have been admitted to. They told us that patients were reviewed late in the day and a member of the surgical ward staff was not always present meaning that updates on the patient's treatment were not communicated effectively.
- We observed a medical team arrive to review a patient on a surgical ward. The patient confirmed that they had seen their doctor daily. The team did not have a nurse from the surgical ward attend the patient review which meant that the nursing team were not immediately kept up to date with any changes in the patients care.
- Staff told us that medical outliers placed on a surgical ward were risk assessed by a clinical nurse before being allocated to the ward. Staff reported that the patient's medical team bleep number was not always in the records meaning that it was difficult to contact the medical team if the patient's condition changed. We reviewed two patient risk assessments for medical patients on Chalkwell ward and found that the contact bleep number was not recorded in either case. The senior nurse told us that there was a telephone number to contact a medical team if they were unable to contact the patient's doctor.
- An overflow ward had been established on the surgical assessment ward by partitioning a section of the children's ward. The doors to the children's ward were locked. Temporary patient call bells had been set up and would alarm at the nurses station. Staff expressed concern that the six beds in this area were not visible from the nurses station or other areas of the ward.
- Due to bed capacity issues elective surgical procedures were cancelled. At our last inspection we found that the decision around cancellations was not being made by a clinical member of staff. We found that now all cancellations received a clinical review and input which meant that patients clinical needs were risk assessed before a decision was made to cancel operations.
- Data provided showed that in November 2016 planned versus actual staffing numbers were over 100% for both registered nurses and HCA's across all surgical wards. In January 2017 this figure dropped. For example Chalkwell SAU had 93.4% of their staff number of registered nurses at night and Shopland ward had 80.6% of registered nurses during the day shift. Shortfalls were covered by bank and agency staff where possible. Staff would also be allocated from other wards. Three senior nurses told us that this impacted the skill mix on the wards. They said that on occasion shifts would not be covered.
- Staff told us that teams are regularly short staffed and that staff were relocated to cover short falls in staffing in other areas. During our inspection we saw an HCA on Balmoral ward requested to cover on the stroke unit. The ward were already one HCA short for that shift. The ward manager contacted the matron who over rode the decision and the HCA stayed on the ward. The ward manager confirmed that this was a recurring problem.
- Theatres had a full establishment for nursing staff. There were six vacancies for operating department practitioners (ODP's). Short falls in the rota were covered by bank and agency staff.
- In the theatre office we saw a file with an induction checklist for bank and agency staff and student nurses. We saw that the check list included induction to the environment, incident reporting, emergency procedures, IT systems and WHO check. Staff CV's were held on file and the checklists were signed and dated.
- A senior nurse on Chalkwell ward told us staffing could be a challenge because the planned levels did not account for the extra medical patients on the overflow ward.

Surgical staffing

- All specialities reported that consultant on call cover was available providing 24 hours access to consultant led care.
- Consultant level ward rounds occurred daily including at the weekends in all specialties. One consultant felt that there was a reduced nurse attendance on elective ward rounds due to work load and staffing levels. This led to failures in communication, repetition and inefficiencies.
- Orthopaedics staff reported that there were vacancies for a specialist registrar and three junior doctors. Gaps in the rota were filled by locums.

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 levels.

Surgery

- Six members of staff reported that medical patients on the ward were the last to be reviewed. Communication with the medical team was sometimes difficult and they often were not notified that the team were on the ward and so it was difficult to find out about care for the patients.
- Junior doctors reported that they were well supported by consultants in surgery, and felt that they were always able to discuss issues with them.

Are surgery services effective?

Good



Are surgery services caring?

Good



Are surgery services responsive?

Good



We have rated this service as Good for the responsive domain. We found:

- The proportion of patients waiting 18 weeks or less from Referral to Treatment (RTT) in general surgery was 76%, trauma and orthopaedics 79%, ENT 86%, urology 84% and ophthalmology 89%. This was in line with the England average.
 - Theatre had established five extra Saturday all day theatre lists to help manage waiting lists. These lists were flexible and could be utilised by each speciality.
 - There was an ambulatory wound care service based on Balmoral ward. This was a three bedded unit that took referrals from GP's, podiatry, other wards in the hospital and A&E. This helped improve access and flow by preventing admissions and enabling earlier discharge of surgical patients as their wound care could be managed in the clinic.
 - The emergency service ambulatory care service had been established on Chalkwell ward to support the surgical assessment unit to help prevent unnecessary admissions
- . However:
- In January 2017 there were 429 medical outliers across the surgical wards which was one issues having an impact on the cancellations of elective surgery.
- ### Access and flow
- The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. The data provided by NHS England for December 2016 showed the proportion of patients waiting 18 weeks or less from Referral to Treatment (RTT) in general surgery was 76%, trauma and orthopaedics 79%, ENT 86%, urology 84% and ophthalmology 89%. This was in line with the England average.
 - During our inspection five senior nurses and two consultants raised concerns about the number of medical outliers on the surgical wards impacting the cancellation of elective surgery. Data provided by the hospital showed that in November 2016 there were 171 medical patients on surgical wards. In December this figure rose to 281 and in January 2017 the figure was 429.
 - Data provided by the hospital showed that between November 2016 and January 2017 162 elective surgeries across all specialities were cancelled at short notice. Sixty-two were cancelled due to no beds being available, 24 because theatres were unavailable and 15 because of emergency admissions. A general surgeon told us that cancellations increased steadily due to internal critical incidents around bed capacity and medical outliers. Data provided by the hospital showed that between November 2016 and January 2017 21 general surgery elective operations were cancelled because there was no bed available for the patient.
 - During the period October to December 2016 146 operations were cancelled of which 24 patients were not offered another appointment with 28 days.
 - The process for cancellation of elective operations was discussed at the bed management meeting and discussed with clinicians before a final decision to cancel was made which meant that the clinical needs of the patient were risk assessed before a decision was taken to cancel a patient's operation.
 - There were 1000 patients waiting for total knee and total hip replacements. An orthopaedic consultant told us that elective joint replacements were cancelled due to medical outliers on orthopaedic wards and trauma

Surgery

cases being placed on the joint replacement unit. Data showed that between November 2016 and January 2017 15 orthopaedic cases were cancelled due to no beds being available and four were cancelled for an emergency.

- There was good overview and management of theatre utilisation by the theatre manager and matron. Theatre had established five extra Saturday all day theatre lists to help manage waiting lists. These lists were flexible and could be utilised by each speciality. For example on the Saturday 11th February we saw that orthopaedic, gynaecology, urology and general surgery lists had been scheduled. Trauma theatre ran for emergency cases on Saturday morning between 8am and 1pm.
- Theatres had an organised process for extended stay in recovery for nephrectomy patients. Surgery was scheduled for Mondays with additional recovery staff allocated overnight. This meant the patient stayed in recovery and were then discharged to the ward the next day, alleviating the pressure and capacity in the high dependency unit (HDU).
- A patient flow officer worked within the musculoskeletal service. They liaised between elective orthopaedic and trauma and social care. This had increased flow and helped to facilitate earlier discharge of patients through establishing links between hospital and social care.
- There was an ambulatory wound care service based on Balmoral ward. This was a three bedded unit that took referrals from GP's, podiatry, other wards in the hospital and A&E. This service helped improve access and flow by preventing admissions and enabling earlier discharge of surgical patients as their wound care could be managed in the clinic.
- Balmoral ward was one of the wards trialling red and green days, a system that tracks patient's progress to discharge. There were plans to roll this out across the hospital to improve patient flow and help to prevent delays in patient discharge.
- Patients for elective procedures attended a nurse led surgical pre-assessment appointment. Within pre assessment they were trialling a new triage system to assess which patients had more complex needs. This meant they could allocate patients longer appointment times to try to improve flow through the clinic.
- Anaesthetic consultants were rostered to cover pre-assessment and were available to review patients if required. Anaesthetists were available in clinic on

Tuesday and Friday afternoons and on call outside of these times. A business case had been submitted for an anaesthetic lead to be available every day. Pre assessment guidelines were being reviewed. We were told that currently a patients' assessment was valid for up to four months before the patient would have to be reassessed if they were still waiting for their surgery.

- The emergency service ambulatory care service had been established on Chalkwell ward to support the surgical assessment unit to help prevent unnecessary admissions. The service saw 8-10 patients a day. They accepted referrals from GPs, A&E and community nurses. Nurse navigators triaged patients and organised blood tests and diagnostic imaging. Patients were then seen by a consultant.
- Discharged patients attended the service for drain assessment and wound review which enabled the patient to be discharged from hospital earlier.

Meeting people's individual needs

- Single sex accommodation was available across all clinical areas.
- Staff told us they had access to translation services. Translators could be organised to attend the hospital or were available by telephone if required at short notice.
- 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 forget me not identifiers on the ward to ensure staff awareness. There was a lead dementia care nurse for the musculoskeletal service and a dementia lead nurse on the surgical assessment ward. Staff we spoke with were aware of needs of patients living with dementia.
- All five patients we spoke to were positive about staff meeting their needs. One patient told us that they felt safe as staff kept them informed at all times. Another patient said that they had been very happy with their care and felt that all their needs had been met.
- Medical staff had support from psychiatry and the mental health team when providing care to patients with complex needs. Staff said the team were very responsive.
- The learning disability nurse was notified when a patient with a learning disability was on the ward via the hospital computer system. This meant that a specialist nurse was aware of any patient with a learning disability admitted to the hospital and could provide appropriate

Surgery

support. Staff were able to tell us about extra support that may need to be provided when caring for patients with learning difficulties. This included taking extra time to explain things to the patient and facilitating allowing carers to stay with the patient for the duration of their stay in hospital.

- The spiritual needs of patients, staff and visitors were supported by the spiritual care and chaplaincy department.
- Diabetic patients could access ambulatory wound care service based on Balmoral ward on the day of referral meaning that they could access prompt wound evaluation and treatment.
- A consultant on Balmoral ward told us that there was very good multidisciplinary working to meet the individual needs of patients with many comorbidities that were being treated on the ward.
- A support tool to help patients keep informed about their care had been implemented on Balmoral ward. On each patient trolley there was a sign outlining four questions the patient should ask their doctor. These were: what's wrong with me, what are you looking for? What's going to happen today and tomorrow, what needs to be achieved to get me home and when is this going to happen? This helped patients ask the right questions so they understood and were involved in the care they were receiving. One patient we spoke to said that it had been very helpful to them as they would often forget what to ask when the doctors did their ward rounds and this acted as a useful prompt.

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.
- Learning from complaints was shared locally to staff at team meetings. We saw examples of minutes of staff meetings dated 17th January 2017 and 16th October 2016 which showed discussion of complaints was a standing agenda item.

Are surgery services well-led?

Good



We have rated this service as Good for the well led domain. We found:

- There were clear governance processes and information sharing with staff in the service. Senior staff shared information with staff through team meetings, information noticeboards and through the newsletters.
- Leaders were visible and approachable. There were opportunities for leaders to engage with staff at ward level and listen to their concerns.
- Staff described positive working relations within their speciality teams and across the hospital as a whole. Junior doctors were positive about the support they received from consultants.
- Consultants we spoke with confirmed a positive culture of interdisciplinary working. There was regular internal multi-disciplinary team working with all teams supportive to provide the best outcome for their patients.

However:

- A member of staff told us that due to the fact that the hospital had been at capacity for six weeks prior to our inspection there had been a lot of pressure on staff and this had caused some team members to be quite abrupt.

Leadership of service

- We saw strong leadership across the surgical service. In the operating theatres both the theatre manager and matron worked clinically alongside the theatre team.
- Staff were positive about visibility of senior leaders. Three members of staff told us that the managing director and the head of nursing were "very visible and approachable". A consultant told us that the executive team were working hard to improve the hospital.
- Junior doctors told us they felt well supervised by consultants and described consultants as supportive and encouraging.
- There were three matrons across the surgical service. Staff told us that they were very supportive and would visit their areas of responsibility daily and were available to offer assistance when required.

Surgery

- Nursing staff told us that they felt supported by their direct line management and felt able to raise any issues or concerns.
- One trauma and orthopaedic consultant felt that their concerns were not listened to by senior management and felt marginalised.
- There was strong, cohesive management of theatres between matron and the theatre manager.

Governance, risk management and quality measurement

- A governance framework was in place to monitor performance and risks. The surgical risk register reflected the risks we identified within the service. We saw that all risks recorded had recorded cause and effect, control measures documented and dates for completion or review of actions. These risks were escalated to the corporate risk register.
- The three directorates covering surgical services 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.
- Staff were able to escalate information to senior managers. For example, a “Safe at Southend” meeting took place daily and provided a forum for staff to escalate concerns to senior managers. Staff told us issues discussed included bed state, patient flow, ward moves and plans for improving the system for managing outlying patients.
- Ward managers understood and implemented processes for escalating staffing concerns. This meant that senior staff had oversight of staffing issues and could allocate any available nursing staff to areas of greatest need.
- Staff said that safety and governance issues were highlighted to staff groups through the monthly team brief, at sisters and team meetings and by email.
- Trust board involvement was evident in relation to risks such as never events and serious incidents.

Culture within the service

- Staff across the surgery service told us that staff at all levels were supportive, approachable and friendly.

- There was open communication and effective team work within theatres between all staff grades and between medical and nursing teams. Staff felt able to provide feedback and raise concerns and described a positive working environment
- There was a strong emphasis on promoting wellness. Staff reported that they felt supported by their local managers and had regular meetings providing support around health and wellbeing which was especially valuable as the service had been under so much pressure.
- Staff reported strong working relationships with teams throughout the hospital including the outreach team, dementia team and the hospital at night team.
- All patients we spoke with acknowledged a caring and positive culture within surgery and were happy with their care and treatment.
- Consultants we spoke with confirmed a positive culture of interdisciplinary working. There was regular internal multi- disciplinary team working with all teams supportive to provide the best outcome for their patients.
- We saw staff interacted in a supportive way within the department to ensure a safe and positive environment for patient care despite the pressures on the service. One staff member told us that the hospital felt a better place to work than it did a year ago. Another staff member said that they were very proud of their team.
- Senior staff we spoke with knew of their responsibilities in relation to the Duty of Candour.

Staff engagement

- Notice boards were located across the service. They shared information to keep staff up to date with the latest developments within the service, performance against targets, training opportunities and patient outcomes.
- A weekly newsletter was produced by the matrons updating staff on developments within the service and across the hospital.
- Monthly staff meetings took place on surgical wards and within theatres allowing local leaders to engage with staff and offer staff the opportunity to share concerns and receive feedback on the service performance.
- The daily safe at Southend meeting was an opportunity for staff to engage with issues affecting the hospital as a whole. However on a number of wards we visited staff said it was not always possible for a staff representative

Surgery

from the ward to attend due to short falls in staffing numbers. The deputy sister on Stambridge had been allocated non clinical time to support new staff. Staff reported that they had regular 1:1 meetings and felt that they were well supported and issues were dealt with quickly. Two members of staff told us that this had helped them feel involved and engaged with the ward and the service.

- A simulation unit opened last year in the education centre. It was designed to look and feel like a typical patient bay and could stage any medical scenario for training and better understanding. The simulation suite could be adapted for all levels of clinical need and allowed staff to practice skills and management of patients. Senior staff told us that the unit had created a “buzz and momentum.”

Innovation, improvement and sustainability

- The hospital offered an outpatient service to improve diagnosis and treatment for patients with pelvic floor problems. The pelvic floor dysfunction unit was for patients across Essex which had prevented the need for patients to travel to London for treatment. This was an award winning unit which offered a one stop clinic to improve patient flow and reduce waiting list pressures.
- A glaucoma shared care programme was being established. Working with the clinical commissioning group (CCG) and local optometrist the programme aimed to offer patients an initial review at hospital, the next two reviews in the community and third review at the hospital. The aim is to get 4000 optometrists trained giving patients choice to be seen at hospital or in the community.
- There was a consultant led emergency surgery ambulatory care service located on the surgical assessment unit to help prevent admitting patients unnecessarily. They were winners of the hospital hero award in October 2016.
- We saw that there had been improvements in the infrastructure in theatres. Two theatres had been renovated and an endovascular theatre had been opened. The laparoscopic theatre was in the progress of being renovated as part of a rolling programme of maintenance and improvement.
- The ambulatory wound care service based on Balmoral ward helped improve access and flow by preventing admissions and enabling earlier discharge of surgical patients as their wound care could be managed in the clinic.

Outstanding practice and areas for improvement

Outstanding practice

- There was a stroke emergency phone, which provided direct contact between the emergency department and the stroke ward.
- Surgeons are undertaking innovative surgery for stroke patients during which they remove the blood clot to ease pressure on the brain. This reduces the symptoms that stroke patients' experience.
- Ambulatory wound unit on Balmoral ward taking referrals from community, podiatry, GP's as well as wound care for discharged patients. Focused on early intervention and admission avoidance.
- The ED had created a Trauma Assessment Centre (TAC) as an extension of the fracture clinic, where patients were streamed directly to be seen for treatment.

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- The hospital should ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced consultant medical staff to meet the needs of patients in the medical service.
- The hospital should ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced junior medical staff available on BAMS to meet the needs of patients.
- The hospital should ensure there are sufficient numbers of suitably qualified competent, skilled and experienced nursing staff available in the medical and surgical services to meet the needs of patients.
- The hospital should ensure that there are processes in place to make sure that medical outliers are reviewed by their speciality team in a timely way.
- The hospital should ensure that staff complete mandatory and safeguarding adults and children training in line with trust targets.
- The hospital should ensure staff are trained in the recognition and management of sepsis to the appropriate level in line with trust targets.
- The hospital should ensure all fridge temperatures for the storage of medication are recorded and acted upon in line with trust guidance.
- The hospital should ensure that male and female patients are not accommodated in the same bay on the stroke unit.