

## Basildon and Thurrock University Hospitals NHS Foundation Trust

# Basildon University Hospital

## Quality Report

Nethermayne

Basildon

Essex

SS16 5NL

Tel: 01268 524900

Website: [www.basildonandthurrock.nhs.uk](http://www.basildonandthurrock.nhs.uk)

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

## Ratings

### Overall rating for this hospital

**Good**



Urgent and emergency services

**Good**



Medical care

**Good**



Surgery

**Good**



Critical care

**Good**



Maternity and gynaecology

**Outstanding**



Services for children and young people

**Good**



End of life care

**Good**



Outpatients and diagnostic imaging

**Good**



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Basildon and Thurrock University Hospitals NHS Foundation Trust serves a population of around 405,000 in south west Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point. The trust also provides services across south Essex. The trust provides an extensive range of acute medical services at Basildon University Hospital, which includes The Essex Cardiothoracic Centre and Orsett Hospital as well as x-ray and blood testing facilities at the St Andrew's Centre in Billericay. The trust employs more than 4,000 staff and has more than 10,000 public members. The trust was awarded the status of Associate Teaching Hospital by the Royal Free University College London Medical School in 1997 and in 2002, the Secretary of State for Health conferred University Hospital status. The trust became one of the first 10 NHS foundation trusts in April 2004.

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

We returned to inspect on 17th and 18th March 2015 and inspected those key questions where the service had been rated as requiring improvement. We did not undertake a full comprehensive inspection. We did undertake an inspection of the critical care service during this inspection due to concerns received about the leadership and responsiveness of the service. The report for this service is reported separately due to it being inspected against the new methodology used by the Care Quality Commission.

In 2014 we inspected Basildon University Hospital and found significant improvements to the care delivered to the population. We found very good care in most of the services we inspected. We saw some very good examples of care and treatment in maternity and children's services. Patients who needed end of life care were supported by staff that were compassionate and caring.

The service in A&E was improving and patients were mostly seen within the four-hour target. However, we also found areas where the hospital needs to continue to improve. We have said that the hospital needs to improve the way it manages medication on some wards. We have also said the hospital must improve how it treated some people with respect and dignity.

When we returned in 2015, we saw that significant changes had been implemented across the medical care and surgery services and several areas of improvements, particularly on the management of medicines; overall we rated these services as good. A&E services the last inspection required improvement on safety and whilst we saw significant improvements in the waiting area, streaming and triage process which was now robustly embedded some minor concerns were found with the level of staffing in the clinical decisions unit. The rating for the safety in A&E for this reason remains 'Requires Improvement'.

Overall the rating for Basildon University Hospital remains as 'Good' and the compliance action issued on the last inspection has been removed following improvements in the management of medicines.

Our key findings were as follows:

- Within the A&E service improvements were noted in the waiting area with patients being routinely observed and monitored for signs of changing or deteriorating conditions. However we identified that the protocol for patients to be admitted to the CDU was not being adhered to at the time of the inspection as the hospital was on black alert at the time of our inspection and nurse staffing levels were not appropriate.
- The streaming process within A&E was now embedded and working effectively as a pathway for patients through the department.

# Summary of findings

- Medicines management in all areas inspected had improved significantly and was safer for patients, though improvements in the recording of medicines administration was still required on Osler Ward.
- We noted significant improvements in the care provided to patients in surgery. Patients' privacy and dignity was respected and patients spoken to all felt well cared for.

We identified the following areas of outstanding practice:

- We found the innovation around development of medical staff in the A&E service with career progression to consultant level to be a very innovative response to a national shortage of emergency department medical staff.
- The preparedness of staff for major or emergency incidents in the medical care areas was outstanding. Staff were very aware of their responsibilities and were engaged with the trust's processes.

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

The trust should:

- Improve the management of medicines across the medical care directorate. There is a particular need to improve the recording of medicines administration and storage and prescription of oxygen.
- Improve the governance from the top at executive level to the local wards and departments and ensure that risk assessments and service plans are available to staff providing direct patient care in escalation areas.
- Continue to work and improve on the skill mix and staffing levels throughout the hospital.

**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?

In 2014 the department did not have enough consultants to provide care 'on site' all of the time, but there was a system of on call duty that did provide staff with access to a consultant at any time on the day. The hospital had an active recruitment programme in place to improve this situation. The hospital needed to improve the observation of patients in the waiting area prior to entering the A&E department. In 2015 we found that service had improved the observation of patients in the waiting room and the trust had taken action to ensure that there was adequate medical cover provided to the A&E department. The service was continuing their work on recruitment and safe staffing levels in the department. We noted that work was on going to improve the development and training of staff internally with progression routes to consultant level which was positive."

Patients were treated with compassion and respect throughout their stay in the accident and emergency. Staff made sure patients were involved in discussions about their care and understood what was happening to them.

The services in A&E were responsive. In 2014 the department had improved the patient flow through the system because of the greater numbers of patients attending. As a result patients were seen and treated in a timely way upon their arrival in the department. In 2014 it was evident that the culture of the department had changed in the past 12 months. We found complaints were investigated in line with the trust policy and senior staff made sure that all staff learnt lessons from this process in order to improve patient experience.

There had previously been concerns about the effectiveness of the leadership within the department that affected its performance. In 2015 we found there was good clinical leadership and that staff continued to work well as a team and were motivated and positive about working for the trust and in A&E. Staff were well supported by clinical leads and senior management.

# Summary of findings

We however identified new concerns regarding the Clinical Decision Unit (CDU). We found that there was not enough registered nurses to provide safe care and that the CDU admission protocol was not followed as the trust was on black alert.

## Medical care

Good



The service was issued a compliance action around the management of medicines following the inspection in March 2014. When we returned in March 2015 we found that the safety of medicines management had improved but further improvements were needed. We found that the number of patients experiencing delayed discharges because of medicines delays had reduced. The recording of administration of patient's medicines needed to be improved on Osler, along with storage on Osler ward. Patients care was effective because staff used evidenced based guidance and research to support their practice. We found that teams of staff worked well together and this made patients care less disjointed. We found that patients were cared for with compassion. We saw improvements had been made with record keeping to make sure patients care needs were accurately recorded. Innovative practice was being used in order to reduce the amount of falls and injury patients experienced. Pressure ulcer prevention was proactively managed by staff on wards. Infection control and prevention was effectively managed on all the wards we visited. Data reviewed also told us that the trust was performing the same as others in England. We noted continual improvements in falls management, accurate record keeping practices and venous thromboembolism assessments in March 2015. Staff awareness was good in safety management and ongoing monitoring was being actioned to safeguard patients. All acute medical patients were seen within 12 hours by a consultant seven days a week. Medical staff told us that led to clear management plans being in place. Consultants told us that their on call commitments were manageable and systems in place worked well. The service was well led because; staff were involved and understood their role within the hospital in terms of being part of the continuous improvement.

## Surgery

Good



In 2014 we identified that improvements were needed in the way the trust managed the use of the day surgery unit at night. We found bed capacity was pressured and patients who could not be accommodated on a general surgical ward were being placed in the day surgery unit

# Summary of findings

overnight. When we returned to inspect the day surgery unit in March 2015 we found the day surgery unit was not used as an escalation ward to accommodate hospital beds.

In 2014 improvements were needed to make sure the administration of controlled drugs was accurately recorded in some of the surgical areas. In March 2015 we checked controlled drug records and procedures and found all records to be correct using safe procedures and practices.

Patients care was effective because staff were using evidence based guidance and research.

In 2014 people were well cared for but some people were not included in conversations about their care during ward rounds and information above people's bed did not promote their dignity. We saw patient's privacy and dignity was respected in all areas during our inspection in March 2015. Individual patients were included within ward rounds and the planning of their care.

Information that should help staff understand what they are doing well and where they need to improve was not available on all the surgical wards we visited. In 2014, staff on some of these wards did not understand what they could be doing better in terms of falls and pressure ulcer prevention. In March 2015 we visited two surgical and two trauma and orthopaedic wards during our inspection and within the ward entrances, we saw performance notice boards with up to date information informing both staff and patient's what care was being delivered well and what areas could do better.

## Critical care

Good



We have reported our current findings for critical care services in 2015 in a separate report.

## Maternity and gynaecology

Outstanding



We did not inspect Maternity and family planning during our inspection in March 2015.

In 2014 we found maternity services provided to women and babies were outstanding. There were arrangements in place to implement good practice, learning from any untoward incidents and an open culture to encourage a strong focus on patient safety and risk management practices.

The trust had provided safe staffing levels and skill mix and had encouraged proactive teamwork to support a safe environment. We noted that with increasing numbers of births, the trust should consider national guidance which recommends additional consultant

# Summary of findings

hours and the employment of consultant midwives to maintain safe practice in the future. Patients told us they felt safe in the hands of the staff and staff said they felt supported by the trust in managing risk and keeping their patients safe.

There was strong evidence of research and an embedded ethos of shared learning. National guidance was being implemented and monitoring systems to measure performance were in place. We found a consistent track record of high quality, safe care which delivers good outcomes. Care was consistently delivered in line with evidence-based, best practice guidance and the highest professional standards. There was good collaborative working with partners and other agencies and maternity specific training courses across all groups of staff to support effective care was of a high standard. The maternity services continuously reviewed and acted on information about the quality of care that it received from patients, their relatives and those close to them and the public. They were able to demonstrate the difference this has made to how care was delivered. Risks at team and directorate level with regard to the delivery of high quality care were identified, analysed and mitigated systematically before they become issues which impact on the quality of care. The leadership model in maternity services encouraged cooperative, appreciative, supportive relationships among staff and teams and compassion towards patients.

## Services for children and young people

Good



We did not inspect services for children and young people during our inspection in March 2015. In 2014 we found that services for children and young people provided by the hospital were good. There were good staffing levels; a strong skill mix had encouraged proactive teamwork to support a safe environment. There were arrangements in place to implement good practice, learning from any untoward incidents and an open culture to encourage a strong focus on child safety and risk management practices. Families told us they felt safe in the hands of the staff and staff said they felt supported by the trust in managing risk and keeping their patients safe. Evidence based practice was being implemented and monitoring systems to measure performance were in place. We saw good examples of care being provided with a compassionate and dignified approach. Children and

# Summary of findings

young people were involved in planning their care and making decisions about the choices available in their care and treatment, including appropriate discharge planning.

The children and young people's service understood the different needs of the communities it serves and acted on this to plan and design services. It was proactive in taking action to remove barriers that parents, children and young people face in accessing or using the service. There were good mechanisms for information sharing and willingness from staff for flexible working around responding to the needs of parent's children and young people. The service had introduced several initiatives to encourage children, their relatives and those close to them to provide feedback about their care and were keen to learn from experience, concerns and complaints. The service was well led, staff felt supported by senior management.

## End of life care

Good



We did not inspect end of life care services during our inspection in March 2015.

In 2014 we found end of life care was safe, effective and responsive of patient's needs. Care was delivered in line with current best practice and we saw very good care for those patients who chose to end their lives at home. The rapid discharge pathway enabled patients to leave the hospital within four hours.

All of the patients we spoke with told us that care was good. They were treated with respect and dignity and felt involved in their care and treatment. The trust had developed its own end of life care pathway which had replaced the Liverpool Care Pathway. This had yet to be evaluated but staff told us it was effective and working well.

We found that the way in which the hospital managed medication could be improved to make sure it was in date and stored securely. Improvements were needed to make sure all patients' records in relation to 'do not attempt to resuscitate' decisions were completed. For the deceased we found they were cared for by a team of dedicated staff who maintained patient's dignity after death. Bereavement staff supported families effectively.

## Outpatients and diagnostic imaging

Good



We did not inspect outpatient services during our inspection in March 2015.



## Summary of findings

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In 2014 the outpatient's department was clean and safe for use. Equipment was well maintained but storage could have been more secure in order to prevent theft, damage or misuse occurring.

Patients were treated with compassion, dignity and respect. The outpatient survey in August 2013 showed that the majority of patients felt the care they received in the department was excellent, very good or good. We identified some good practice in the way the service responded to patient feedback and planned care to meet individual patient needs.

The outpatient service was responsive to the needs of the patients and was meeting the 95% target for referral time to treatment.

The outpatient service was well led because staff felt supported and received appropriate professional development. Meetings were held across the service to improve performance. There were innovative ways to gain patient feedback that were considered in planned service developments.

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# Basildon University Hospital

## Detailed findings

### Services we looked at

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

# Detailed findings

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## Background to Basildon University Hospital

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

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

## Our inspection team

Our inspection team was led by:

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

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

## How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place on 17 and 18 March 2015. Before visiting, we reviewed a range of information we held, and asked other organisations to share what they

knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England; Health Education England (HEE) and the local Healthwatch. We carried out an announced inspection visit between 17 and 18 March 2015. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, and pharmacists. We also spoke with staff individually as requested. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and

# Detailed findings

treatment. We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at Basildon Hospital.

## Facts and data about Basildon University Hospital

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

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

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

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

## Our ratings for this hospital







Our ratings for this hospital are:

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

# Detailed findings

## Notes

# Urgent and emergency services

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

## Information about the service

The Accident and Emergency Department (A&E) consists of a separate resuscitation, majors and minors injuries area, GP services and a clinical decision unit (CDU.) Ambulance patients who are unwell and may need admission are assessed and directed through to the 'majors' area, consisting of 25 bays including three rapid assessment and treatment cubicles. The A&E is subject to high levels of demand; patient activity has been rising by approximately 8-10% for the past two years. There were over 400 attenders on the day of our inspection. In 2012-2013 the unit had 93,123 attenders. The A&E department has been refurbished within the last five years to become a safer clinical environment for patients. Included in the refurbishment was the provision for a specialist children's A&E unit. In 2014-15 the service has treated over 100,000 patients and on average is treating approximately 750 more patients per month than in 2014.

We spoke with patients, relatives and staff, including nurses, doctors, consultants, managers and support staff. We observed care and treatment and looked at care records. We received comments at our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust. When we returned to inspect the A&E department on 17th and 18th March 2015 we spoke with 14 members of staff, which included nurses, doctors, support workers and senior managers. We spoke with eight patients, reviewed patient notes and observed care being delivered.

## Summary of findings

In 2014 the department did not have enough consultants to provide care 'on site' all of the time, but there was a system of on call duty that did provide staff with access to a consultant at any time on the day. The hospital had an active recruitment programme in place to improve this situation. The hospital needed to improve the observation of patients in the waiting area prior to entering the A&E department. In 2015 we found that service had improved the observation of patients in the waiting room and the trust had taken action to ensure that there was adequate medical cover provided to the A&E department. The service was continuing their work on recruitment and safe staffing levels in the department. We noted that work was on going to improve the development and training of staff internally with progression routes to consultant level which was positive."

Patients were treated with compassion and respect throughout their stay in the accident and emergency. Staff made sure patients were involved in discussions about their care and understood what was happening to them.

The services in A&E were responsive. In 2014 the department had improved the patient flow through the system because of the greater numbers of patients attending. As a result patients were seen and treated in a timely way upon their arrival in the department.

# Urgent and emergency services

In 2014 it was evident that the culture of the department had changed in the past 12 months. We found complaints were investigated in line with the trust policy and senior staff made sure that all staff learnt lessons from this process in order to improve patient experience.

There had previously been concerns about the effectiveness of the leadership within the department that affected its performance. In 2015 we found there was good clinical leadership and that staff continued to work well as a team and were motivated and positive about working for the trust and in A&E. Staff were well supported by clinical leads and senior management.

We however identified new concerns regarding the Clinical Decision Unit (CDU). We found that there was not enough registered nurses to provide safe care and that the CDU admission protocol was not followed as the trust was on black alert.

## Are urgent and emergency services safe?

Requires improvement



### Safety in the past

In 2014 we examined the incident data recorded between December 2013 and January 2014 and found that no never events had been recorded during this time within the A&E department. We noted the organisation had reported seven serious incidents (this number does not include children's services which had been reported under the children and young people section of this report.) This equated to 7% of the total number of serious incidents reported which is well within expectations for the size of the trust. We examined all serious incident investigations completed for the events in A&E. All incidents had a root cause analysis investigation completed in line with the National Patient Safety Agency (NPSA) guidelines. All incidents were linked to the category of delayed diagnosis. The learning from the incidents had been shared amongst relevant department including A&E, radiology and intensive care. We spoke with two consultants who told us that they shared learning from incidents with junior grades to ensure that the learning is embedded to reduce the likelihood of similar events occurring.

### Screening and monitoring

In 2014 the Department of Health have introduced a new national Commissioning for Quality and Innovation (CQUIN) goal for dementia care. Patients aged 75 years or over must have a dementia screening when admitted through the accident and emergency department. The aim of the dementia goal is to identify patients with dementia so they get the appropriate care and follow up when they leave hospital. We found through the department's integrated governance report dated January 2014 that the trust had screened an average of 89% of patients, which almost met the target of 90%.

### Learning and Improving

In 2014 we found that learning from the incidents had been shared amongst relevant departments including A&E, radiology and intensive care. We spoke with two consultants who told us that they shared learning from incidents with junior grades to ensure that the learning is

# Urgent and emergency services

embedded to reduce the likelihood of similar events occurring. We spoke with three staff grade and junior doctors about reporting incidents and all informed us that they were encouraged to report incidents by the consultants and the consultant would take them through the events to identify any immediate learning. All three told us that they felt supported to report and learn from incidents. All nursing and support staff we spoke with said that they were encouraged to report incidents and received direct feedback from their matron. We examined the national reporting and learning scheme tool for the past 12 months which showed that the department had continually increased the reporting of incidents during this time. This included the reporting of low impact and near miss incidents which evidenced that staff were encouraged to report incidents and recognised potential harm at an earlier opportunity. We viewed the department meeting minutes which demonstrated that themes from incidents were discussed and staff were able to give us examples of where practice had changed as a result of incident reporting.

## Systems and Processes

### Environment

In 2014 the accident and emergency department had been fully refurbished within the last five years. The layout of the majors and resuscitation area, where patients were at higher risk of deterioration due to their clinical conditions, was designed with input by clinicians and ensured continual monitoring of high risk patients. From the central bay within the majors and resuscitation areas each bay could be observed by nurses and doctors. At each of the main areas there were duplicate monitors that mirrored the monitors in the bays where patients were located. If a patient was linked to a heart monitor, blood pressure monitor the readings would be displayed in the bay and at the main staff base. This ensured that patients could be monitored locally and centrally within the department.

### Equipment

At both inspections in 2014 and 2015 we found that equipment was appropriately checked and cleaned regularly. We examined the resuscitation trolley in the minors, majors and resuscitation area. We found that the

trolleys had been regularly checked and restocked each shift and after every use. Our audit of the stock in each trolley showed that the trolleys were safe for use during resuscitation.

### Medication management

Medicines were stored behind doors with restricted swipe card access. The controlled drugs were securely locked within a cupboard. In 2014 we found in the medicines room in the 'minors' area, the antibiotics cupboard was unlocked and keys were left in the lock unattended. We reviewed the room and fridge temperatures and found that the staff had recorded the temperatures and all had been within the acceptable temperature range. When we returned in 2015 we found that medicines were secure within the accident and emergency department.

### Infection control and prevention

The department was clean and we saw staff regularly wash their hands and use hand gel between patients in resuscitation, majors, minors and CDU. Bare below the elbow policies were adhered to. However we observed that staff did not always wash hands between seeing patients in the streaming room were appropriate.

### Mental Capacity Act and Safeguarding

Patients' consent was sought appropriately and correctly. We observed that nursing and medical staff asked for consent prior to entering a cubicle area. We spoke with five members of nursing staff about consent and all informed us that they always asked patients prior to undertaking any care for example when taking blood, monitoring blood pressure or supporting them to change into a gown.

We spoke with four nurses specifically about the procedures to provide care for a patient who may not have mental capacity to make decisions regarding their treatment. All four informed us that they had received training in the Mental Capacity Act 2005. They referred us to their protocol that they had in place for admissions through A&E and talked us through this in detail. They informed us that they would escalate any concerns to medical staff who would undertake a 'mini mental exam'. The mini test is the hospital's pre examination for mental capacity assessments. Should this test identify a concern they will proceed to refer this patient to the medicine team. The medicine team and the A&E team would then



# Urgent and emergency services

undertake a mental capacity assessment. We examined the records on line of two patients who had been admitted in the last two weeks where mental capacity to understand treatment was questioned. We found that the Mental Capacity Act 2005 was adhered to appropriately in conjunction with the medical teams.

## **Safeguarding vulnerable adults**

During the inspection in 2014, we examined the records of a patient who was treated in the department. We spoke with the nurse in charge who informed us that the team providing care to the patient were in the process of raising a safeguarding alert for their welfare. A safeguarding alert is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. There was evidence that the A&E team had taken the appropriate action by immediately informing the relevant authorities and following their own procedures for responding to it. This ensured the safety patient. We also reviewed the Director of Nursing and Medical Director quality report submitted to the board in January 2014 which showed that A&E had identified and reported 10 new safeguarding concerns to the local authority within a one month period. This meant that staff were identifying and reporting safeguarding concerns as required by trust and local authority policies.

## **Monitoring safety and responding to risk**

In March 2014 in line with national clinical guidelines for emergency medicine, patients should see a doctor or clinical decision maker within one hour. On average patients waited less than 50 minutes to see a clinical decision maker. During our 2014 inspection there were very busy periods where patients waited up to three hours to see the clinical decision maker which was outside of the national guidelines and not always safe for the patient. In the majors department patients are seen within the first 15 minutes following booking the patient into the department. We examined the records of eight people in majors during our inspection and found that the department had followed this guidance, all had been seen by a doctor within 15 minutes and appropriate referrals had been made.

In 2014 we found that patients who are assessed as 'clinically safe' can be transferred to the clinical decision unit (CDU) within the accident and emergency

department. CDU, is run by a senior nurse who is permanently based on the unit with support from a consultant doctor where required. Patients who wait in the CDU are those unlikely to be admitted but require additional tests prior to going home. The CDU has two beds and four chairs for people to wait, we found that people had access to drinks throughout the day and meals were provided to those waiting. We found that through busy periods within the hospital there are occasions where people who are ready for discharge stay in the CDU prior to their discharge the following day. The staffing rotas examined supported that the patient's received care for the 24 hour period. We also spoke with the nurse in charge of CDU during our inspection and a matron who explained it was always a senior or experienced nurse present to provide support due to the skill mix requiring experience to run the unit. This meant that the CDU service was operating safely.

In March 2015 we were concerned that the safety of CDU had deteriorated. We observed that one registered nurse and a support worker cared for eight patients. A senior manager told us that this nursing establishment should actually be one registered nurse to four patients, based upon a recent acuity measurement. They also told us that there were plans to implement this although the service was awaiting refurbishment of CDU first whereby the number of CDU beds would be increased to four. The trust informed us that the staffing ratio in this area was actually one nurse to eight patients. However this did not take into account the acuity of the patients in the CDU during the black alert. Staff also told us that because there was no medication kept on CDU, the one registered nurse had to frequently leave the unit for up to 15 minutes which meant at times eight patients were being cared for by a support worker only.

Our concerns were heightened because some of the patients on CDU were acutely unwell patients whose condition was not stable. For example, one patient was awaiting emergency theatre from CDU for probable appendicitis and they had a fever during admission, and a second patient presented with exacerbation of asthma requiring regular nebulisers. Staff we spoke told us that the unit was being used as a ward. We asked staff and senior managers to provide us with a copy of the admission protocol for CDU. This document was not accessible to staff and was not provided to us promptly. The trusts escalation policy is that this area will be used

# Urgent and emergency services

to ensure the flow within the A&E department. Whilst the usual CDU admission protocol had been suspended and a senior nurse was overseeing this area we found that the dependency of patients in this area was greater than usual.

## Medical Staffing

In March 2014 we found that the A&E at the hospital is under-resourced for consultants. We found that there were currently 7.3 whole time equivalent (WTE) consultants employed. The College of Emergency Medicine recommends that, for the number of patients seen in the A&E at the hospital, it should have up to 10 consultants to provide cover 16 hours a day, seven days a week. The trust had been advertising to recruit new consultants but to date no appointments had been made. The A&E makes up for the shortage of full-time consultants by employing locums. The hospital's A&E had a number of consultants working between 8am and 5pm, but after 5pm there was often only one consultant available until 9pm. After 9pm there is a consultant available on call. At the weekends there was a working arrangement for a consultant to be present on the 'shop floor' to provide direct consultant support between the hours of 10am and 4pm. There was a consultant on call for the weekend. The current consultant staffing levels were not in accordance with the guidance from the college of emergency medicine and work is required to ensure there is more consultant presence at the weekends.

In March 2015 we found that the department continued to operate below The College of Emergency Medicine guidelines for consultant cover. There were four whole time equivalent (WTE) consultants employed which was less than our previous inspection. However the trust acted to mitigate this risk by employing a further three locum consultants, ensuring that there was a consultant available 24 hours a day 7 days per week, and they had increased the number of middle grade doctors with some on pathways to become consultants. Furthermore, a senior manager told us that they had recently submitted a proposal to the board to increase the amount of consultants to nine WTE and were awaiting approval. We recognise that there is national shortage of Emergency Department consultants and overall we were assured that the trust was taking appropriate action.

## Nursing Staffing

In 2014 the A&E department had 106 members of nursing staff. Staff told us they are able to ensure there is sufficient nursing cover by using agency and in-house bank staff (staff who work overtime in the trust.) We discussed the use of agency workers with three senior nurses on duty who told us that they try to ensure that agency workers are regular workers. One nurse told us, "Most are pretty good; we request that they do not come back if there are concerns about their practice."

In 2014 we reviewed the number of nurses in the A&E department, which was busy during our inspection. We examined the nursing rotas and observed the actual number of nurses on duty. We found that there was always an emergency nurse practitioner (ENP) in the minors department. This department was nurse led a majority of the time. There was always a senior nurse on duty in majors. There were an additional 14 members of nursing and support staff on duty to work between resuscitation, majors, minors, streaming and CDU. In majors during a busy period we observed that there were was a ratio of one nurse to four patients at quieter periods the number of patients to nurses was even lower. The management of skill mix, staffing ratios and distribution of staff throughout the department demonstrated that the staffing levels were safe to meet the needs of patients. This was corroborated by staff who felt supported and that they worked well together as a team when the department was busy.

In 2014 we visited the department unannounced at night during this inspection to observe staffing levels and determine if they were safe. There were nurses on duty including the nurse in charge, supported by health care assistants across resuscitation, majors, minors, streaming and CDU. We visited the resuscitation department where a clinically unwell patient was being cared for and found staffing levels to be safe. There were support workers to provide cover during the day and at night. This arrangement according to the rotas was 24 hours a day, seven days per week. This role ensured that patients were properly supported with nutritional and personal care needs. This meant that at night there were safe staffing levels and skill mixes allocated to provide safe care.

In 2015 we were concerned that the acuity and nurse staffing levels of the CDU did not reflect the needs of patients. The CDU was being used for additional bed capacity and the patients had varying dependency levels.

# Urgent and emergency services

We observed that the nurse had to leave the CDU to attend the main department when ambulatory patients were attending the CDU and that there was not sufficient in line with the CDU admissions protocol. Two members of staff also raised concerns with us directly about the staffing cover on CDU. We raised this with senior staff within the department who informed us that they would review the concerns raised.

## Records

All records were in paper format for the medical and nursing staff to complete a patient's episode on. The notes were stored in each bay with the patient and all health care professionals documented in the same place. Access to diagnostic and imaging records were available at the main desk in majors where screens were available to obtain test results. In the minors and resuscitation area they were available in the individual rooms and bays to use. Once a decision to discharge or admit the patient had been made the records of admission were uploaded to the electronic system and the paper copy sent with the patient to the ward. This ensured that there was a record of the person's A&E care at the time they left the department.

## Nursing and Medical Handover

In 2014 we observed both medical and nursing handover, in and out of hours. We also spoke with the consultant and nurse in charge about the handover both said that they felt that the joint handovers were important to ensure that attention was brought to the clinical and operational risks within the department prior to starting their shifts. Nursing handovers occurred twice a day, and all commenced with a discussion on nursing and operations status for the department and for the hospital as a whole. Staffing for the shift was discussed as well as any high risk patients or potential issues. Medical handover occurred twice a day and was led by the consultant in the department and focused on the high risk patients and clinical decisions to be made. The consultant would also allocate where staff would be sent to if needed. We observed the consultant in charge allocate additional doctors to the minors department to help reduce the waiting times and to treat people more quickly whilst majors was quieter. We spoke with the consultant about this who informed us that the department had an escalation protocol where staff can raise if they have concerns about capacity or delays and

this enables them as the lead to make changes to the rota required. The consultant within the department was supportive of open communications and working together between nurses and doctors to improve patient care.

## Managing patient care

In 2014 we found that the care provided to patients was well managed and that care was provided in a timely manner. Over the two day inspection, in 2014, we examined the records of 11 patients and found that patients had received observations in a timely manner, frequent monitoring around pain relief, referrals to specialist doctors had been made.

In 2014 we found that the waiting room posed a potential risk to the safety of patients waiting to receive treatment. We observed two people with head injuries sat in the waiting room; one had been there for over two and a half hours. We also observed six people with suspected fractures sat in the waiting room. We spoke with all eight patients and found that no pain relief had been offered to them, that they had not seen a nurse since they first arrived. We examined the records of the two people with head injuries and found that no observations had been undertaken since their arrival in the department. We viewed the procedures in place for the new systems in the waiting room for streaming patients and found that there was no provision for the monitoring of patients whose conditions may deteriorate between the times of streaming to the time a clinical decision was made. The clinical decision should be made within one hour to meet the national clinical guidelines however on the day of our inspection the wait was up to two and a half hours due to the volume of patients in the department. The gap between streaming and clinical decision making meant that the waiting area was not always safe because staff were unable to observe potential patient deterioration.

Our concerns were escalated to the matron, divisional head nurse, clinical director and the board regarding the potential clinical risk in the waiting room. The senior management for the department responded swiftly and ensured that the process was adapted whilst we were on site to ensure the safety of patients. The nurse in streaming provided a list of patients who required

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monitoring to an auxiliary staff member who would monitor observations frequently until they saw the clinical decision maker. We also observed that pain relief was now being offered to those in pain.

In March 2015 we found improvements had been made to address our previous concerns about the A&E waiting room area. We observed that patients were streamlined to the relevant area for assessment safely and within a timely manner. There were also systems in place to ensure that patients in the waiting room were continually supervised so that any deterioration in their condition could be addressed immediately. This included a band two support worker who was allocated to the waiting room on each shift, to meet and greet patients entering the department, repeat observations and observe patients in this area for signs of deterioration. These support workers had undertaken competencies relative to this role.

## Major Incident awareness and training

The nurse in charge would follow the departmental escalation process to raise the incident to the site management team implementing the major incident protocol. We examined the training matrix for staff within the department and found that all staff had received major incident training which included the arrangements in place to deal with casualties contaminated with chemical, biological or radiological material (HAZMAT.) During the inspection, in 2014, we observed an internal incident where the computer system that monitored patient admissions, flow and discharge from the A&E failed for a period of 20 minutes. At this time there were eight ambulances in the ambulance bay waiting with patients and the waiting room was very busy. We observed the nurse and consultant in charge calmly take control of the situation and implemented their internal major incident procedures for IT failure. We observed the nurse in charge immediately escalate the issue to the site management team and within five minutes of the phone call being made a senior operation manager, site manager, IT support and hospital on call manager attended the department to provide support. Our observations of this incident evidenced that staff had a clear understanding of major incident and internal procedures, acted calmly and professionally during this time which ensured continuity of care and patient safety during the incident.

## Are urgent and emergency services effective?

(for example, treatment is effective)

Good



**We did not inspect this aspect of the service in 2015.**

## Use of National Guidelines

The A&E department used a combination of NICE and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. Local policies were written in line with this and were updated every two years or if national guidance changed. The department ensured that the A&E was managed in accordance with the principles in 'Clinical Standards for Emergency Departments' (CEM). We viewed the minutes of the monthly departmental meetings any changes to guidance and the impact that it would have on their practice was discussed and action taken. This meant that the service was monitoring national guidelines to ensure their practice was current and up to date.

There were specific pathways designated for certain conditions. For example sepsis, falls, fractured hip, mental health, head injury, dementia and chest pain. Use of the pathways was regularly audited as part of patients care pathway audit throughout the hospital. For example in the fractured hip pathway the pathway follows NICE guidelines in how to reduce mortality on admission for people aged over 65 with a hip fracture. This pathway was followed through with direct admissions to an orthopaedic ward where specialist orthopaedic care could be provided. The orthopaedic teams then undertook the audits against the NICE guidelines and shared learning with the A&E department. This meant that there was multidisciplinary team working to identify learning to improve patient care.

## Ambulatory Care Pathways to support effective patient care

We also observed further escalation on demand discussed during an operational bed management meeting which demonstrated that the trust was listening

# Urgent and emergency services

and responding capacity risks in A&E. We were told that if patients were to be kept in the department for over four hours, efforts would be made to try and ensure the patient was transferred into a proper bed with a pressure relieving mattress if appropriate. This practice was monitored and the trust was able to tell us how long after four hours some patients spend on a trolley in A&E. This was monitored daily on the A&E dashboard with the results sent daily to the management team for the department. This meant that there was continual effective monitoring of the performance, crowding and patient flow within A&E.

## Management of the deteriorating patient

The department used a recognised early warning tool. There were clear directions for escalation printed on the reverse of the observation charts and staff spoken to were trained and aware of the appropriate action and protocol to follow if patients scored higher than expected. The training matrix confirmed that training had taken place. We looked at completed charts of three patients within the majors and resuscitation department and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.

## Multidisciplinary Team working and working with others

The department was supported by specialist nurses from stroke, cardiac care and intensive care dependent on patient need. These services were available seven days per week. A&E also had access to the lead nurse for dementia, learning disabilities, diabetes and tissue viability from Monday to Friday 9am-5pm. There were protocols in place for accessing specialist services in and out of hours.

We found that there was regular input from a mental health liaison team within the hospital. We spoke with two nurses and three doctors about the team who told us that they received good support from the mental health team a majority of the time. They told us that at weekends it can be a challenge to obtain support but recognised that this was often the busiest time for the team.

We observed good working relationships with the intensive care teams during our inspection who were working with the A&E teams on resuscitation cases. We also observed good relationships with the medical teams

who visited the department to undertake medical reviews. We spoke with one consultant and two junior doctors about working relationships between the teams within the hospital and all told us that this worked well. The consultant told us that where there were concerns they tried to resolve them quickly to maintain the cohesive working relationship between specialties. This demonstrated that there was a good level of multidisciplinary team working throughout the interlinking departments.

## Mortality

Prior to this inspection we viewed the overall mortality rating for the A&E as a specific department. This showed that in May 2013 the death rate as a percentage of discharges was 3.75% which was above the hospital mortality indicator of 2.25%. The clinical director for A&E informed us that the department has worked to reduce the overall mortality for the department by learning from incidents, increased monitoring of high risk cases and training staff to recognise the signs of deterioration. We examined the mortality figures for the last three months which showed a steady decline in the overall mortality at discharge to 2%. This meant that the service had learnt from patient harm and improved the overall mortality outcomes for the service.

## Are urgent and emergency services caring?

Good



## We did not inspect this aspect of the service in 2015

### Compassionate Care

The A&E NHS Friends and Family Test (FFT) carried out between September and December 2013 highlighted that the trust was performing significantly lower than the England average score for three of the months, with October score being the lowest score at minus 11, compared to the England average score of 55. September received the lowest response rate, at 3.7%, compared to the national average of 13.2%. We noted that by December 2013 that the service had increased its response rate to 11.0%, compared to the national average of 15.3% to. We viewed the divisional governance



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report and patient safety meeting minutes where the FFT was discussed. It was evident through the minutes that the staff were working to improve patient perception and response to the FFT. The work evidenced by the department is shown through improvement in the number of responses received since October.

The results of the CQC adult inpatient survey from 2013 detailed two questions which related to people's experiences in A&E. The first concerned whether people felt that they were treated with dignity and respect when being examined or treated. The second concerned whether patients felt that they had to wait a long time to get a bed on the ward. The results showed that the trust performed 'about the same' as other acute trusts for both questions.

We looked at patient records of 11 patients during our inspection and found they were completed sensitively and detailed discussions that had been had with patients and relatives. We observed nursing staff challenge medical staff around protecting the dignity of patients. In one example we observed that a doctor had asked a patient to change into a gown and this was questioned by the nursing staff. It was agreed by both teams that it would be the patient's choice and that clinically they did not require a gown at that time. This evidenced that staff were mindful and aware of patient's choice and dignity and treated them with respect. It was positive to note the open discussions between the medical and nursing staff in the department about how best to treat the patients with dignity and respect and ensure continuity in care.

We observed positive interactions between staff and patients and noted that they always spoke to people in a kind manner. We observed staff go to a bay and wait and ask for a patient's permission to enter to speak with them and provide any care required. This demonstrated that staff treated patients in A&E with dignity and respect. Patients received adequate nutrition and hydration while they were in A&E. We saw staff take a drinks trolley around the major's area ensuring that people were offered hot and cold drinks. People in A&E for an extended period were offered a hot meal. We also saw that healthcare assistants and nurses assisted people who needed support with eating and drinking.

## Patient involvement in care

We spoke with 26 patients and 12 relatives. We did not receive any negative comments regarding the caring approach of either nursing, medical or support staff. All patients were complimentary about the caring and kind manner of staff they had seen. One relative told us, "They took the time to answer all my questions, they didn't rush me and I felt like they were honest with us which is all I could ask for. They are good here". Another relative told us, "I cannot fault them here, we have always received good care and the staff smile, they are polite and they work hard." Patients told us, "They are brilliant staff, all of them", and, "They must be under pressure but you would not know it because they are so nice". Another patient told us, "I come here regularly and it is the same every time the staff are wonderful".

## Emotional Support

We saw patients being treated with compassion, dignity and respect. In one example we observed a nurse and a doctor provide support to a family who had received sudden and difficult news. We observed that staff were compassionate and respectful towards the family and listened to them. We heard the doctor deliver a difficult message in a caring and empathetic manner that the relatives understood. The doctor and nurse provided comfort to them when they had questions. Staff demonstrated through this period that they cared about the patient and the family.

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

Good



## We did not inspect this aspect of the service in 2015

### Meeting people's needs

The department leads were proactive in working with the commissioners and local GP's to introduce admission avoidance measures. For example they had established ambulatory care pathways for deep vein thrombosis (DVTs) and cellulitis. The department had an 'enablement team' which consisted of a physiotherapist, occupational therapist and social worker who were on site Monday to Friday 9am-5pm with a reduced service at weekends. The

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department had a clear escalation policy which is based on advice contained in the 'Crowding in Emergency Departments' document compiled by the College of Emergency Department. The department worked with other departments in the trust so that there was joined up working at busy times. During the inspection period we observed that the escalation process worked well.

## **Vulnerable patients and capacity**

Support was available for patients with dementia with the use of dementia champions. The dementia champion was responsible for educating and promoting dementia care through A&E which involved ensuring that doctors undertook a dementia screening check on any patient over the age of 75.

We spoke with three nurses, a junior doctor and a Consultant about care and support to patients with learning disabilities who attend the A&E. The nurses comprehensively explained that the people with a learning disability in the local community will often come in with hospital passports and they plan their care based on what is detailed in their passport. This included if they prefer to be supported by male or female staff, if they would be more comfortable around people or in a quieter area. They also told us that they spoke with the patient, their carers and families where appropriate. The junior medical staff said that they felt challenged when caring for a person with a learning disability and said they would seek support from their consultant or senior doctor. The consultant told us that there was a training module available on e-learning but that this was not mandatory and does not detail the real life care scenarios and challenges faced by medical staff. Staff felt that more could be done to support the understanding of learning disabilities within A&E with additional training, guidance or learning disability champions.

## **Access to services**

The trust is required to meet an operational standard of 95% for patients being seen and discharged within four hours. We looked at the data we held and spoke with other regulators. We found the trust had met this standard in both quarter three and four of the year 2013/14. Improvements in this performance were being closely monitored by the hospital, the clinical commissioning group and Monitor. We also reviewed the data held for patients waiting to be admitted within four – 12 hours,

the trust had not consistently met this standard but since November 2013 to March 2014 improvements were noted and it was steadily getting better. The trust was rated 28 out of 143 other A&E departments for the responsiveness of their service.

## **Management of patient attendances**

On average patients arriving by ambulance were handed over to staff and assessed within 15 minutes. It was evident from the integrated governance report that over the last six months 100% of patients care was handed over by ambulance crews to accident and emergency staff within 20 minutes. This demonstrated that handovers between care providers ensured the safety of the patient. The trust operated a contracted GP service through A&E which was launched in January 2014. The purpose of the contract was to minimise the numbers of inappropriate patients seen by accident and emergency staff. This service operated from 8am to 10pm seven days per week and saw on average 60 patients per day reducing the pressure on the main A&E.

## **Maintaining flow through the department**

There was a clear process in place to support patient flow through the department, including the CDU. The trust had done extensive work at investigating the 'pressure times' in their A&E department, and had adjusted their staffing rota to try to alleviate the peaks of attendances. The A&E department had implemented a new patient flow coordinator. This administrative role monitored the patient flow and watched the patient list to ensure that people were treated in a timely manner. If any delays were identified the coordinator would escalate the concerns to the nurse and consultant in charge for their action. This enabled the nursing and medical staff to focus on clinical care whilst the coordinator organised beds on wards with the site management team. A&E department attended the operational site management meetings that take place between three and five times per day to provide feedback on any delays experienced within departments in the hospital. With the representatives from each department present this ensured that messages were delivered and that actions could be taken to improve support the A&E department when required.

## **Translation, Interpreter and support services**

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A translation telephone service was available at the reception desk so that patients who English was not their first language were able to communicate with the receptionist at initial triage. Within the department it was possible to request a translator within working hours, though staff admitted that they would rarely do this. The staff have a wide multicultural background in line with the population the hospital serves, and therefore they told us they would usually use other staff members to help translate. There were multiple information leaflets available for many different minor complaints. These were available in all of the main languages spoken in the community.

## Learning from experiences, concerns and complaints

Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the shift coordinator. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department and was depicted on posters and banners.

The governance coordinator for the A&E department received all of the complaints which were then given to the matron and divisional head nurse. The investigating officer for the complaint was then appointed and an investigation was undertaken in accordance with the trust policy. A response was then compiled and passed by the divisional head nurse and matron prior to the response being sent by complaints. Complaints were sent to the chief executive for signing and approval and if people remained unsatisfied they could request a meeting to discuss and resolve their concerns. Themes from both formal and informal complaints were collected and shared with staff for learning. The department held regular meetings to ensure learning was disseminated messages of learning and feedback was shared by senior nurses to staff on duty throughout the twenty four hours. This ensured that messages were shared with all at the earliest opportunity.

## Are urgent and emergency services well-led?

Good



Historically there have been concerns around leadership within the department and leadership from the trust which affected the performance of A&E. During this inspection we found that A&E had good clinical leadership from both nursing and medical leads. We observed that staff were well led by the senior staff present, staff were motivated and we observed good examples of team working within the department.

## Vision and strategy for this service

The trust vision was visible throughout the wards and corridors. We spoke with staff about their understanding of the trust board's vision for improving the service. All informed us that they were aware the board were moving in the right direction and knew what the key messages were. Staff were able to repeat the vision to us at focus groups and during individual conversations.

Following the identification of the risk to patient safety in the waiting room we met with the clinical director and divisional head nurse to talk through the concerns in detail. They clearly demonstrated a recognised understanding of the risk and detailed how they envisioned a change to the process to ensure patient safety was risk assessed to assure the department and the board that the department was safe. This approach demonstrated recognition of risk and a good example of leadership to improve the service.

## Leadership and Culture

We spoke with the clinical director and divisional head nurse who had a good understanding of the risks and issues the department faced. Consultants and senior nurses gave clear guidance and support to junior staff. One patient told us, "This place runs like clockwork". We observed that staff were motivated, with good team working and communication between all grades of staff. Staff said they felt well supported by A&E managers. We examined the staff rotas which showed that all clinicians in senior leadership posts attended a clinical leadership and management courses.

Staff worked well together and there was obvious respect between not only the specialities but across disciplines. The unit was well engaged with the rest of the hospital



# Urgent and emergency services

and did not operate in isolation. This was evidenced when we attended the operational site management meeting. During this meeting it was evident that departments needed and were encouraged to work together to improve the performance of the hospital.

We were told by staff that they regularly see the CEO in the department, 'with sleeves rolled up and ready to help'. Staff told us this made them feel valued because senior management were aware of their concerns about how the department was running.

## **Governance arrangements**

The unit contributed all of the key CEM audits including consultant sign off, renal colic, pain relief in children, vital signs in majors, fractured neck of femur, severe sepsis and septic shock. The trust provided us with a list of all completed audits during their past year and the dates that they were presented to the monthly departmental meeting. We saw in the audits for A&E that trainees were encouraged to partake in completion of audits. There were clear action plans indicating what improvements were needed as a result of the audits. The action plans were monitored at the divisional governance meetings. This meant that audits to identify learning and improve the service were undertaken. Also that where actions were identified that monitoring was in place to ensure outcomes of audits were learnt from.

## **Innovation, learning and improvement**

We viewed the General Medical Council (GMC) National Staff training survey published in June 2013. We found that the Emergency medicine specialty which included A&E was performing worse than expected in six of the 12 areas of the survey. Since the release of the survey results we viewed an updated review undertaken by the trust dated January 2014 which showed that the department had made significant progress to improve medical staff







training. This was further supported by the updated report from the General Medical Council in February 2014 which stated that progress is being made. The trust reported in January 2014 that the medical training lead in A&E was working with the Royal College of Physicians to progress middle grade doctors through the 'Medical Training Initiative' scheme and that this had been well received by staff.

We spoke with one consultant, two middle grades and two junior doctors during the inspection. The majority of the doctors spoken with felt that they received support and education required for their roles. One person told us that they did not feel supported by their consultant. The other staff felt that they received a high level of education and learning from the trust and had no concerns. One doctor told us, "the educational support I have had here is better than the previous trusts I have worked at".

## **Patient experience, staff involvement and engagement**

Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience is seen as a priority and everyone's responsibility. Staff repeatedly spoke of how they were encouraged to speak up if they saw something they were unhappy with regarding patient care. On one of visits we noted that staff were released from the department to attend a 'stepping up' meeting which took place in the hospital each morning. This meeting was chaired by a member of the executive team and all staff were invited to attend if they wanted to share their feedback or any concerns. One staff member told us, "Stepping up is good, I feel that the management team listen which is why I go". This demonstrated that openness and honesty was the expectation for the department and was encouraged at all levels.

# Medical care (including older people's care)

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

## Information about the service

The hospital provides medical care on 13 wards and two medical assessment wards. Two wards are dedicated to the care of stroke patients. Patients are cared for on Lister and Pasteur wards and consist of six hyper acute stroke beds, 21 acute stroke beds and 24 rehabilitation beds.

Other wards provide acute medical care for patients in respiratory care, short stay care, diabetes, renal, frailty and gastroenterology. Care is also provided in the acute medical unit.

## Summary of findings

The service was issued a compliance action around the management of medicines following the inspection in March 2014. When we returned in March 2015 we found that the safety of medicines management had improved but further improvements were needed. We found that the number of patients experiencing delayed discharges because of medicines delays had reduced. The recording of administration of patient's medicines needed to be improved on Osler, along with storage on Osler ward.

Patients care was effective because staff used evidenced based guidance and research to support their practice. We found that teams of staff worked well together and this made patients care less disjointed.

We found that patients were cared for with compassion. We saw improvements had been made with record keeping to make sure patients care needs were accurately recorded. Innovative practice was being used in order to reduce the amount of falls and injury patients experienced. Pressure ulcer prevention was proactively managed by staff on wards. Infection control and prevention was effectively managed on all the wards we visited. Data reviewed also told us that the trust was performing the same as others in England.

We noted continual improvements in falls management, accurate record keeping practices and venous

# Medical care (including older people's care)

thromboembolism assessments in March 2015. Staff awareness was good in safety management and ongoing monitoring was being actioned to safeguard patients.

All acute medical patients were seen within 12 hours by a consultant seven days a week. Medical staff told us that led to clear management plans being in place. Consultants told us that their on call commitments were manageable and systems in place worked well.

The service was well led because; staff were involved and understood their role within the hospital in terms of being part of the continuous improvement.

## Are medical care services safe?

Good



### Safety and Performance

At our inspection in 2014 there had been a recent never event relating to medical services. This is something reported because it should never have happened. This related to a nasal gastric tube in May 2013. We found that to keep patients safe those who needed a nasal gastric tube were placed on specific wards where all nursing staff were appropriately trained to care for them. We spoke to nursing staff on Lister and William Harvey wards. They confirmed that they were aware of the incident and learning that had taken place. The ward sisters confirmed that all staff on these wards were appropriately trained. Staff had received additional training in the new pumps for nasal gastric tube feeding that were soon to be introduced. We examined records that showed appropriate safety checks were frequently carried out on individual patients.

In March 2015 staff on the medical wards at all levels of the organisation demonstrated that openness and transparency about patient safety was encouraged. They were aware of the required improvements from the previous inspection in March 2014 in the safety around medicine and records management practices. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses such as patient falls and medication incidents and they were fully supported when they did so.

Safety thermometer information was clearly displayed at the entrance to each ward. Patient safety 'hotspots and topspots' highlight lessons learnt from incidents and patient safety concerns and are shared across the trust. This included information about falls with harm, medicine management and new pressure ulcers. We asked staff on Lister Ward about this information and how matters were being managed to improve people's safety. We were informed that the information was trust wide and therefore did not refer specifically to that ward.

The Department of Health requires that venous thromboembolism (VTE) risk assessments take place for every patient, and that results are closely monitored. In January 2014 the medical department had achieved 94%

# Medical care (including older people's care)

of assessments. The department needed to improve on this in order to meet the required 95% standard. We followed this up in March 2015 by spot checking ten patients' records where the assessments had been completed appropriately and the latest dashboard February 2015 showed 100% compliance with VTE assessments across all the medical wards.

## Learning and Improving

All staff we spoke with said they were encouraged to report incidents and received direct feedback. Themes from incidents and near misses were discussed at hand over meetings and staff were able to give us examples of where practise had changed as a result of incident reporting. Staff informed us about incident reporting and action plans that were in place to prevent any reoccurrence where possible.

Staff confirmed that during Heads of Nursing unannounced visits in 2015 staff were routinely asked about recent incidents and risks for their ward or department area to ensure that all the governance arrangements such as new systems for recording controlled drugs were communicated, known and embedded by all staff.

There had been a recent increase in falls in 2014. Data told us that over the previous 12 months falls with harm have been double the national average in 10 out of 12 months. This was around 2.0% for the trust compared to the national average of around 1.0%. The most concerning month was May 2013, 2.9% compared to the national average of 1.0%. The data for falls with harm for the over 70s also compares poorly to the national average. In response the trust had introduced 'fallsafe' which reflected the Royal College of Nursing's project. This had been focused on Kingswood and Osler ward as both wards had a higher number of falls. This project used yellow magnets above people's beds to show that they were a risk of falling and yellow slipper socks were used to increase foot grip and lessen slip hazard. Early indications have shown that this strategy has lessened falls on these wards. In addition, falls champions have been trained and linked to wards. Risk assessments for the above were being completed appropriately on admission. Patients that were judged to be at high risk of falling were also moved to a high visibility spot on the ward to enable staff to see them. This was evident on Kingswood ward where the layout of the ward made observation of patients difficult.

Due to the high levels of falls previously reported we followed up in March 2015. From April to November 2014 there had been an 8% reduction in adult inpatient falls across the trust compared to the same period the year before. 32% of adult inpatient wards have had a greater than 20% reduction in falls numbers, such as Kingswood, Lionel Cosins, Orsett and Pasteur medical wards which is noted as good practice. Staff were proactive in monitoring practices to keep patients safe. Monitoring and reviewing activity enables staff to understand risks and gives a clear, accurate and current picture of safety.

## Cleanliness, Infection control and hygiene

Ward areas were clean. We saw staff regularly wash their hands. Bare below the elbow policies were adhered to. Bare below the elbows meant that all staff in contact with patients could effectively wash their hands and wrists between each patient. It is not possible to do this properly with cuffs, watches and jewellery. Medical students we spoke with knew infection control policies and protocols with regards hand washing, bare below the elbows and the prescribing of antibiotic treatment for patients.

Ward staff explained purple washing bowls were used for personal washing tasks. In 2014 we saw that staff did not always routinely empty these bowls in the sluice, but in a wash hand basin and therefore could compromise cleanliness.

In March 2015 we observed practice on five medical wards and found satisfactory infection control practices. Staff regularly washed their hands. Bare below the elbow policies were adhered to and washing water was disposed of appropriately. Infection control audits were being actioned with action plans in place to address areas below standard. The 10 March 2015 audit highlighted poor documentation around cannula sites and insertion dates, which was also identified by inspectors as an area for development during the follow up inspection. Actions were in place to address this such as divisional spot checks.

We found that MRSA and Clostridium-difficile (C-Diff) rates for the trust were within expected limits. We found that one patient was placed in a side ward as they had diarrhoea. We saw in place a c-difficile monitoring sheet care pathway. These actions were taken to lessen risk to people. In

# Medical care (including older people's care)

January 2014 some of the medical wards were closed due to an outbreak of Norovirus. This was managed well and staff were able to tell us about the infection prevention and control precautions they took in order to manage this.

## Environment and Equipment

The environment on the medical wards was mostly safe. In 2014 on one ward, Katherine Monk, female shower room (A023) had a folding shower screen with loose, ill-fitting rubber seal that was hanging off and dirty.

In March 2015 the environment on the medical wards was safe. The female shower room (A023) on Katherine Monk was now marked out of action and part of a redesign plan for an ambulatory medical day ward in the near future.

Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the wards. We saw that people were individually assessed for moving and handling and that they had a personalised sling for their stay. This was located in their bedside locker. Those patients who needed pressure relieving equipment in order to reduce the risk of pressure ulcers developing were provided with appropriate support.

## Records

In 2014 all records were in paper format and all health care professionals documented in the same place. We found that assessment of people to keep them safe with specific conditions was inconsistent. The Waterlow pressure sore risk assessment tool is used for improving care and prevention of pressure ulcers/bed sores. We looked at two records and found that on both the risk score was incorrectly calculated. This related to the neurological deficit section. Given this section had a high weighting score; miscalculation could place people at risk. Despite the miscalculation of these records we did not find that this had impacted upon patient care.

In March 2015 we reviewed six patient records and found the risk calculations were correct for waterlow pressure sore risk assessments. Fluid balance charts were also totalled correctly and the ward dashboard showed regular monitoring of these risk factors. Two patients were complimentary about the safe care they had received.

## Medication

In March 2014 the Care Quality Commission raised a compliance action around medicine management at

Basildon hospital. A comprehensive action plan was submitted and has been reviewed and updated with associated evidence by the trust and followed up by the inspectors in March 2015. We found that adequate systems and processes had been put in place to encourage safe administration and monitoring of medicines in the medical division.

People we spoke with who had been admitted to the hospital were generally complimentary about their treatment, how their medicines were managed. They told us they were provided their medicines including pain relief when they needed them without delay, however, some said they had not received enough information about newly prescribed medicines.

In March 2015 we followed this up with pharmacists, ward staff and patients. A new web portal was being piloted that nurses, doctors and pharmacists could access to automatically produce general information on newly prescribed medicines. Examples were observed and staff we spoke with were aware of it. Two Patients told us they were well informed regarding their medication.

The Trust has a patient medicines group and this has facilitated a plan being put together in 2015 for improving access to information for the existing patient medicines helpline. Posters and contact numbers were displayed for patient information.

When we spoke with nurses in 2014, they told us that pharmacy services provided on the wards included the checking of people's medicines within 24 hours after they were admitted on the wards and also the regular provision of medicine supplies to the ward. Nurses said they could access pharmacy services and advice during the day including weekends and out of hours. However, when we looked at people's prescription charts we noted that sometimes when people were admitted to the wards they were not administered some of their medicines for up to 24 hours or more after admission because the medicines had not been obtained and made available to administer. Nurses on the wards reported that there had been improvements in times taken to obtain medicines for people to take away when discharged from the hospital. Nurses at the discharge lounge also told us this had improved and medicines were no longer the main reason for delays at discharge.

# Medical care (including older people's care)

A detailed audit was actioned in September 2014. At the follow up inspection in March 2015 the pharmacist and staff were aware that actions were being taken to improve communication with patients of the importance of bringing medicines into hospital with them and reminders sent to staff regarding the new emergency drugs store room to access critical drugs out of hours to reduce delays. We looked at fifteen medicine charts and whilst there were some omissions this was not due to the medicines being unavailable.

Whilst we were on Osler ward, in 2014, we observed one person who had been provided their morning medicines taking them unsupervised by nursing staff. When we looked at their prescription chart we noted that records of administration of the medicines had already been completed by a nurse on duty. This was unsafe practice as steps had not been taken to ensure the person had taken their medicines. We also noted on Marjory Warren and Kingswood wards that there were some gaps in records for the administration of medicines prescribed for regular administration so we could not determine if the medicines had been administered. Whilst most records indicated reasons when medicines were not administered we noted other records that were incomplete.

In March 2015 we looked at eighteen medication records the vast majority of which were completed appropriately. On Osler ward we noted omissions in two records but were assured by the clinical lead and pharmacist that by daily pharmacy input and on-going audits and monitoring practices these issues were being picked up. Practice changes were being made as a result of medication audits and incident reporting and staff confirmed feedback via the audit and ward meetings routes to continually improve standards such as medicine security practices.

In 2014 we saw on Osler ward that when medicines are prescribed for occasional 'as required' use to be administered at the discretion of nursing staff there was a lack of written information available to assist nurses to administer these medicines appropriately. Where more than one medicine was prescribed in this way for the same stated circumstance, for example, for anxiety or agitation, there was no guidance about which medicine to administer in preference. We discussed this with one nurse on duty who was unable to describe to us in detail the circumstances when psychotropic medicines prescribed in this way for a person would be considered for

administration. Another nurse agreed that more written guidance was needed. This meant we could not be assured that the use of medicines prescribed for 'as required' use was always justified.

In March 2015 we looked at eighteen medication records the vast majority of which were completed appropriately and indicated the rationale such as nausea, anxiety or sedation for "as required" drugs. There were still some charts with little guidance however staff spoken with were aware of the new web portal being piloted that nurses, doctors and pharmacists could access to automatically produce general information on prescribed medicines. Nursing staff were complimentary regarding the information and guidance provided from the ward pharmacists to support safe medicine practices.

In clinical areas of the hospital we visited there were dedicated rooms where medicines including intravenous fluids were being kept. Some rooms were secured by a door keypad system and others by a security card swipe system. On two wards (Marjory Warren and Kingswood) where keypads were in use nursing staff confirmed that the combination codes used to access the rooms had not recently been changed. Not all medicines were kept in cabinets or refrigerators that were lockable within the rooms. We therefore concluded that improvements to the security for medicines was needed.

In March 2015 the provider reported that an on-going work plan is in place by Estates in support of the medicines management agenda. Significant work has been undertaken that has included the replacement of any broken locks for medicines storage areas and a complete change of Digi code locks across all Trust medicine room doors. Clinical ward staff have received a Medicine Handling Standards Aide Memoire which includes medicine security arrangements. Security practices have been strengthened with only senior staff holding the medicine keys and the codes being changed regularly on the medicine access rooms. On the 9 March 2015 a programme commenced to install air conditioning in all medicine rooms with a completion date of the end of April 2015 and all cabinets and fridges checked on the medical wards were locked and drug fridge temperatures logged appropriately.

Nurses we spoke with on the wards were familiar with systems in place to record medicine-related incidents and errors and told us how these were investigated and that



# Medical care (including older people's care)

staff learnt from them. However, nurses were generally unaware of systems in place to monitor and improve the quality of medicine management at the service and that they were unaware of the findings or receive feedback information about issues identified by audits.

In March 2015 wards now had a standardised consistent approach to ward meetings to improve safety communication. Templates were used to document ward meetings with a standardised agenda which included: Risk register, Incidents, medicine management and audit outcomes. Minutes of meetings showed the systems in place to monitor and improve the quality and safety of services including medicine management. A printed staffing list to enable non-attenders to sign they have read and understood the minutes to the meeting was in place and filed with the minutes at ward level, which is good practice.

Nurses were aware of a Pharmacy & Nursing Medicines Management Working Group established to review the controlled drugs procedures. An E-Learning training package on controlled drugs was crafted by key personnel in Pharmacy and rolled out to relevant staff. Staff were familiar with new controlled drugs registers and confirmed receipt of a Controlled Drug Standards for Nurses & Midwives Aide Memoire to support good practice. A separate Controlled Drug assessment had been designed and the pass rate for both Core Skills and Induction will be 100%.

## Monitoring safety and responding to risk

In 2014 we found that patients were consulted with appropriately and correctly in relation to the giving of consent about their care and treatment. We saw examples of patients who did not have capacity to consent to their procedure. The Mental Capacity Act 2005 was adhered to appropriately and we saw that deprivation of liberty safeguarding was applied. We saw good examples of both capacity assessments and applications to deprive patient's liberty on William Harvey Ward. Decisions made were in the best interests of patients and were under continual review. Both processes had involved the patient, their family and consultation with appropriate professionals from the local authority who took the lead in this matter. Staff were able to describe the process for assessing capacity and

confirmed that assessments were carried out on the ward. There were no patients at the time of the inspection subject to a mental capacity assessment or who had any Deprivation of Liberty Safeguards in place

We spent time, in 2014, speaking with staff about safeguarding and the care of vulnerable patients. All of the staff knew what to do if they suspected abuse had occurred and who to report it to. We saw training figures from that trust that showed over 92% of staff had completed training in this area. The trust provided us with evidence of 10 referrals it had made to the local authority in relation to safeguarding since January 2014. This showed us that the process for referral and keeping vulnerable patients protected from harm was working.

Nursing numbers were assessed using a recognised staffing matrix tool. The tool used at this hospital was the safer nursing care tool as used by the Association of UK University Hospitals. We saw that funded, safe and actual staffing numbers were displayed at the entrance of every ward. Staff were keen to tell us of the new recruitment of nurses within the trust. Majority of staff reported that the minimum safe staffing levels assessed for each ward was maintained.

In 2014 nursing staff on certain wards said they were reticent to staff up to the maximum allowed as staff were then moved to cover minimum levels on other wards and this led to low morale of staff that were required to move. On one night during our inspection staff informed us that both Katherine Monk and Lionel Cousins wards were short staffed. The impact of this was that care rounds were not completed and paper work seen supported this and people were not offered enough personal care. One patient told us the commode almost over flowed as staff did not have time to empty it and they had to use the same commode three times.

We reviewed staffing levels on the medical wards in March 2015 and again the majority of staff reported that the minimum safe staffing levels assessed for each ward was maintained. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Senior staff were aware of staff reticent to move areas and that this at times could impact on staff turnover. We visited seven wards all of which were adequately staffed.

## Anticipation and planning

# Medical care (including older people's care)

There was consultant presence on the AMU that meant patients were seen within 12 hours of admission by a consultant. On other medical wards consultants undertook wards rounds three to five times a week. Medical staff told us they felt better supported by the trust, they told us they felt at ease contacting senior staff for advice and guidance when they needed another opinion.

## Are medical care services effective?

Good



**We did not inspect this aspect of the service in 2015**

### Using evidence based guidance

The Myocardial Ischaemia National Audit Project (MINAP) began in late 1998 to assess how effective treatment was in hospitals. Basildon Hospital's performance was rated as similar to expected or better for all five of the Myocardial Ischaemia National Audit Project indicators. The trust participated in the Sentinel Stroke National Audit Programme (SSNAP). This audit measures how well the hospital performs in relation to stroke care. The audit shows the hospital performed in the middle half of all the trusts participating in England.

There were specific care pathways for certain conditions. We saw the use of care bundles. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. For example, SSKIN (Surface, Skin inspection, Keep moving, Incontinence, and Nutrition) bundle was used for the prevention of pressure sores. Nurses also told us that they regularly used other care bundles for nutrition, sepsis and urine/chest infections.

Clinical pathways were in place to help reduce the risk to patients in relation to falls, pressure ulcer development and hip fracture. NICE guidance was used to inform practice and support staff.

**Performance, monitoring and Improvement outcomes.**

**The SSNAP results showed the hospital had enough beds for patients who needed stroke care. Patients did not wait longer than necessary for treatment and were supported at the point of discharge and beyond by community teams for longer term management.**

**The hospital's own data showed that care pathways in place for the reduction of falls and pressure ulcers were beginning to be effective and improvements were noted in the reduction of incidents.**

### Staff equipment and facilities

The use of electronic white boards made for effective communication on each ward using them. Patients with additional conditions such as a learning disability or dementia were noted. Confidentiality was preserved because the screens did not display information once staff had finished looking at it.

All acute medical patients were seen within 12 hours by a consultant seven days a week. Medical staff told us that led to clear management plans being in place. Consultants told us that their on call commitments were manageable and systems in place worked well.

We did not find any patients with medical conditions being cared for in other specialities such as surgical wards during this inspection. When this did happen staff told us that steps are taken to bring the patient back to the medical care wards as quickly as possible.

### Multidisciplinary working and support

We saw input whilst on wards from occupational therapy and physiotherapy. Nurses spoke about how they were able to refer to dieticians, the falls prevention team and mental health services as needed. This was evidenced in records. Some of the staff we spoke with told us that access to some services such as occupational and physiotherapy was difficult for them. We did not find any evidence that suggested these views had an impact upon patient care during our inspection.



# Medical care (including older people's care)

## Are medical care services caring?

Good



### We did not inspect this aspect of the service in 2015

The in patient Friends and Family Test (FFT) results (people are asked would they recommend the service to their family and friends) showed that the trust scored below the England average for four months from September – December 2013. When questioned in survey, Marjorie Warren was the ward people were 'extremely unlikely' to recommend. However Marjorie Warren ward was reopened as a respiratory care ward 2013 and returns for this FFT may not be accurate because the speciality of the ward had changed. The wards that patients rated as 'extremely likely' to recommend were AMU West and East.

#### Compassion, dignity and empathy

We saw patients being treated with compassion, dignity and respect. Staff routinely pulled curtains around patients before they started helping with personal care. We saw that call bells were answered promptly and a patients and relatives spoke favourably of the care and support they received. One person told us, "I feel the care is excellent". Another patient said, "The staff here are very very kind". Not all of the people we spoke with were happy with their care. Some people told us staff left the light on at night on one ward. This had made it difficult for them to sleep. Another person told us they were not clear about what was happening to them in terms of their discharge planning.

We observed staff interaction and whilst staff were caring and supportive, some staff used language that was disrespectful. We heard staff refer to patients as 'sufferers', and 'feeders'.

We observed junior and middle grade doctors working with patients who lived with dementia. We saw that that curtains were drawn to maintain patient dignity. We heard that they introduced themselves and asked

about pain, but we did note that the patient was not asked explicitly for their consent to a physical examination and the doctors gave a limited explanation of the procedure.

We saw that comfort rounds were undertaken on all the wards we visited. Patients were given drinks, meals and personal care.

#### Involvement in care

Patients and relatives we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their consultant and the named consultant was written above their bed.

#### Emotional support

We saw staff of different disciplines talk with patients in an encouraging, kind and compassionate manner. Staff answered call bells promptly and we observed that privacy and dignity were maintained during intimate procedures. Staff supported both the patients and their families. Patients reported that they felt well looked after by the multidisciplinary team.

## Are medical care services responsive?

Good



### We did not inspect this aspect of the service in 2015

#### Meeting people's needs

The hospital had introduced an electronic patient record (Cayder patient flow manager) to improve patient information, including discharge information across the patient pathway. The system included a patient's full medical and social history information. This had led to information about the patient being available when they were transferred and allowed information about the status and care needs of the patient to be available to the receiving ward at the point of transfer. Staff told us it had improved the information about the needs and care of the patient.

#### Vulnerable patients and capacity

# Medical care (including older people's care)

The trust had introduced the Royal College of Nursing Dementia Development Programme, a dementia strategy, which involved staff taking on the role of dementia champions. The hospital is also supported by a dementia lead nurse. Additional external training for senior medical and nursing staff had been procured for staff to help embed critical staff knowledge and develop appropriate skills. Dementia training was available for staff to access as an E-Learning programme, on the new staff foundation programme.

We found that most of the staff aware of the strategy and patients were screened and assessed on admission. Patients diagnosed with dementia were identified by a butterfly symbol placed on the ward notice board and at their bed heads. Each person diagnosed had a patient profile developed based on their known likes, dislikes and activity patterns but these were not consistently completed. We did find that not all staff were aware of current best practice when caring for patients with behaviours that challenged them. On one ward they told us that patients were managed by the security staff if they became too agitated. The trust told us in response to this, the presence of security staff on the wards is to help calm agitated patients and provide support for staff.

## Leaving hospital

There was a daily ward round on the AMU including weekends. Katherine Monk ward had a clinical pathway facilitator. They worked Monday to Friday. Staff on this ward expressed a view that patients were not often discharged at a weekend.

We spoke with a patient on Katherine Monk ward. They were due to be discharged that day. They were aware of the plans in place and their medication was ready for them to take with them. There was evidence of a multidisciplinary review round all aspects of their care was checked and completed for this patient. On the same ward there was a clinical pathway facilitator. They described their job as chasing other departments within the hospital to

ensure all aspects of discharge were in place. In addition to this they needed liaison with external people such as families and social services to ensure patients were supported upon discharge.

Staff attended patient safety bed meetings, which they felt were useful as they provided multidisciplinary support to help relieve pressure on beds. Multidisciplinary meetings were also held daily to discuss when people were medically fit for discharge but required support at home. This helped identify the discharge needs of patients.

Discharge planning was started when the patient was admitted to hospital. The trust had 'in-reach' staff from all wards. These personnel told us they could access care services and liaise with care homes to begin the discharge process. All ward teams had trajectories for morning discharges and daily discharge numbers required. Not all areas were achieving the necessary number of morning discharges. Matrons focused on this by undertaking daily board rounds in the afternoons to improve the discharge planning. (Corporate Performance Report, Quality and Safety, January 2014.) In-reach staff told us they felt that the coordination of the transfer of patients had improved. However, analysis of patient feedback data and views expressed at the listening event showed that some patients were still experiencing problems with discharge arrangements.

## Learning from experiences, concerns and complaints

Patients we spoke with during our inspection said they felt comfortable about raising a complaint if it was needed. Some of the people who attended our listening event told us they had not had a positive experience but wanted to go through the process so that other people would not have to. Staff told us that the emphasis about complaint resolution had changed over the past 12 months. Staff felt more involved in the process, they were able to take part in investigations and did not consider complaints to be a negative experience. Staff told us they wanted to learn from mistakes and to make sure that when things went wrong they could try to prevent situations from arising again. We spoke with senior nurses and medical staff who also confirmed that there had been a change culture at the hospital and

# Medical care (including older people's care)

this had encouraged a more open approach to investigating complaints. Staff told us they are trying to ensure early resolution of complaints by getting patients and staff to work together. Consultants told us they were now notified when a complaint had been made. This allowed them to be part of the process this was an improvement on past action when they said they were not told when complaints had been made by patients.

## Are medical care services well-led?

Good



### We did not inspect this aspect of the service in 2015

#### Governance arrangements

Staff spoken with told us that things were improving day by day. They spoke of learning from incidents and discussions about near misses, involvement in action plans and developments such as the falls prevention programme. We saw action plans in place for individual wards to help them improve patient care and treatment. We did not see individual statistics for each ward listed at their entrance for incidents of falls, pressure sores and medicine management. These were trust wide statistics and therefore patients, relatives and staff could not be certain how well-led an individual ward was.

#### Leadership and culture

We spoke to 46 staff of varying designations during this inspection. The main message we heard from staff was that there was undoubted change for the better within the hospital. The CEO, executive team and Board all provided leadership and a visible presence. One nurse told us that she could email the CEO and would get a personal response. Patients also told us the leadership team were visible and available to speak with them.

We were told by nurses that the nursing leadership on some wards is very good. This included the short stay

ward and William Harvey Ward. Other wards had recent appointments that nurses were positive about. Nurses were positive about the new recruitment of additional nurses throughout the hospital.

#### Patient experiences and staff involvement and engagement

All of the staff and patients we spoke with told us they were engaged with the hospital. Staff told us the effectiveness of the 'stepping up' meetings had meant they were all working better as teams and were able to see action and resolution to issues raised. This had included staffing levels, concerns about care and safety in the past. In the focus groups we held staff told us that they were supported by senior managers, the trust board were visible and regularly visited the wards. This made them accessible to both staff and patients receiving care.

Patients who attended our listening event told us in the past care at the hospital had not always been good and they had complained. They also told us that they had seen a marked improvement in the care and treatment of patients over the past 12 months.

#### Learning, improvement, innovation and sustainability

In November 2013 the trust launched the Royal College of Physicians Fallsafe initiative. Osler and Kingswood ward were chosen as they has a higher number of falls, some of which were injurious. The interim report found that the introduction of slipper socks and yellow magnets to visually note patients at risk of falls had seen a reduction in falls and none resulted in a serious injury.

We were given a recent document entitled Pressure Ulcer Brief March 2014. This set out how the trust is tackling the acquisition of pressure ulcer whilst in hospital. It sets out the trusts projects and involvement in pilots. In the year 2013/14 there had been a steady decline. In the first quarter there were 36 hospital associated pressure ulcers in the third quarter there were 29.

All the staff we spoke with during our inspection had received an annual appraisal and had set learning and development objectives for the following year. Mandatory training was up to date or programmed to

## Medical care (including older people's care)

take place in most areas we visited. Staff were happy with the access to training within the trust. They were informed in advance of any necessary training they

needed and the training would be scheduled in. The training was competency based and everyone thought the training provided within the trust was of a good standard.

# Surgery

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

## Information about the service

The acute surgical service at Basildon University Hospital provided a range of surgical specialities. During our inspection in 2014, we visited four ward areas. There are eight wards providing a surgical service in the hospital. These included general surgery, trauma orthopaedics, gynaecology, and the day surgery unit and pre assessment areas. We also visited the main theatre suite and a ward within the Essex Cardiothoracic Centre.

In 2014 we talked with nine patients, three visitors and 16 members of staff. We observed care and treatment, looked at care records and attended scheduled ward handovers.

During our follow up inspection on the 17 and 18 March 2015 we spoke with eleven patients and eight members of staff in various seniority. We looked at five patient care records and observed care being provided on two surgical and two trauma and orthopaedic wards. We checked ward documentation with regards to medicine management and looked at three risk assessments.

## Summary of findings

In 2014 we identified that improvements were needed in the way the trust managed the use of the day surgery unit at night. We found bed capacity was pressured and patients who could not be accommodated on a general surgical ward were being placed in the day surgery unit overnight. When we returned to inspect the day surgery unit in March 2015 we found the day surgery unit was not used as an escalation ward to accommodate hospital beds.

In 2014 improvements were needed to make sure the administration of controlled drugs was accurately recorded in some of the surgical areas. In March 2015 we checked controlled drug records and procedures and found all records to be correct using safe procedures and practices.

Patients care was effective because staff were using evidence based guidance and research.

In 2014 people were well cared for but some people were not included in conversations about their care during ward rounds and information about people's bed did not promote their dignity. We saw patient's privacy and dignity was respected in all areas during our inspection in March 2015. Individual patients were included within ward rounds and the planning of their care.

Information that should help staff understand what they are doing well and where they need to improve was not available on all the surgical wards we visited. In 2014,

# Surgery

staff on some of these wards did not understand what they could be doing better in terms of falls and pressure ulcer prevention. In March 2015 we visited two surgical and two trauma and orthopaedic wards during our inspection and within the ward entrances, we saw performance notice boards with up to date information informing both staff and patient's what care was being delivered well and what areas could do better.

## Are surgery services safe?

Good



### Safety and performance

In 2014 wards displayed information for patients and visitors showing staffing levels and monitored trust initiatives to maximise patient safety. We saw data displayed on the wards about the trusts 'hot spots' and the top patient safety risks.

In March 2015 we found improvements had been made with the introduction of performance data notice boards on each surgical ward. We spoke with eight members of staff who all demonstrated knowledge around the ward performance and incidents that had been reported. We looked at safety thermometer information on Horndon Ward at our inspection in March 2015 and saw the last hospital acquired pressure ulcer on the ward was 280 days as of 17 March 2015 and the last patient admitted onto the ward with a pressure ulcer was 69 days as of 17 March 2015. We also saw that Venous Thrombo Embolism (VTE) assessment compliance was 98% on Horndon Ward.

There was consistent performance with infection prevention and control (IPC) screening across all surgical wards. For example, meticillin-resistant staphylococcus aureus (MRSA) which we saw an average compliance of 98% across all surgical wards.

In 2014, we spent time in the main theatre suite and observed the care delivered. Patients were protected from avoidable harm during surgery. We observed a theatre team undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist. The theatre staff completed safety checks before, during and after surgery. The use of the WHO surgical safety checklist had improved in all theatres and this was monitored through a shared governance approach with both the clinical and management team. We visited the day surgery unit where we looked at the care of three patients who had been admitted for surgery and found that all the relevant checks had been undertaken.

### Learning and improvement



# Surgery

In 2014, staff reported incidents as normal theatre practice. Incidents were analysed and appropriate specialists made recommendations for improvements which included tissue viability nurses. Consultants told us in the focus group that each clinical division had been asked to develop a five year strategy for their area. They told us they felt this was a change “we all welcome”. They told us that senior management were more willing to trial new improvements rather than ‘top down edicts’. They cited the ‘deteriorating patient’ project as an example. This project helps focus us all staff on patient care and responding promptly when their condition deteriorated. Staff also told us about serious incidents and how learning had taken place, not only in relation to the incident but in how they investigated them. Staff had been given extra support and training to build on their skills to give them more confidence dealing with serious incident investigations.

## **Systems processes and practices**

### **Hospital infections and hygiene**

In 2014 the hospital had appropriate infection control systems, but we noticed that they were not strictly observed in all areas. For example, we saw staff opening pedal operated bins by hand. Staff who had not used the bin properly did not always clean their hands afterwards. We also observed a member of staff using the same blood pressure cuff to record patients’ blood pressure measurements and not clean the equipment between patients. This created a risk of cross-contamination. We did observe that the majority of staff were adhering to the ‘bare below the elbow’ policy. Staff also had access to personal, protective equipment such as gloves and aprons and there were sufficient hand washing facilities.

In March 2015 we observed all staff following the trusts policy and procedures with regards to infection prevention and control. Staff within clinical areas were bare below the elbow and there was systematic hand washing between patient care.

Patients and visitors were provided with information on how to prevent infections and there was hand hygiene gel in all ward areas for patients, staff and visitors to use. Patients with spreadable infections were treated in side rooms. Overall, we observed on the wards and departments that we visited, that the environment was kept clean as part of the infection control measures.

We did note good practice in the main theatre suite and observed good infection prevention practices. We met with the theatre manager who informed us that there was a lead for infection prevention within theatres and we saw that data had been collected and published about how the theatre staff were performing in relation to saving lives data. We found that hygiene audits completed in theatres showed 100% compliance for the previous month.

### **Medication**

In 2014 we noted some concerns around the safe management of controlled drugs across the surgical unit. We checked the controlled drug register and noted in main theatres that there had been omissions by staff to enter who had administered the drugs and the amount given to the patient. This had happened at least once a week. We raised this with the recovery team leader and theatre manager immediately who took action to rectify it.

We reviewed this on the other wards which we visited. We found on one ward that the controlled drug cupboard was open and saw a drug had been given and not signed for by the member of staff who had administered it. This was raised with the nurse in charge. We also found that wards had several different methods of recording when the balance of controlled drugs in stock had been undertaken. One ward signed a book; another had a sheet of paper inside a book. This meant that there was no continuity in how staff were recording the stock balance.

In March 2015 we inspected controlled drug records, stock and administration procedures on four wards and we found all four wards to be compliant. The trust had introduced a generic controlled drug record book which was in use and all entries were correct.

All drug cupboards were locked including the external door to the clinical room that stored drugs. Intravenous fluids were locked away and only those nurses qualified to carry access keys to controlled drugs and complete drug administration did so.

### **Monitoring safety and responding to risk**

In 2014 we visited Basildon Day Unit [BDU] staff told us about the use of this area for emergency surgical patients who could not be accommodated on general wards. The bays on the ward were large enough to incorporate five patient trolleys, however, on a regular basis; staff told us that full size beds were put into the bays and that at times

# Surgery

there were six beds in these areas. This had been raised with the trust infection prevention team by the senior members of the nursing staff. The trust told us that the BDU could accommodate seven trolleys on either side or five full sized beds on either side. It was strictly monitored and not exceeded.

In 2015 we visited the day surgery unit and found that the day surgery unit no longer placed patients onto the unit who could not be accommodated on general surgical wards. There were no full sized hospital beds in place and the appropriate amount of trolleys were in use.

There were sufficient numbers of staff on duty at any one time and there was use of bank and agency staff. Regular staff also worked extra shifts within the wards which covered gaps in the roster. This meant there was always a sufficient number of staff who were familiar with the wards and the way it worked, ensured consistency of care for patients. We noted that agency staff were used on a regular basis to cover the escalation beds on the day surgery unit. Staff told us that they tried to ensure consistency by booking the same staff but that this was not always possible.

Staff we spoke with understood safeguarding and how and when to report abuse. Staff told us they had been provided with training and the trust's training information confirmed this.

There was an effective system in place to make sure that patients were asked for their consent prior to any procedure being carried out. Staff were able to talk with us about how to determine whether or not a patient had the capacity to consent to their treatment. Staff were also clear about who to involve if patients did not have the capacity to do this.

## Anticipation and planning

In 2014, we also attended a nurse hand over at night on the day surgery unit due to the concerns we had about the use of the beds for emergency surgical admissions out of normal working hours. We spoke with the staff on duty who told us that they would get admissions "day and night" and how this had a major impact on how they managed elective admissions the next day. This resulted in patients being moved out of this area to free up bed spaces for elective admissions.

The trust had responded to the risk and following a review of winter pressures the trust opened a new ward and created a further 14 escalation beds. In addition the trust can offer further treatment for patients in the BDU overnight. The use of the BDU in this way had not impacted upon patient care. Some of the staff we spoke with were feeling pressured by this arrangement and thought at times the unit was very busy and this had impacted upon the work they needed to do in day surgery.

We also noted that this area currently shared a resuscitation trolley with the theatre recovery area. The trust told us the resuscitation trolley was used for the theatre area, recovery area and the BDU. Once the theatre lists are completed the resuscitation trolley is then moved to the day surgery unit if being used overnight. This meant although the resus trolley was shared between the departments it was not shared at the same time. The risk to patients was reduced as a result.

## Are surgery services effective?

Good



## We did not inspect this aspect of the service in 2015

### Using evidence based guidance

Care and treatment was delivered in line with current legislation, standards and nationally recognised evidence-based guidance. We observed care in both theatres and the recovery area, reviewed records and spoke with staff. Care observed was in line with the trust policies and procedures, and patients' care plans. Medical and nursing documentation was appropriate, and staff were knowledgeable about the patients in their care and the care required.

### Performance monitoring and improvement of outcomes

Patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS, were asked to complete questionnaires before and after their operations, to assess improvement in



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health as perceived by the patients themselves. These results are known as patient reported outcome measures (PROMS) and they showed that there were good outcomes for patients and no evidence of risk.

## Staff equipment and facilities

Appropriate equipment was available for patients when required.

The clinical areas were clean and uncluttered. There was hand gel available in all areas and staff were seen using it appropriately.

## Multidisciplinary working and support.

We saw evidence of good team working across the surgical department. There were systems in place to include all staff in the development of the division.

## Are surgery services caring?

Good



## Compassion dignity and empathy

In 2014 we saw good examples of care in the main theatre suite, and patients told us, that staff treated them with kindness and compassion. Patients also told us that they were pleased with the care they had received and that they were happy with the way staff had treated them. We observed on the cardiothoracic ward that there was a positive relationship between staff and patients and people also told us that they were pleased with the care they had received. We saw the use of signs about patient's beds on Bulford Ward that did not promote people's dignity. This included, 'I need my food cut up', 'Feed me' and, 'To be fed'.

In March 2015 we observed that the practice of placing signs above patients beds to advise if they needed their food cut up or a patient needed to be fed and specifically 'feed me' had stopped and was replaced with a colour coded 'sticker dot' system for which the nurses knew which colour reflected the patients care needs. This was across all surgical wards that we inspected.

There were single-sex bays and single side rooms to ensure privacy and dignity for patients. Privacy screens were used by staff when appropriate. However, we observed on the day surgery unit when we arrived, that the dignity boards

were not in place. This meant that patients sat in the waiting area could see into the bay opposite where female patients were cared for. In 2015 we visited the day surgery unit and saw that patients were cared for with dignity and respecting privacy. We visited Burstead ward whereby the nursing staff also ensured that side rooms opposite all same sex bays were occupied by the same sex as well.

In 2014 we observed several incidents when patients had to wait for care. One patient waited for 20 minutes for their pain relief and another was left in a wet bed for 30 minutes. Both issues were raised immediately with the staff in charge and the patients were attended too.

In 2015 we observed care throughout the whole of our inspection and found that care was provided in a timely manner. We witnessed that call bells were answered quickly. We spoke with three patients about their pain relief and all patients received their pain relief within an appropriate time. We witnessed one patient receive their pain relief within five minutes of requesting it.

## Involvement in care

We were told that staff were hard working and were on hand as quickly as possible. One person told us, "It really has been a wonderful place to stay in. The staff have been fantastic and have been there for me whenever I needed anything". Another told us, "I've had no problems with pain after my surgery and the staff have been good". A relative we spoke with told us, "I have been surprised about how well things have gone. We have no complaints".

## Trust and respect

In 2014 we attended a structured nursing handover meeting where each patient was discussed in detail, including discharge plans. Staff then walked around the ward for the remainder of the handover and we noted that there was little interaction from staff towards patients. Most staff stood and listened and made no attempt to make eye contact with patients or interact. Patients and their relatives however, told us that they were treated with dignity and respect.

In 2015 we observed a nursing handover during our inspection and spoke with two registered nurses about patient involvement in handover of care. We saw the

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nursing teams interact with patients during handover and gain their opinion on the care they received. One patient told us “I am kept fully informed and the nurses are always asking me if I am ok.”

## Emotional support

We also observed good practice on several wards where staff interacted well with patients and it was clear that staff addressed the physical, social, psychological and emotional needs of patients where possible on these wards.

### Are surgery services responsive?

Good



## Meeting people's needs

The Department of Health monitor the proportion of cancelled elective operations. This can be an indication of the management, efficiency and the quality of care within the trust. The trust scored similar to expected on both questions regarding cancelled operations when compared with other trusts.

We looked at the surgical targets for the hospital and found the referral time to treatment (RTT) for admitted patients was meeting the required standard for 10 of the last 12 months. For patients who were not admitted the hospital met the standard for 11 of the last 12 months. In the last quarter four the hospital met the standard for all of its surgical pathways.

## Access to services

In 2014 we had concerns about the management of emergency surgical patients and the use of the day surgery unit as an escalation area on a regular basis for these patients. There was a standard operating procedure which included criteria for admission, and staff were able to show us this and discuss in detail which patients could be admitted to the ward. The trust had responded to the risk and following a review of winter pressures the trust opened a new ward and created a further 14 escalation beds. In addition the trust can offer further treatment for patients in the BDU overnight.

In March 2015 we visited the day surgery unit and found that the trust no longer used it as an escalation area and

had responded to the risk that was associated with using the day surgery unit for an escalation area. The capacity was managed within a safe process responding to patients care needs including privacy and dignity. However, we visited the recovery area within theatre's and found that patients were kept in this area longer than anticipated and the facilities within recovery did not support patient needs. For example, lack of private toilets.

## Vulnerable patients and capacity

Staff we spoke with were aware of their role in identifying vulnerable patients and how to raise a concern. Nursing staff were able to show us information about advocacy services that were available to patients, and they explained that they would also direct patients and relatives to the PALS if they needed any further information.

## Leaving hospital

In 2014 on the day surgery unit staff told us about the use of this area for emergency surgical admissions. Staff felt this was not the best use of the unit and the hospital was not effectively managing its bed capacity for surgery. We were told by staff that they had raised this as a risk with the senior management. Patients were cared for in the day care unit overnight, although staff felt this was an inappropriate area to do this, we did not find this had an impact upon patient care. The trust had taken action to ensure staff were in place to care for these patients.

Staff also told us that the use of these beds had an impact on how they managed the elective admissions. On most mornings they started with a full ward, which meant that patients were moved out of the day surgery unit to create capacity for the planned admissions. Senior staff we spoke with told us that this was due to delayed discharges on the general wards and staff did not utilise the discharge lounge effectively.

In March 2015 we noted that there was still a minor concern that patients for elective admissions were delayed due to delayed discharges within the wards and could at times cause a patient flow problem. However, we did see that ward managers communicated around this issue which provided the support to staff and information provided to patients.

## Learning from experiences, concerns and complaints

The surgical unit responded to all complaints appropriately and in line with trust processes. There was a process in

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place to monitor and review complaints and suggestions for improving the service. Complaints were audited, trends identified and action taken, where necessary. We saw a copy of a quality improvement plan for the surgical unit dated 2013/2014, which detailed action plans to address concerns raised in complaints and noted that the majority had been completed.

## Are surgery services well-led?

Good



### Quality performance and problems

In 2014 staff said they knew how to report incidents. We found in some areas staff were able to tell us about incidents that had occurred in their area of work and the lessons learnt. However, staff in other wards were not aware of these and the learning had not been shared. As part of our inspection we asked staff in wards about how this quality assurance process fed back to them and whether they had opportunities to learn from audits. In some wards staff were able to tell us how they discussed the results of audits, lessons from incidents and complaints as part of team meetings and considered how they would put this learning into practice. In other wards staff had very little awareness and did not understand the quality assurance information displayed in the ward and how well they were doing against the targets.

In March 2015 we spoke with eight members of staff who explained to us they always received feedback from any incidents they submitted and provided us with examples of changes of practice. For example, on Burstead ward they had changed their medication trolley to a different design due to errors using a small trolley previously. This decision was supported by the divisional management team.

We looked at the regularity of governance meetings and saw that the trust had introduced half day clinical governance quality meetings with separate half day for quality audit checks. These were attended by both medical and nursing staff with varied seniority.

### Leadership and culture

In 2014 a number of staff we spoke with said that they thought the leadership of the trust had improved as a result of the new senior management team and told us that

they felt proud to work at the trust. The results of audits and of feedback from the Friends and Family test were on display in all the wards we visited. We saw that following restructure the surgical division now had a senior management team which comprised of a clinical director, a general manager and a head of nursing and quality. The division included general surgery, trauma and orthopaedics and anaesthetics (theatres). Staff also said they saw the senior management team had visited parts of the trust as part of their work to assure themselves of the quality of care being provided, and welcomed this.

In March 2015 we saw that one band 7 was redeployed and another band 7 was moved further to a management decision. A senior ward manager was subsequently deployed to assist and support from another ward. We spoke with the matron of surgical services and we were reassured that a business continuity plan was in place with succession planning and development for band 6 nurses for promotion. We spoke with the band 7 managers looking after two wards and they told us that their work load was manageable and if they had any concerns they were able to bring them to the attention of their manager without any repercussion towards their individual ability and were encouraged to create and maintain an open culture.

### Patient experiences and staff involvement and engagement

In 2014 the 'Stepping up meeting' took place each morning. Staff are invited to attend to identify key risks in the trust on that day and how they can be addressed. All of the staff we spoke with told how this meeting had made them aware of not only the issues arising in the area they worked but that of the whole hospital. Staff told us this had led to them understanding the pressure points across the hospital and how important it was for staff to work together.

Information was available for staff and patients about the trusts performance in terms of reducing the incidence of falls, pressure ulcers and blood clots. Patients were regularly asked to give their feedback and views on the care and treatment they had received. Some of the staff we spoke with did not understand how the trust information about falls, pressure ulcers and blood clots related to them and the care they gave patients on the wards they worked on.

### Learning, improvement, innovation and sustainability

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In 2014 there were concerns about how well the surgical division is responding to provide capacity caused by current and sustained high levels of activity which has resulted in patients being admitted to escalation areas such as the day surgery unit. Risks have been identified by senior staff working in this area however, the practice of admitting patients to this area continued.

In March 2015 at our inspection, we spoke with two senior managers about their current concerns around any capacity and if their voice is now heard by the trust with

their concerns. We were told that the trust has listened and the practice of patients being admitted to the day surgery unit does not happen. One member of staff told us “I really feel that the trust has taken ownership of its previous issues and wants to achieve.”

Staff told us they were encouraged to learn and take part in training. This included junior medical staff who said that the system in the hospital had improved; they had better access to training, senior staff support and enjoyed working in the hospital.

# Critical care

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

## Information about the service

The critical care service at Basildon and Thurrock University Hospital NHS Trust has 34 beds that provide intensive care. These are intensive therapy unit (ITU) and high dependency beds (HDU) beds, which deliver care to patients of all ages with serious life-threatening illness and for patients who are too ill to be cared for on a general ward. A critical care outreach team assists in the management of critically ill patients on wards across the hospital.

Also on the hospital site is the Essex Cardiothoracic Centre which provides specialist treatment and care for people with heart or lung problems. There are 22 critical care beds available within the centre, 14 intensive therapy beds and eight high dependency beds. The centre has its own dedicated critical care outreach team to assist with the management of patients who have undergone cardiothoracic surgery.

During our inspection in 2014 we visited both units. We spoke with five members of the medical team (senior and junior) and nine members of the nursing team. We also spoke with two patients and visiting relatives for their views on the care provided.

**We inspected this service in 2015 please see the separate report for this inspection.**

## Summary of findings

The critical care departments in the hospital provided safe and effective care. They had enough staff on duty to meet the needs of the patients they were caring for. Staffing levels were in accordance with national guidance.

We found there were systems in place that demonstrated learning had taken place to improve clinical care when incidents had occurred. Patients and relatives told us that staff were caring and responsive to patients' needs. We saw staff delivering care that was compassionate and caring.

The service was well-led; we found good clinical leadership and no concerns with the way in which services were provided for patients.

# Critical care

## Are critical care services safe?

Good



### Safety in the past

The trust shared its data about risk through the 'hot spots' and 'top spots' initiative. This information was displayed on the ward for staff to see and take action with. Information included risk in relation to falls prevention, pressure ulcer development and infection control.

All of the staff we spoke with were aware of this and their role in taking action to improve patient outcomes.

### Learning and improvement

Staff we spoke with were open in discussing and learning from incidents. One member of staff we spoke with told us, "I raised an incident form about an aspect of patient care, and really felt I was listened too and was given feedback on the steps taken to ensure it didn't happen again". Staff appeared to be very engaged in making care as safe as possible.

We found that the critical care units had systems and processes for reporting and recording adverse events. There were systems to ensure monitoring at a local and trust-wide level. We saw that staff handovers were used to share any learning. A new 'patient safety briefing' had been introduced on the general critical care unit and now took place at each handover. This ensured that information was shared with the whole team in relation to any identified patient risks. Staff we spoke with told us how this briefing had improved communication and highlighted any patient safety triggers for the forthcoming shift.

### Systems, processes and practices

#### Equipment, and facilities

There were security systems in place on the entrance doors to both critical care units which meant that access by other hospital staff and members of the public was managed.

Both the general intensive care and cardiothoracic units had been purpose built and were of a considerable size, with ample space around each bed space to accommodate equipment and provide a suitable working environment for staff. The atmosphere on both critical care units was calm and relaxed. There was adequate storage available which ensured that equipment was well managed and stored

appropriately. The critical care units were tidy and visibly clean. We saw that there was appropriate equipment available to deliver care safely. There were suitable systems in place to ensure that equipment was ready for use and functioning effectively at all times. Staff carried out suitable checks and kept appropriate records, and everybody we spoke with knew how to report any problems with equipment.

### Infection control

We observed that all of the staff on the critical care units cleaned their hands after every patient contact. There was anti-bacterial hand gel available and we noted that all staff had adhered to the 'bare below the elbow' policy. This meant that the critical care units took appropriate steps to control and reduce the risk of infection.

### Monitoring safety and responding to risk

We found that both critical care units were appropriately staffed to ensure safe care for critically ill people. There were sufficient numbers of suitably qualified nursing staff to meet patients' needs and provide safe care. Staff rotas provided a balanced skill mix and allocation of staff. There was always a senior nurse identified as the lead for the critical care units. When there were unexpected staff absences, systems were in place to ensure that any shortfall was addressed. Certain staff had specific responsibilities or interests, such as infection control. There was good educational support to promote practice improvement, and arrangements to learn from research and any incidents. Patients had either one to one nursing, or one nurse to two patients. If these ratios could not be maintained then the critical care units had policies to bring in staff from other wards to ensure that emergency patients could be admitted. The critical care units did not admit any more patients if a safe level of nursing care could not be assured.

The anaesthetic consultants were responsible for the patients in both critical care units. We met with the lead consultant for governance within the general critical care unit who explained how clinical cover was provided. Currently, one consultant was 'in charge' for a week at a time, which ensured continuity for the care of patients. We were informed that a management review was taking place in relation to current medical staff numbers. Two new consultant posts for critical care had been advertised. There were currently five consultants working on the unit.



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The increase in numbers proposed would also involve a change to the working rota, which was based on seven consultants providing cover from 8am to 8pm. This would improve continuity in patient care.

## Anticipation and planning

We saw that the critical care units had a range of systems and procedures to ensure the safety of its patients. For example, it had checklists for procedures and safety handovers. We did not find any examples of when the critical care unit was unable to provide care for patients through lack of available beds.

### Are critical care services effective?

Good



## Evidence-based guidance

The trust submitted the required data to the Intensive Care National Audit and Research Centre (ICNARC), which aims to foster improvements in the organisation and practice of critical care (intensive and high dependency care) in the UK. The results showed the trust mortality rates for this unit were within acceptable levels. We met with the critical care matrons for both critical care units and also senior consultants who told us that there were plans in place to review the data collected through this tool. We saw a copy of a local compliance review action plan which demonstrated that data collected about delayed discharges from the units was discussed monthly at local governance and multi-disciplinary team meetings. This data was used to improve the patient journey through the critical care units. The review of the data is important to monitor the effectiveness of the unit and allow comparison with other intensive care units nationally.

There had been significant improvement in the management of patients who had or were at risk of getting a serious infection because of their critical condition with the introduction of a sepsis care bundle. Medical staff we spoke with and members of the critical care outreach team considered that the sepsis care pathways they had developed to be clear, and they believed that the pathways were responsible for improving the effectiveness of care.

This was an area of good practice which was being rolled out across the trust.

## Monitoring and improvement of outcomes

We saw robust evidence on the cardiothoracic intensive care unit which demonstrated how the ICNARC data had been used to drive improvement of patient outcomes and also found that senior medical and nursing staff were fully involved and able to demonstrate how they used this audit data to evaluate clinical practice.

## Sufficient capacity

Staff confirmed that they received suitable training to carry out their roles and that the training took place in protected time (time that was dedicated to training). Nursing leadership and accountability were clearly defined. Staff rotas identified a senior coordinator for each shift. Nurse to patient staffing ratios were in accordance with nationally accepted guidance for specialist areas. This ensured there were enough suitably skilled nurses to provide patient care.

## Multidisciplinary working and support

We saw that staff had improved their handover paperwork and processes between shifts to ensure that relevant information about patients was passed on the general critical care unit. This had been supported by the introduction of a daily 'patient safety briefing' at each handover. We saw that there were systems in place to ensure senior intensive care medical expertise was available to the critical care areas at all times. Staff were well trained, and there were clear systems in place for contacting specialist surgeons or anaesthetists, including out of hours.

Staff we spoke with told us allied healthcare professionals supported patients' recovery because there was access to physiotherapy, speech and language therapists and dietetic services.

### Are critical care services caring?

Good



## Compassion, dignity and empathy

Patients in the critical care units told us that care was good. We saw that the critical care areas were clean and well organised and that patients looked comfortable. A relative of a person who was being cared for on one of the units told us, "Everything is very good. Communication has been great and the environment is excellent". Another told us, "I really can't fault anything. The staff have been very

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professional and nothing has been too much trouble". Staff respected patients' privacy and dignity. For example, we saw staff pulling curtains around patients' beds while caring for their needs. This demonstrated that staff acted appropriately to maintain patient's privacy. Most patients were aware of their care and treatment and described their clinical care as very good or excellent. We found that staff were caring and compassionate on the critical care units and we saw staff providing care in a sensitive and dignified manner.

## Involvement in care

Patients' care needs were assessed and plans were in place to meet those needs. Staff had kept records up to date and had completed daily observation charts. We saw evidence that patients' fundamental care needs were met, for example through pressure ulcer prevention and management. Throughout the visit we observed staff caring for people on the critical care units in a timely manner. This showed that patient care was delivered as planned to meet patients' needs.

## Emotional support

People we spoke with about the care on the critical care unit told us they were kept informed by staff and were told about any changes in their relative's condition.

### Are critical care services responsive?

Good



## Meeting people's needs

We saw that the critical care units were designed to support patients' changing health needs. The critical care units were well equipped and staffed so that people's needs were met without any delay.

## Access to services

The hospital had a critical care outreach team which included nine nurses (not all full time) and they currently had one vacancy. The team provided a service 24 hours a day, seven days a week. It reviewed all patients within 24 hours of discharge from the general critical care unit. Staff also attended bed management and hospital at night handover meetings to make sure patients were placed in the right area for their clinical needs. It also responded by

reviewing patients who staff were concerned about on other wards. This demonstrated that systems were in place so staff could respond appropriately to patients' needs, particularly for patients whose condition was deteriorating.

## Vulnerable patients and capacity

There was access to services for patients with learning disability. Information was available for patients in alternate formats if needed.

## Leaving the unit

All patients were accompanied by a member of the staff team when transferred to other wards in the hospital. This enabled staff to give face to face handovers to new staff and make sure patient's care needs were understood.

## Learning from experiences, concerns and complaints

Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint then they would speak to the shift coordinator. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department.

### Are critical care services well-led?

Good



## Vision, strategy and risks

Staff we spoke with understood the trust vision. The service was well-led and staff told us they were supported by management and senior staff. The executive team were visible and demonstrated a good understanding of the service and its potential risks. Staff told us they liked the 'stepping up' meeting and they felt involved not only with the care of patients in their unit but the whole of the hospital. Staff told us they worked well as a team and were proud to work in the hospital.

## Quality, performance and problems

The critical care unit and cardiothoracic units were well-led. Senior managers and clinicians had an understanding of the performance of their department and staff were a cohesive team. An internal compliance review of the general critical care unit in February 2014 had highlighted several areas where improvement was

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required. We met with the consultant who was the lead for governance within this unit to discuss some of the actions which had been highlighted, which related to staff involvement in risk and governance issues within the unit.

We saw from the action plan that many of the actions had been completed and dates for completion were in place for those outstanding.

The service had other monitoring processes and projects such as the management of ventilated patients. We noted that there was a clear visual display on the general critical care unit of safety information and performance against specific improvement targets so that staff were aware of how well they were working and in what areas they needed to improve.







## **Leadership and culture**

Staff told us that they felt included and part of the team and that on both units, management were accessible. Staff were able to ask about anything and to discuss any concerns they might have. Monthly meetings demonstrated that staff openly discussed concerns about the service and clinical care, and discussed how the service could improve.

## **Learning, improvement, innovation and sustainability**

We noted several comments from staff about the recent appointment of the critical care matron and how they all felt that they had had a positive impact on the management of the unit and how things were. One member of staff told us, "We are moving forward and we are getting to grips with some issues which have been on-going".

# Maternity and gynaecology

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

## Information about the service

The maternity service at the hospital provides antenatal, intra partum and postnatal care. It consists of a labour suite and delivery theatres, antenatal clinic, midwifery-led birthing unit, antenatal and postnatal wards and neonatal unit. The services provided include peri natal diagnostic screening, antenatal care services, peri natal mental health and counselling services, parent craft as well as education sessions and tours of the maternity unit. The midwife-led birthing unit includes water birth facilities, fully-equipped delivery suite, birthing at home support and infant feeding support services. In the last year 4,560 babies were delivered at the hospital.

## Summary of findings

### We did not inspect Maternity and family planning during our inspection in March 2015.

In 2014 we found maternity services provided to women and babies were outstanding. There were arrangements in place to implement good practice, learning from any untoward incidents and an open culture to encourage a strong focus on patient safety and risk management practices.

The trust had provided safe staffing levels and skill mix and had encouraged proactive teamwork to support a safe environment. We noted that with increasing numbers of births, the trust should consider national guidance which recommends additional consultant hours and the employment of consultant midwives to maintain safe practice in the future. Patients told us they felt safe in the hands of the staff and staff said they felt supported by the trust in managing risk and keeping their patients safe.

There was strong evidence of research and an embedded ethos of shared learning. National guidance was being implemented and monitoring systems to measure performance were in place. We found a consistent track record of high quality, safe care which delivers good outcomes. Care was consistently delivered in line with evidence-based, best practice guidance and the highest professional standards. There

# Maternity and gynaecology

was good collaborative working with partners and other agencies and maternity specific training courses across all groups of staff to support effective care was of a high standard.

The maternity services continuously reviewed and acted on information about the quality of care that it received from patients, their relatives and those close to them and the public. They were able to demonstrate the difference this has made to how care was delivered.

Risks at team and directorate level with regard to the delivery of high quality care were identified, analysed and mitigated systematically before they become issues which impact on the quality of care. The leadership model in maternity services encouraged cooperative, appreciative, supportive relationships among staff and teams and compassion towards patients.

## Are maternity and gynaecology services safe?

Good



### Safety in the past

There were 12 serious incidents declared during 2013/14 in maternity services, all were dealt with in line with the trust reporting system.

### Learning and improvement

There were arrangements in place to implement good practice, learning from any untoward incidents and an open culture to encourage a strong focus on patient safety and risk management practices. Patients told us they felt safe in the hands of the staff and staff said they felt supported by the trust in managing risk and keeping their patients safe. The trust had a reporting system to ensure all incidents were reported in line with defined time scales including those reportable to the National Patient Safety Agency. We found that patients in the maternity unit were protected from abuse and avoidable harm as staff we spoke with were confident to report serious incidents, whistle blow or challenge if they suspected poor practice which could harm a person. There were effective arrangements in place for reporting patient/staff safety incidents and allegations of abuse, which were in line with national guidance. There were clear accountabilities for incident reporting and staff at all levels could describe their role in the reporting process. They told us they were encouraged to report, and were treated fairly when they did, and got feedback on what had happened as a result. Staff could provide examples of reported incidences and the lessons shared to improve practice, such as:

- Information governance breaches- which resulted in a clean desk policy.
- Lack of monitoring information and timely transfer requiring improvement in record keeping.

### Systems, processes and practices

Ward areas appeared clean and we saw staff regularly wash their hands and use hand gel between patients. Bare below the elbow policies were adhered to. A recent Infection control audit outcomes 98% and we saw that audits showed compliance with emergency caesarean section timings which averaged at 12 minutes. Staff were

# Maternity and gynaecology

supported by managers when they raised infection control concerns such as fathers sleeping on patient's beds and were assured that appropriate action would be taken to discourage this practice.

## Monitoring safety and responding to risk

The process for learning lessons and facilitating learning to support pregnant women and their babies is now well established. This was reinforced during the inspection by reports which showed a continual robust examination of all key risks such as swab counts and standard practices such as vaginal examinations during labour where guidance was continually being reviewed to ensure safe practices in line with national guidance. Staff awareness of key risks at all levels of the organisation was good and they could show there was a shared perception of the key problem areas between the board and front line staff such as capacity management and financial constraints. Staff were confident that managers ensured where able that the right staffing levels and skill-mix across all clinical and nonclinical functions and disciplines were sustained at all times of day and week to support safe, effective and compassionate patient care and levels of staff wellbeing. They gave examples of increased staff numbers when demand was high and that managers were responsive to changing needs and circumstances, such as cover for long term sick leave or study leave. Staff noted that administration support for clinics was stretched at times and we saw that the lack of availability of a doctor for the maternity assessment unit caused occasional delays which had been logged as an incident and raised with managers to review.

We saw that staff retention was good, sickness absence for midwives was 2.7% compared to the England average of 4.3%. The Midwife/Birth Ratio 1:29.3 (Jan 14) and Supervisor of Midwives Ratio 1:16 was within national guidelines. The maternity unit currently has 60 hours consultant cover weekly, the provider should consider increasing this level as the Royal College of Gynaecologists (RCOG) green top guideline which has been published 2010 states from 2009 births of 4000-5000 need 98 hours cover. There were also no consultant midwives for the unit currently, which is recommended by the safer childbirth guidelines 2007. There were on call midwives for home births and emergency care each night, supported by the home birth leads. Staff were willing to be flexible where needed and told us they were proud to work there and patient safety was a priority. We saw staffing levels

displayed for patient reference which was good practice. Patients we spoke with were very positive about the approach to safe care on the unit. One patient told us, "They kept checking me as I am higher risk; there is a high level of care here". Staff had received training in the mental capacity act to support people who lacked capacity and we noted that there was a specialist mental health midwife available for counselling and staff said there was some access to counselling services in the ante natal phase if required to support women during their pregnancy.

## Anticipation and planning

The information management systems for managing risks were good. We looked at the serious incident policy and within the Maternity Services Risk Management Strategy 2011-12 the process for escalation of serious incidents has been expanded to clearly demonstrate the individual roles and responsibilities. We looked at a root cause analysis report September 2013 carried out by an independent investigation officer of a still birth and there were clear lessons learnt and actions to be taken to share learning and improve outcomes for people. We saw the action plan and completion dates had been complied with and reported back to staff through the clinical governance newsletter system.

## Are maternity and gynaecology services effective?

Good



There was strong evidence of research and an embedded ethos of shared learning. National guidance was being implemented and monitoring systems to measure performance were in place. We found a consistent track record of high quality, safe care which delivers good outcomes. Care was consistently delivered in line with evidence-based, best practice guidance and the highest professional standards. There was good collaborative working with partners and other agencies and maternity specific training courses across all groups of staff to support effective care was of a high standard.

## Evidence-based guidance

The maternity service could demonstrate that there was a systematic process for identifying relevant legislation, current and new best practice and evidence based guidelines and standards throughout the service. We



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interviewed the research and audit lead midwife who could show the maternity unit used a combination of national guidelines such as Safer Childbirth: minimum standards for the organisation and delivery of care in labour to determine the treatment they provided. Local policies were written in line with this and were updated regularly or if national guidance changed. The quarterly Maternity Clinical Governance Newsletter made constant reference to National Institute for Health and Care Excellence (NICE) and Royal College of Gynaecologists (RCOG) guidance and it was evident that staff were encouraged by the supervisors of midwives to follow best practice guidelines at all times.

## Monitoring and improvement of outcomes

We saw numerous examples of local audits highlighting good practice such as 100 % compliance on swab, instrument and needle count in theatre; 100% anaesthetic records secured, WHO checklist 98%. The outcomes also picked up areas for improvements such as: Maternity record keeping audit 2013 showed poor compliance on completion of fluid balance charts and a 37% decrease in compliance with documenting discussion of birth experience. Areas for improvement were well documented in minutes of meetings, e-mails and newsletters. We found by talking to staff and patients that care was consistently delivered in line with evidence-based, best practice guidance and the highest professional standards. Staff told us they would actively challenge without fear and were enthusiastic about making changes to improve the experience for their patients.

The maternity service participates in national clinical audit, reviews of services, benchmarking and clinical service accreditations and could show initiatives to improve care and share with external organisations as best practise. We found a consistent track record of high quality, safe care which delivers good outcomes. We looked at three indicators used as part of the maternity outlier surveillance programme which is bench marked with other trusts, where the department had significantly lower than expected numbers of maternal re-admissions, perinatal mortality and puerperal sepsis and other puerperal infection which indicated a safe effective service was being provided.

## Effective delivery of care.

We saw some excellent initiatives to improve outcomes for women and babies such as:

- In May 2013 the trust won a UNICEF award for its work to support and encourage mothers who want to breast feed their babies.

- The trust is now one of 120 baby friendly healthcare facilities in Britain, and the first hospital in the East of England region, to win the Baby Friendly Award from UNICEF. The UK Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.

- A care pathway was implemented in 2010 by a Specialist Midwife and Consultant Obstetrician for pregnant women and postnatal women identifying their risk of a blood clot. This model for reducing the risk of blood clots has been rolled out over many maternity units across the region.

Where performance indicators have been below target we saw actions taken to improve quality of service. Elective caesarean section rates were higher than national average; the midwives introduced a birth choice clinic three times a week last year to discuss choice of delivery with new mothers considering a section and assess higher risk patients suitability for natural births. A breech delivery care pathway was introduced six weeks ago and the last quarter statistics indicate a drop in elective sections and an increase in home deliveries. A patient story was recently in the local press “natural birth for concerned mother” where praise was paid to the midwives for providing good information to make the choice.

Staff were very positive about continual professional development opportunities and support mechanisms to develop competencies which support the effective delivery of care. The maternity and Obstetrics dashboard December 2013 showed over 90% for mandatory training and appraisals. Staff we spoke with told us they felt respected, valued, supported, cared for by the organisation and were actively engaged in developing services for patients.

## Multidisciplinary working and support

We found by observing ward areas, listening to focus groups and individual doctors, midwives, support workers and administration staff that there were detailed and timely multi-disciplinary team discussions and hand overs to ensure patient's care and treatment was coordinated and the expected outcomes achieved. Care and treatment

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plans were recorded and communicated with all relevant parties to ensure continuity of care. Patients spoke of good effective care being provided before, during and after giving birth. One patient told us “the midwife was always there helping with birthing, food and pain relief”. Another noted “birthing options were discussed and documented in the notes, the staff were so helpful”.

## Are maternity and gynaecology services caring?

Good



We found that the care given was good. Patients and those close to them were proactively encouraged to be involved in their care, treated as equal partners, listened to and were involved in decision making at all levels. There were consistently positive views from a breadth of patients and those close to them about the care provided, which were supported by the views of the staff and also recognised by external professional bodies. Care was person-centred with patients being involved throughout the birthing plan and parents sensitively supported where bereavement occurred.

### Compassion, dignity and empathy

We could see that staff in all roles put significant effort into treating patients with dignity and patients felt well-cared for as a result. Privacy and dignity posters were displayed and 'please do not enter' signs were observed. Patients told us that staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way. We were informed that with fathers acknowledged as an integral part of the pregnancy process it was felt that the loss of contact between the parents and their new-born following the birth could lead to dissatisfaction and disconnection. 24 hr visiting was available for all partners on Midwifery Led Birthing Unit (MLBU) to keep the family unit together. We received consistently positive views from a breadth of patients and those close to them about the caring approach of staff at all levels of the department. Throughout our inspection we witnessed women being treated with compassion, dignity and respect. We saw that call bells were answered promptly and women we spoke to told us, "There is a high level of care", and "Welcoming and friendly staff, service brilliant".

### Involvement in care

CQC Survey of Women's Experiences of Maternity Services 2013, the trust scored about the same as other trusts for all 17 areas of questioning. The trust showed improvement in six of the eight questions that can be compared between the 2010 and 2013 surveys. Patients and those close to them were proactively encouraged to be involved in their care, were treated as equal partners, listened to and were involved in decision making at all levels. Women we spoke with stated that they had been involved in decisions regarding their choice of birth location and were informed of the risks and benefits of each. They felt that once they had made the decision they had been appropriately supported. Women who chose to have their birth in the hospital were offered a tour of the unit with their partner prior to the birth, and there was also the option of a 'virtual' tour online, to prepare them.

Verbal, electronic and written information that enabled patients to understand their care was available to patients and their relatives in ways that met their communication needs. This included advice such as healthy eating and managing gestational diabetes. There were posters indicating different language options and staff were aware of the provision of information in different accessible formats and interpreting services. All women booked into the unit had a named midwife and their contact details.

Staff were aware of diversity needs and confirmed that an e-learning module on equality and diversity was available to all employees as well as face to face training sessions. There was also an equality and diversity course specifically tailored for consultants. We were told that equality and diversity is embedded into all training modules and part of the e-induction for new starters.

### Emotional support

The maternity department provided a specialist bereavement service which was entered for an award with the Royal College of Midwives (RCM) in 2013. There was a specialist midwife and team giving support to women and their family after loss of a baby whatever the gestation at the time of loss. This included individualised follow up care, telephone contact and/or home visits and annual forget-me-not remembrance service for parents and their family to attend. This was organised in conjunction with the

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spiritual and pastoral care team. There was also care in next pregnancy with an early referral into the system and organising of early reassurance scan which was noted as good practice.

## Are maternity and gynaecology services responsive?

Outstanding



The responsiveness of services was outstanding. The maternity services continuously reviews and acts on information about the quality of care that it receives from patients, their relatives and those close to them and the public. They could show the difference this has made to how care was delivered. There were joint working arrangements and integrated pathways in place to support patients. The needs and wishes of people with a learning disability or of people who lack capacity were assessed and monitored appropriately. Initiatives were seen which offered women the opportunity to discuss their birth choice and experience if they felt the need to, therefore responding to the needs of the population.

### Meeting people's needs

We could see that the midwifery led birthing unit had been designed to provide a non-clinical, calm, home from home environment. The midwifery led birthing unit (MLBU) has recently benefited from an additional birthing pool and the expansion of three delivery rooms with en-suites. There was a rolling equipment programme in place. They were aware of a business plan going to the board in late March 2014 for refurbishment of key areas such as the ante natal clinics and an internal lift to transfer patients to the neonatal unit.

We noted that the early labour ward had mobilisation aids such as birthing ball, mats, birth stool available along with piped in Entonox. Television and audio equipment provided. Early labourers were also offered the use of hydrotherapy in a conventional bath to aid comfort and relaxation.

### Access to services

We found that the maternity service actively engages and works with local commissioners of services, the local authority, other providers, GPs, patients and those close to them to coordinate and integrate pathways of care that

meet the health needs of pregnant women. We saw there was a multi-disciplinary collaborative approach to care and treatment such as a service for 'Young parents to be'. This service provided antenatal sessions within the community setting to enhance knowledge of pregnancy, labour, birth and postnatal care. The sessions run over weeks and have input from community and hospital services to improve access to support pregnant teenagers.

The Early Pregnancy Clinic which was introduced to encourage increased uptake of early blood screens in pregnancy. It is a drop in clinic for women to have early bloods taken and receive early pregnancy advice. The clinic is advertised via GP/Child Health Centres and via Maternity Direct to encourage attendance, the take up of eight week ante natal screen was improving at 49% response in December 2013.

Staff told us there had been an increase in the number of midwives trained in the examination of the new born to ensure one staff member on each shift, which had improved assessment practises and discharge times. On average Midwives now discharge 50-60% of the babies at weekends. The appointment of two home birth lead midwives in 2012 has seen home birth rates increased from 1.6% to 3.7%.

### Vulnerable patients and capacity.

The provider ensured that the needs and wishes of people with a learning disability or of people who lacked capacity were assessed and monitored appropriately. The trust was proactive in taking action to remove barriers that patients face in accessing or using the service. The hospital had a lead learning disabilities nurse to support people whilst in hospital and also in preparation for discharge back into the community. There were clear posters displayed including pictures and contact numbers to encourage people to get in touch for support and guidance during a stay in the hospital. There were also interpreting services available and staff noted that the multi ethnic work force could also support communication where necessary.

Patients, relatives and those close to them say they feel involved in deciding whether they were ready to leave The diabetic outpatient team had seen an increase in requests for information and in response had just initiated a telephone service with dedicated time to improve information to women with gestational diabetes. The maternity direct service allows all women to refer direct to the service regardless of gestation or postcode. This is via a

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dedicated telephone line or email address. Details of the service are distributed to all GP/Child Health Centres and pharmacies in the area. This service now accounts for 70% of all referrals and allows women early access to ultrasound/advice and antenatal screening.

## Learning from experiences, concerns and complaints

We looked at the results from the CQC national survey of women's experiences of maternity service at Basildon hospital and found that maternity scores were similar to other trusts. We saw that complaints were handled in line with the trust policy and we saw that delays in responses and actions needed were dealt with through the women's health governance group meetings. Staff said they were empowered to discuss complaints with patients where possible and resolve issues in a timely manner. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department.

We found managers and staff to be open and transparent about how they had dealt with complaints and concerns in the past. Staff had picked up a theme from survey results and complaints that indicated "women did not always feel listened too". They introduced a Birth Afterthoughts clinic which was short listed for a RCM award in 2012. The focus of this service was to enable all women, including those that do not have English as their first language and those with learning disabilities, to be given the opportunity to discuss their experience of childbirth. To be listened to, helped to understand their experiences, and to have acknowledgement of their journey by midwives who have had additional training in listening skills. Staff were very positive regarding this service and said that patient comments were picked up in team meetings to promote quality improvements. We saw this as outstanding practice.

## Are maternity and gynaecology services well-led?

Outstanding



We found a positive culture of openness and candour with a collective responsibility for quality, safety and service improvement. Risks at team and directorate level were

identified and captured risks to the delivery of high quality care were identified, analysed and mitigated systematically before they become issues which impact on the quality of care. Staff reported being held to account for the management of specific risks. The leadership model in maternity services encouraged cooperative, appreciative, supportive relationships among staff and teams and compassion towards patients. Staff reported that the managers ensured they feel respected, valued, supported and cared for. Staff contributions and performance were recognised, rewarded and celebrated.

## Vision, strategy and risks

The maternity service could demonstrate that they were monitoring capacity and forward planning to reduce the pressure on bed availability going forward. The maternity strategy and internal review 2012/2013 noted that the birth rate in 12/13, as predicted, had risen again to 4560. During the year the maternity unit had expanded capacity by reclaiming clinical space that had been turned into offices and completing the move of the maternity assessment centre. The total of these moves had given 12 extra spaces and should be enough to cope with the predicted rise in birth rate again in 13/14 to 4700.

## Quality, performance and problems

Monthly governance meetings were held within the directorate and a clinical governance newsletter was provided to all staff. Complaints, incidents, audits and quality improvement projects were discussed and a quality dashboard was presented so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to be able to provide.

Staff understood the views of patients about their care. Concerns or best practice were shared to improve performance. Where issues were identified, action plans were put in place and feedback sought from patients to ensure that their experience has improved. The birth aftercare clinic provided patient stories regarding their pregnancy and delivery experiences, which staff used to shape future care.

We saw that there were quality management systems in place which enabled learning and improvements in performance, such as top risks on the register were regularly reviewed and reported back to staff. An adverse event trigger list was maintained which highlighted risk themes for staff awareness. We saw there were regular clinical audit reviews with findings disseminated to all

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staff. For example information about post natal readmissions was not included in the current collection of data; this was recognised as an area for improvement and included. The Basildon Supervisors of Midwives Team had been awarded the Supervisors of Midwives 2013 Team of the Year award, at the Local Supervising Officer's Annual Forum in December 2013. The award was presented by NHS England Regional Director of Nursing for Midlands and the East, who commended them for promoting compassionate care.

## Leadership and culture

We saw that the leadership of the maternity unit encouraged strong team based working, which was characterised by a cooperative, inter-disciplinary, cross-boundary approach to delivering care in which accountability levels were clear and decisions were made by teams to develop services.

Staff were positive about the leadership structures and familiar with the statement of vision and values encompassing key elements of the NHS constitution such as compassion, dignity, respect, and equality with quality the top priority. We saw that risks at team and directorate level were identified and captured effectively and staff recognised their role within the risk management system. We noted positive recognition of the leadership qualities within the maternity services from other external bodies such as the Supervisors of Midwives, NHSLA and the Royal College of Midwives which was evidenced through service awards and service reviews as highlighted throughout this report.

Staff were consulted on service designs and upgrades to premises through multi-disciplinary meetings, focus groups and emails. They were encouraged to be involved in service developments, such as :

- The breast feeding App, 'Feeding Together' which has been short listed for an RCM award, in 2014.
- Following the success of the Health Eating and Lifestyle Study undertaken by the research midwife, Basildon Hospital has joined partnership with Thurrock Public Health. Thurrock Public Health has given 238 slimming world vouchers for use at Basildon Hospital.
- Midwife U-Tube educational vide

The culture was open and transparent; staff were clear where they were performing well, but also fully aware of areas for improvement. There were no surprises, staff were consistent in what the key risks were and this fitted with the current risk profile for the department.

## Learning, improvement, innovation and sustainability







We saw innovation was encouraged from all staff members across all disciplines. Staff were able to give examples of practise that had changed as a result, such as waiting times in the ante natal clinic were now displayed and waiting areas changed following an 'observe and learn day' to improve patient flow and inform patients. Success was celebrated through the 'Glimpses Of Brilliance' noted in the clinical governance newsletter. A recent example was, "Congratulations to the three community midwives faced with difficult home deliveries of breech presentation and a shoulder dystocia where they managed the obstetric emergencies effectively with good outcomes for mothers and babies".

There was strong evidence of innovation and a proactive approach to performance improvement across the service. Staff worked well together and there was obvious respect between not only the specialities but across disciplines. Two staff we spoke with travelled from outside the area to work in the unit and one said, "I love working here, the team are like my family". The other staff member told us, "It's brilliant; I would recommend this service 100%".

Patient involvement to improve care in the maternity services was actively encouraged. The Maternity Services Liaison Committee (MSLC), chaired by a patient representative met six times a year and user representatives on the MSLC are also members on various sub-committees in the Maternity Service. User reps are also conducting unannounced visits in the unit, to ask women and their families about their care. It was reported that this was an innovation to ensure that the maternity service had a check and balance to the staff ward rounds and patient experience questionnaires, ensuring a true picture of how services are perceived by the public. Results of these visits are distributed to staff and discussed at team meetings. This is viewed as outstanding practice.



# Services for children and young people

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

## Information about the service

Basildon Hospital's paediatric clinical service provides acute clinical care to children and young people aged 0 – 16 year olds, requiring both medical and surgical care. It is responsible for the paediatric inpatient wards including a school room, 24 inpatient beds, six paediatric day care beds and the paediatric outpatient department. There is also a Ronald McDonald House providing accommodation and cooking facilities for parents and siblings of long-stay patients and an indoor and outdoor play facility.

## Summary of findings

### **We did not inspect services for children and young people during our inspection in March 2015.**

In 2014 we found that services for children and young people provided by the hospital were good. There were good staffing levels; a strong skill mix had encouraged proactive teamwork to support a safe environment. There were arrangements in place to implement good practice, learning from any untoward incidents and an open culture to encourage a strong focus on child safety and risk management practices. Families told us they felt safe in the hands of the staff and staff said they felt supported by the trust in managing risk and keeping their patients safe.

Evidence based practice was being implemented and monitoring systems to measure performance were in place.

We saw good examples of care being provided with a compassionate and dignified approach. Children and young people were involved in planning their care and making decisions about the choices available in their care and treatment, including appropriate discharge planning.

The children and young people's service understood the different needs of the communities it serves and acted on this to plan and design services. It was proactive in taking action to remove barriers that parents, children and young people face in accessing or using the service.



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There were good mechanisms for information sharing and willingness from staff for flexible working around responding to the needs of parent's children and young people. The service had introduced several initiatives to encourage children, their relatives and those close to them to provide feedback about their care and were keen to learn from experience, concerns and complaints.

## Are services for children and young people safe?

Good



### Safety in the past

It is mandatory for NHS trusts to monitor and report all patient safety incidents. We looked at incident reporting policies, a database of paediatric incidents raised by staff and safety meeting minutes and found that there were effective arrangements in place for reporting patient/staff safety incidents and allegations of abuse, which were in line with national guidance. There were clear lines of accountability for incident reporting and all staff we spoke to stated that they were encouraged to report incidents. They usually received direct feedback from their matron or through team meetings.

### Learning and improvement

Themes from incidents were discussed at weekly meetings and staff were able to give us examples of where practice had changed as a result of incident reporting, such as improving communication and pathway practices with the surgical team around abdominal surgery assessments. We also saw the action plan from a recent paediatric confidentiality incident, including lessons learnt and methods of sharing to demonstrate actions had been taken, time frames had been complied with and staff we spoke with were aware of practice changes such as a clean desk policy. We noted that the trust was on track to meet its target for Information Governance Training to heighten staff awareness around confidentiality practices.

Staff showed us 'Hotspots', a regular trust wide communication on risk management practice. Staff were aware of key risks at all levels of the organisation and there was a shared perception of the key problem areas between the board and front line staff, such as capacity management and financial constraints.

### Systems, processes and practices

The trust had recognised whilst the paediatric ward environment is safe, it was cramped and the layout was not user friendly or ideal for privacy and confidentiality requirements. We also noted that the junior doctor's rest room was small and not supportive of a restful environment. The chief executive was clear they did not want to do a quick fix, but action the changes needed

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robustly. Staff confirmed that they had been consulted about how to develop the unit and a business case is due to be presented to the board shortly. Infection control practices were satisfactory. "I am clean stickers" were displayed on all equipment and parents noted the wards looked clean. We saw staff regularly wash their hands and use hand gel between patients. The bare below the elbow policies were adhered to in all areas we visited.

## Medicines

On Puffin ward where card-swipe systems were in use senior nurses could not assure us that only authorised persons could access the rooms. The trust told us that each drug room had restricted access and only staff who worked on the ward and pharmacy personnel had access. Not all medicines were kept in cabinets or refrigerators that were lockable within the rooms. We therefore concluded that improvements to the security for medicines was needed.

On Puffin ward we noted there were many gaps in records of medicine refrigerator temperatures so we could not be assured medicines requiring refrigeration had been kept within the appropriate temperature range and were still safe to use. We noted that room temperatures were high and may have been above temperatures appropriate for the storage of medicines. Not all medicines were kept in cabinets or refrigerators that were lockable within the rooms. We therefore concluded that improvements to the security for medicines was needed.

## Safeguarding vulnerable children

Statutory guidance and policy was clear in relation to safeguarding and promoting the welfare of children and young people. We obtained feedback from the Clinical Commissioning Group and Area Quality Surveillance Group which monitor the trusts performance externally. They told us that the trust had strengthened its reporting processes and protocols. The head of paediatrics and the lead consultants were all on board and working well. The groups stated there was good evidence that children were being protected. Safeguarding action plans were being monitored externally through safeguarding executive and full boards and internally through Children's Safeguarding Meetings and Trust Patient Safety committee, which both meet monthly to ensure lessons are learnt.

Staff told us that they had a voice at board level now and that they were listened too and empowered to make changes where necessary. The Children's Safeguarding Team which includes a named nurse and named doctor

carry out level three children's safeguarding training within the trust. All staff we spoke with had received safeguarding vulnerable children training at the appropriate level, training records showed good attendances above 90% across the organisation.

## Monitoring safety and responding to risk

We found that staffing levels, skill mix and the levels of training provided throughout the paediatric service had been increased in the last year which supported safe practice. Three new paediatric consultants were appointed in 2013 which has allowed the hospital to extend the hours covered by senior paediatric doctors in the evenings and at weekends. The nursing establishment has been significantly increased by approximately 20 more nurses. Staff noted a significant improvement in leadership and support since the introduction last year of a Senior Paediatric Nurse present between 8am and 8pm, Monday to Friday. Outside these hours a Sister works in the role of Clinical co-ordinator for the acute paediatric service with the support of a Senior Paediatric nurse on call as and when required.

Staff reported that the leadership and additional support has improved safety through more time to monitor practice and was sustained at all times of day and the weekend to support safe, effective and compassionate patient care and levels of staff wellbeing. They noted that staffing levels and skill mix were responsive to changing needs and circumstances such as replacement for long term sick leave.

We observed a hand over between staff, conducted during the day and out of hours. We found they were structured, documented and had the right people attending.

We looked at informed consent and capacity to consent practices and saw the involvement of children and young people who were able to understand the care options. We saw reference to capacity to consent in the care plans and feedback from families was that they understood the care provision. Staff were provided with Mental Capacity Act training and were aware of guidelines on consent. They recognised young people who may not have the capacity to give consent and understood what to do to support them.

**Are services for children and young people effective?**

# Services for children and young people

Good



The effectiveness of services was good. National guidance was being implemented and monitoring systems to measure performance were in place. There was good collaborative working with partners and other agencies and the number of staff receiving mandatory training and clinical supervision was satisfactory. There were detailed and timely multi-disciplinary team discussions and handovers to ensure patients' care and treatment was coordinated and the expected outcomes were achieved.

## Evidence-based guidance

Doctors and nurses in the children's directorate used a combination of NICE, Royal College of Paediatrics and Child Health (RCPCH) guidelines to determine the treatment they provided. They showed us that local policies were written in line with this and were updated regularly or if national guidance changed. We saw that the trust were participating in national paediatric audits such as:

- RCPCH National Neonatal Audit Programme (NNAP) 2013
- National Paediatric Diabetes Audit (NPDA) 2012/2013 in progress
- BTS National Paediatric Asthma Audit 2013 in progress

Reporting arrangements were in place to ensure that the board and the staff see regular and appropriate information about the effectiveness of children and young people's services. We saw that key performance indicators showed overall satisfactory rates of achievement with national targets for children's services. Staff we spoke with were aware of the current outcomes from services provided. We saw minutes of medical and clinical meetings where any changes to guidance and the impact that it would have on resources and staff practice was discussed, such as changes to surgical care pathways to reduce delays in surgical assessments of sick children.

The departments used the Paediatric Early Warning Scoring (PEWS) System. This system was introduced to standardise the assessment of acute illness severity.

There were clear directions for escalation printed on the observation charts which were laminated and displayed for staff reference. Staff knew how to activate escalation processes, which work well, for example, drafting in

additional staff to cover increasing levels of demand or responding to warning signs of rapid deterioration of patients. We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames. Audits showed 100% compliance with PEWS documentation.

## Monitoring and improvement of outcomes

The paediatric departments produced key performance indicators which showed satisfactory compliance with local audit targets. Staff were aware of these indicators and could note areas raised as under achieving which were reported at meetings, including actions taken. Such as improving resuscitation trolley checks and the completion of pain management tools and fluid balance charts for safe effective practice.

Complete, accurate and timely performance information was readily available to staff, families and the public, through posters, meetings and open board minutes. Staff told us they understood the performance information they received. The paediatric lead noted that discharge summaries sent within 24 hours to the GP were below target and now were included in the doctor's performance monitoring reviews which had resulted in a marked improvement in the last fortnight.

## Sufficient capacity

The trust had instigated external reviews to ensure processes were in place for effective care. The second external paediatric review (required as part of the undertakings with Monitor the trust regulator) had been completed on 10 October 2013 through the trust's partnership with the Royal Free Hospital. We followed up on the action plan resulting from this review and found all recommendations had been put in place. This included providing consultant paediatricians covering acute areas with a bleep, so that they could easily be contacted. Further attention had also been given to improving engagement between paediatricians and surgeons for timely assessments which has been actioned.

Clinical practice was also monitored by record keeping audits, regular clinical supervision, and preceptorship for new staff and induction for all staff. Staff were able to arrange cover between them to cover holidays, sick leave and other absences, for example so that their colleagues could attend training without it impacting on the quality of service. Staff told us they had effective appraisals and continual professional development updates to maintain

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and improve their specialist skills. We saw training records which supported this, although some areas of core skills training were below target. We saw minutes of staff meetings which showed opportunities to reflect on practice and workloads. We spoke with numerous medical and nursing staff who noted good supervision, teamwork and peer support was provided to support them in their role. Staff gave examples of additional training funded and provided within protected work time and drop in sessions available from Matrons to discuss practices and develop ideas to improve care.

## Multidisciplinary working and support

A peer visit was being arranged to Luton and Dunstable Hospital which would allow the sharing of good practices and learning between organisations. The Deputy Chief Executive advised the inspection team that through undertaking the second paediatric review, the trust had met the requirements of its undertaking to Monitor. It was noted that the trust could now apply to have the Paediatric undertaking removed from its licence.

We observed detailed and timely multi-disciplinary team discussions and hand overs to ensure patient's care and treatment was coordinated and the expected outcomes were achieved. Care and treatment plans were recorded and communicated with all relevant parties to ensure continuity of care. Parents and children told us they felt informed, understood the treatment options and care being provided and could ask questions if needed.

## Are services for children and young people caring?

Good



Services for children, young people and families were very good and caring. We saw good examples of care being provided with a compassionate and dignified approach. Patients and relatives were involved in planning their care and making decisions about the choices available in their care and treatment, including appropriate discharge planning. The vast majority of families and staff would recommend the service to family and friends.

## Compassion, dignity and empathy

Throughout our inspection we witnessed children and their parents being treated with compassion, dignity and

respect. We saw that call bells were answered promptly and parents we spoke to told us, "Nothing is too much trouble", and one child said, "They always have a smile it makes you feel better". The trust has a business plan going to the board of the hospital March 2014 to improve the environment and facilities on the paediatric wards.

Currently, confidentiality and privacy is compromised at times because of the current lay out. The staff were aware of this and it was noted on the risk register, we could see that staff put significant effort into managing as best they could at this time.

## Involvement in care

Children, young people and their families were appropriately involved in and central to making decisions about their care and the support needed. We found by looking at care plans, observing care, reviewing clinical guidelines and talking to families and staff that care was planned to reach best practise as set down by national guidelines. We spoke to one family who told us, "it was a good smooth admission through the children's emergency department to the ward. We were kept well informed during the process and the surgeon came to see us every day. Most of the staff are superb".

We saw that verbal and written information that enables children to understand their care was available and to their relatives in ways that meet their communication needs, including the provision of information in different accessible formats and interpreting services. Smiley faces were used for directions and we were told further work such as footsteps on the floor to guide children were being actioned. Age appropriate accommodation for adolescents was in place.

## Emotional support

Children and young people were supported to stay connected to their family, friends and community during their hospital stay so that they do not become isolated during their hospital stay. Visitors were encouraged and supported with visiting times that suit them; staff were available for discussions, although there was limited private space for visits. Accommodation in a separate house is provided for families to remain on site where necessary. Staff, parents and children told us the play group teams were excellent and helped children and parents to cope emotionally.

# Services for children and young people

## Are services for children and young people responsive?

Good



The responsiveness of the service was good. The children and young people's service understood the different needs of the communities it serves and acted on this to plan and design services. It was proactive in taking action to remove barriers that parents, children and young people face in accessing or using the service. There were good mechanisms for information sharing and willingness from staff for flexible working around responding to the needs of parent's children and young people. The paediatric department had introduced several initiatives to encourage children, their relatives and those close to them to provide feedback about their care and were keen to learn from experience, concerns and complaints.

### Meeting the needs of all children

The Paediatric service actively engaged and worked with local commissioners of services, the local authority, other providers, GPs, patients and those close to them to coordinate and integrate pathways of care that meet the health needs of the local population.

The Paediatric services were proactive in taking action to remove barriers that families face in accessing or using the service. The hospital has a lead learning disabilities nurse to support children and families whilst in hospital and also in preparation for discharge back into the community.

There were posters displayed including pictures and contact numbers to encourage families to get in touch for support and guidance during a child's stay in hospital. A working group which included contact with school nurses and health visitors was looking at better liaison between the hospital and community to support children with complex needs. There was an open access form linking professionals involved in a child's care and an electronic flagging system to highlight special needs on admission.

This helped ensure a smooth pathway of care including discharge planning at admission stage.

Staff highlighted good support from the children's safeguarding team in meeting the needs of vulnerable children. There was also a Paediatric Health Visitor Liaison (PHVL) role available four days a week to support staff with

any concerns that did not relate to safeguarding but may have needed a child or family to have support from a Health Visitor or school nurse. For example, a disclosure from a child that they were being bullied at school. The PVHL was able to link in with the school and school nurses to get background and highlight any concerns.

Staff were aware of diversity needs and confirmed that an e-learning module on equality and diversity was available to all employees as well as face to face training sessions. There was also an equality and diversity course specifically tailored for consultants. We were told that equality and diversity was embedded into all training modules and part of the e-induction for new starters.

### Access to services

Paediatrics is now included in the hospital's 'right time right place' initiative. This streamlines the patient journey from arrival to discharge. Access to services to ensure children and young people received the care they required was good and was able to be achieved in a timely manner. We saw the trust was responsive to delays in the system such as the recent recruitment to the children's phlebotomy service which improved waiting times for blood tests and delays in discharge summaries to the GP which were now being actively monitored and improvements noted. There was now funding to recruit four Acute Care Consultants in September 2014 to further improve assessment times and reduce delays in the paediatric pathway.

There was collaboration amongst services to support children and young people's care and treatment and action practice changes where necessary to ensure effectiveness of care delivery. Staff had contacts with social services, district nurses, health visitors and school nurses to ensure appropriate support was available to children and families on discharge. We saw open access assessment forms which included discharge planning on admission and where additional community services may be required, such as for looked after children, foster placements or children with complex needs.

The diabetes out patient service received good feedback from patients and staff we spoke with were passionate about supporting children. We noted that psychological support for patients to come to terms with their condition was in place.



# Services for children and young people

## Vulnerable patients and capacity

Staff reported difficulty reaching some specialist services provided by the Local Authority, such as those related to children and young people with mental health needs. For example, the external crisis team were not available out of hours and weekends. There was limited mental health bed availability in the community which could result in a delay in discharge.

## Learning from experiences, concerns and complaints

The paediatric department had introduced several initiatives to encourage children, their relatives and those close to them to provide feedback about their care. The service had developed an idea called 'Tops and Pants' that is being used nationally by other paediatric services, based on a washing line for quality of care and service. Tops are positive and pants are negative and they are hung on a washing line for all to see.

In the children's emergency and outpatient department there were three glass boxes, where a counter is posted to rate the level of service and everyone can see the scores. The service is currently developing a number of patient user groups, to receive feedback and gain information from children and young people that use the service regularly or as an emergency service.

Complaints were handled in line with the trust policy and we saw that delays in responses and actions needed were dealt with at the patient experience group. Staff said they were now empowered to discuss complaints with the families where possible and resolve issues in a timely manner. If this was not able to deal with their concern satisfactorily they would be directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department.

## Are services for children and young people well-led?

Good



The children and young people's service was well-led. The vision and values have been developed with input from key stakeholders including patients, staff, commissioners and

others. Staff spoke of the vision and values and indicated a sense of pride and identification. The paediatric departments could demonstrate that risks to the delivery of high quality care were identified, analysed and mitigated systematically before they became issues which impacted on the quality of care. There was strong team based working characterised by a cooperative, inter-disciplinary, cross-boundary approach to delivering care in which decisions were made by teams.

## Vision, strategy and risks

The senior executive team provided vision and values encompassing key elements of the NHS constitution such as compassion, dignity, respect, and equality with quality the top priority. The majority of children's staff understood the vision and strategy for developing the service and said there was visible leadership across the organisation to support this. The children's and young people's service had a strong voice at board level with a non executive director to champion the service going forward. Staff told us that the service had been developed well strategically through investment in both staff and facilities over the last year.

There was a business plan going to the board March 2014 for extensive further development to the build and design of the paediatric in patient service. We saw through minutes of meetings and staff we spoke with that they had been consulted about service developments and design plans, which is good practice.

## Quality, performance and management systems

We looked at board papers, governance meetings, risk registers, quality monitoring systems and incident reporting practises. These showed that there were management systems in place which enabled learning and improved performance and were continuously reviewed where required. Staff were encouraged to attend risk meetings and feed back to teams on developments such as the formation of a paediatric surgical group to improve communication and timely assessment practices. We saw that the performance and delivery of children's services was mapped efficiently on a dashboard for staff and board members reference. This data was used at a strategic level to ensure the Board were kept aware of the timely delivery of service. These monitoring systems show that the Board and senior managers were informed on quality issues, risk



# Services for children and young people

and general performance regarding children and young people across the organisation. Staff we spoke with were aware of the key performance outcomes for the children's service and "Top spots" where things had gone well.

## Leadership and culture

We saw that leaders and managers encouraged cooperative, appreciative, supportive relationships among staff and teams and compassion towards patients. Staff reported that the leadership of the departments ensured they feel respected, valued, supported and cared for. The Matron provided a strong supportive steer to the team and the three team leaders being able to be 'supernumerary' allowed for supportive clinical leadership and good role modelling. This was valued by the staff and enhanced the level of leadership and organisation of the children's departments.

Staff contributions and performance were recognised with good examples of innovation, learning and improvement such as 'Smile November', where staff suggestions such as providing parents with food and drink when they have been waiting for long periods of time was instigated.

One staff member told us, "doing little things can have a positive impact". Two staff were due to present at a paediatric conference on initiatives such as the "Tops and Pants feedback tool" which had been highlighted as good practice and shared on social media with other organisations.

Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility. Staff repeatedly spoke of approachable managers and how they were encouraged to speak up if they saw something they were unhappy with regarding patient care. One staff member told us 'we raised concerns

regarding the delay in medicines to take home and were confident that changes would be made to improve this". Staff said that openness and honesty was the expectation for the department and was encouraged at all levels. Staff worked well together and there was obvious respect between not only the specialities but across disciplines. We saw in multi-disciplinary team meetings that staff were actively engaged in quality improvement practises and there was little evidence of professional isolation or management-clinician divides.

The paediatric dashboard displayed for staff reference showed over 90% compliance with appraisals and mandatory training. All staff we spoke with reported they had received an appraisal within the last year. This gave them the opportunity to discuss their work progress and future aspirations with their manager. The majority reported receiving regular meetings monthly or every six weeks, where risk management practices were discussed.

We saw team leaders operating an open door philosophy throughout the service. One member of staff told us, "We are focussed on the patient and keeping them safe at all times", another said, "I am proud to work here, we are supported to provide safe care."

## Patient experiences and engagement

The organisation recognised the importance of patient and public views. A full and diverse range of patient and family views were encouraged, heard and acted upon. This included the use of rigorous independently collected and verified information such as patient surveys. We spoke to 16 families who rated the service as good or outstanding. Where minor issues were raised they were about systems not staff performance. We found consistently positive views from a breadth of patients and those close to them, which were supported by the views of the staff.

# End of life care

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

## Information about the service

Orsett ward at Basildon Hospital provided 23 beds for patients who need haematology and palliative inpatient services. Most admissions are unplanned emergency admission and beds cannot be ring-fenced to accommodate potential palliative patient admissions.

We inspected this ward along with seven other wards where palliative patients were receiving care. We also inspected a number of end of life support services, including the multi-faith centre, chaplaincy service, the bereavement centre and the mortuary. The specialist palliative care team provided 24 hours a day service for palliative patients. Between the hours of 9am and 5pm there was a team of specialist nurses and consultant on site. Outside of these hours a consultant provided a telephone on-call service.

We spoke with patients, relatives, and staff, including nurses, doctors, consultants, senior managers, allied health professionals, a chaplain, bereavement staff, mortuary staff and a specialist palliative care nurse.

We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed the trust's performance data.

## Summary of findings

### We did not inspect end of life care services during our inspection in March 2015.

In 2014 we found end of life care was safe, effective and responsive of patient's needs. Care was delivered in line with current best practice and we saw very good care for those patients who chose to end their lives at home. The rapid discharge pathway enabled patients to leave the hospital within four hours.

All of the patients we spoke with told us that care was good. They were treated with respect and dignity and felt involved in their care and treatment. The trust had developed its own end of life care pathway which had replaced the Liverpool Care Pathway. This had yet to be evaluated but staff told us it was effective and working well.

We found that the way in which the hospital managed medication could be improved to make sure it was in date and stored securely. Improvements were needed to make sure all patients' records in relation to 'do not attempt to resuscitate' decisions were completed.

For the deceased we found they were cared for by a team of dedicated staff who maintained patient's dignity after death. Bereavement staff supported families effectively.

# End of life care

## Are end of life care services safe?

Good



### Safety in the past

Staff we spoke with could not recall any incidents happening specifically related to the provision of end of life for patients. The ward monitored pressure ulcer indicators. The ward had a reported nine incidences of patients with pressure ulcers between December 2013 and March 2014. Five of these patients were admitted to hospital with ulcers and the remaining four were hospital acquired ulcers. The ward manager had commented on each incident, appropriate action had been taken to treat each ulcer. We spoke with staff who knew how to care for patients at risk of developing a pressure ulcer. We saw risk assessments called Waterlow assessments had been completed and patients were given appropriate equipment to help reduce pressure damage from occurring.

### Learning and improvement

The specialist palliative care team had developed multiple educational sessions for staff to attend. End of life care training was not mandatory for all staff to complete in the hospital. However there were opportunities for all staff both nursing and medical to take part in this training. Registered nurses and health care assistants we spoke with were aware that they could attend a variety of end of life and palliative care training throughout the year. A palliative care CNS we spoke with told us that the team will informally teach staff whilst working alongside them in clinical areas and although there was still a lot of education required, the educational sessions had been a success and commented, "We can see what they've learnt in practice on the wards." We were told by the palliative care CNS we spoke with that link nurse meetings were held quarterly to support ward staff and disseminate core messages. This meant that nursing staff had suitable training to provide safe care and treatment, and that there was a system in place to inform staff of key messages.

### Systems and processes

#### Environment and equipment

On wards we visited we found equipment was appropriately checked and cleaned regularly. On one ward we found that there were not enough blood pressure

monitors and this had delayed patient observations being completed. We also found that in some cases patients had to wait to use commodes because there were not enough of them.

On Orsett ward there was a clean day room relatives could use, with some children's toys available. Relatives were able to stay overnight on the ward to support patients who were very poorly. We saw there were rooms available where private conversations could happen, to maintain patient confidentiality.

### Cleanliness, infection control and hygiene

Ward areas were clean and tidy. We saw staff followed the infection control policy; they were bare below the elbow, regularly washed their hands and used hand gel between patients. We saw that there was ample personal protective equipment (PPE) available for staff to use. Staff told us how they cared for patients that had an infection, such as clostridium difficile (Cdiff) or MRSA. Patients were isolated in a side room, PPE was worn and hand hygiene was paramount.

### Medicines

Medication was not always stored safely. Medication was stored in a locked room but with no lock on the medication cupboard. Staff told us that the code to gain access to the room was only changed twice in the past six years; the trust policy indicated that this should happen every two to three months. We saw no evidence of a risk assessment to manage medication safety. We reported this to a ward sister.

The trust told us there were plans to address the medication storage in 2014 and this would include lockable cupboards.

On Orsett ward we found out of date nutritional products and nutritional products that had been opened had no date of opening documented. We reported this to a ward sister who disposed of the items. They told us that there was no system in place to check the use by dates of nutritional products stored on the ward and that nurses should be documenting when products have been opened to ensure they are safely consumed. This meant that patients were at risk of consuming products that were not fit for consumption.

### Monitoring safety and responding to risk

The ideal and actual staffing numbers were displayed on each ward we inspected. On the days of our visit we

# End of life care

found that Orsett ward was staffed with the appropriate number of skilled staff. However, for the following night shift due to unplanned circumstances there was not enough staff, the ward manager was aware of this and planned to resolve the issue. Staff reported that the department used agency staff infrequently. This was reflected in the trust's agency spend, which was below the median within the East of England Strategic Health Authority. This meant that there was continuity of care provided for patients.

On one ward we visited we found the appropriate use of the 'increased nursing supervision trigger tool'. Extra nursing staff had been allocated for higher levels of observation in a four bedded bay; when extra nursing supervision was required and the ward had sufficient staff available to care for patients.

## Nursing and medical handover

We saw evidence of the morning nursing staff handover. We noted that safety alerts and organisational updates were discussed so that all staff were informed. Staff told us that the handover of patients happened within the patient's bay or room doorways. One patient in a bay commented that they did not always understand what staff discussed during handover and that they felt uncomfortable with their care being discussed in front of other patients.

## Consent and safeguarding

Staff we spoke with were all aware of the requirements to gain consent from patients. Patients told us that staff asked their permission before examinations.

Staff we spoke with were able to demonstrate a good awareness of their responsibilities for reporting any concerns regarding abuse and the process that they needed to follow. They reported having safeguarding of vulnerable adults training.

## Records

We looked at patient medical notes and found they were completed sensitively and detailed discussions that had been had with patients and their relatives. Notes were in paper format and all health care professionals documented in the same place. Although the chaplain we spoke with told us that they did not in the patient's notes, discussions between the chaplain and nursing staff were recorded in the nursing notes. This meant that important

information such as, patients' end of life religious or cultural wishes couldn't be overlooked by other members of the multi-disciplinary team and that care and treatment of patients could be compromised.

There was an electronic interactive board clearly exposed on Orsett ward. When we visited the ward, the names and diagnostic details of the patients staying there were displayed in sight of all patients, staff and visitors on the ward. This meant that there was a breach of confidentiality of the patient's medical information. We reported this to a ward sister who quickly resolved the issue.

## Anticipation and planning

There was a specialist palliative care team that worked across seven days and were essential to provide with specialist support for patients and their relatives. The Department of Spiritual and Pastoral Care (DSPC) were an integral part of ensuring the care and welfare of all its service users and had a responsibility to provide support to people of all faiths and of none. There was a multi-faith prayer room that offered a peaceful environment and facilities for prayer, worship and contemplation.

## Are end of life care services effective?

Good



We found the end of life service effective. Care plans were in place for patients during for the last days of life that provided effective care. There was a strong multidisciplinary presence for end of life care with regular meeting linking acute and community services together to ensure effective continuity of care and facilitate discharges.

## Evidence-based guidance

The National Institute for Health and Care Excellence (NICE) was rewriting guidance to remove reference to the Liverpool Care Pathway (LCP) following a recent independent review of the pathway. The specialist palliative care team were aware of this change. The team alongside community and hospice teams had recently released 'Individualised Care Plans for the Last Days of Life', supported with a robust educational programme. Ward staff we spoke with told us that they had received training to use the care plan.

The care plan promoted good care and support during the last days of life and after death, including recognition of the

# End of life care

dying the patient, care reassessments at least daily, appropriately prescribed medication and ensuring the patients' psychological, social and spiritual needs had been addressed. We saw the care plan being used on the wards and reviewed one care plan of a patient recently deceased, all the documentation was appropriately completed.

We were told that the team had received funding to audit the care plans in September 2014 to ensure that they were correctly used and assess where improvement could be made.

## Multidisciplinary team working

The ward had a specialist palliative care physiotherapist and occupational therapist team, all of whom were involved in ward rounds and handovers.

The hospital has a specialist palliative care team including doctors, clinical nurse specialists and counsellors. The team provided guidance on making decisions about end of life care and treatment options, and gave specialist holistic advice and support for patients and their relatives.

The specialist palliative care team members attended regular multidisciplinary team meetings (MDT) for specialist teams, such as renal, motor neurone disease and haematology. This meant that patients under specialist teams could benefit from specialist palliative care team involvement and that care, treatment and support was delivered to meet the patients' individual needs. There was also a weekly specialist palliative care MDT that was attended by relevant hospital and community staff, to ensure effective continuity of care and facilitate discharges.

## Are end of life care services caring?

Good



## Compassionate care

Throughout our inspection we saw patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly; refreshments were offered regularly and positive interactions between patients and staff. All of the patients we spoke with expressed high level of satisfaction with their care. Patients commented, "Most of the staff are well trained and skilled", "Staff are helpful and polite", and, "If I need anything extra, I ask and I get it".

We saw Macmillan nurses visit the patients on the ward.

One patient told us that, "They are keeping in touch with me whilst I am here", this demonstrated continuity of care.

We saw the use of, 'comfort round for the last days of life', care plans being used correctly. These helped staff to assess if patients were in pain, distressed, required oral care, nutrition or hydration. They also prompted staff to give family opportunity to ask questions and offer spiritual care.

All of the staff we spoke with demonstrated a genuine commitment and passion to enable patients at the very end of their life in hospital to die in a calm environment, in a private and dignified manner. One nurse commented, "It's a massive privilege to be there at the end of patient lives".

The palliative care clinical nurse specialist we spoke with told us that they had good links with community teams to facilitate the discharge of patients whose wishes were to die in a hospice. Nevertheless, we were told that some patients will die in hospital and that every effort was made to move patients into a side room to protect their privacy and dignity, and provide a conducive environment. They commented that, "It is engrained; you need to respect patient's privacy and dignity".

The chaplain we spoke with told us that they were able to assist the nursing staff to ensure that care and treatment is provided to patients with due regard to their religious persuasion. Patient needs were assessed and support levels were based on individual needs, choices and preferences.

## Patients involvement in their care

Patients we spoke with felt that they had been involved in their care and decisions around their treatment. One patient we spoke with told us that, "I have some control over pain relief", and another, "I'm fully informed, staff explain the latest treatment".

## Emotional support

Staff continued to treat patients with dignity and respect following their death. Death was verified by a competent nurse or doctor. Staff referred to people as 'the patient' or 'the deceased' at all times.

Staff showed considerable compassion towards relatives who wished to see their loved one following their death.



# End of life care

The care plan for the last days of life considered emotional support for the relatives. Relatives were given the choice to participate in last offices and requests regarding religious and cultural practices could be discussed.

We saw guidance that personal items were kept with the patient or returned to the next of kin if requested. Staff told us that these wishes were recorded to avoid anything being missed.

One chaplain we spoke with told us that they provided a service to in and outpatients and had established close links with services across the trust. As they waited to meet the family of a patient who had died, we noted there was a tranquil consultation room for staff to provide bereavement counselling. All of the chaplains subscribed to the Code of Ethics and Conduct of the College of Healthcare Chaplains.

This meant that that chaplaincy service and DSPC were an integral part of ensuring the care and welfare of all people that used the service.

## Are end of life care services responsive?

Good



We found the end of life services to be responsive. There was support available for patients with learning disabilities and/or physical needs. Relatives were able to stay overnight on the ward to support patients who were very poorly. We saw rooms where patients and relatives could have private conversations, to maintain confidentiality. There was a rapid end of life discharge pathway in place for patients who wanted to end their lives in their own home.

Terminal patients could be discharged home within four hours. Staff we spoke with were totally committed to meeting patients' preferences about where they ended their life. This was an example of outstanding end of life practice.

### Meeting the needs of all patients

PCCNSs worked across seven days from 9am until 5pm, including bank holidays. Outside of these hours an on call palliative care Consultant was available to provide symptom control advice via telephone. The palliative care CNS we spoke with told us that, "Seven day working is fantastic". It meant that they could ensure appropriate care was provided to patients requiring palliative treatment

every day and they gave an example of how the service had directly influenced the quick diagnosis and specialist care a patient had recently received. Ward staff were aware of the specialist palliative care teams working hours and complimented the service on the support they offered patients and staff. This was an example of an outstanding end of life service.

Out of hours an on-call physiotherapist covered the hospital and could attend to any urgent patients or those requiring respiratory treatment. There was no out of hours occupational therapist service.

The palliative care clinical nurse specialists (PCCNSs) provided care for patients referred from all specialities. The PCCNSs we spoke with told us that while patients with a cancer diagnosis have traditionally been the focus of palliative care and that ward staff had a good awareness of this, the team were trying to promote the service also provided care to those non-malignant palliative patients.

Since April 2013, non-malignant patient referrals formed over 10% of those received and the team acknowledged that some non-malignant patients possibly were not referred to the service and that this was a challenge to overcome in the future. However, from April 2013 to January 2014 the teams referral rate increased by 31% on the previous nine months. This indicated that more patients received a specialist palliative care assessment to support their individual needs.

We looked at 'do not attempt cardio pulmonary resuscitation' (DNACPR) orders on the wards we inspected.

In all cases, staff had completed these in line with guidance published by the General Medical Council (GMC). The DNACPR orders documentation followed the patient until death, so that all staff could access information quickly. We saw evidence that relatives were aware that the patient was at the end of their life. Staff on the wards confirmed that the trust had systems in place to audit all DNACPR forms. We did not see the results of these audits and staff could not comment on their effectiveness.

The treatment escalation plan (TEP) and DNACPR clearly worked together and had detailed instructions on the back.

However on one ward we reviewed 10 sets of notes and found that four did not have documentation of TEP and DNACPR discussions with patient and or relatives.



# End of life care

## Spiritual support

The hospital had a multi-faith prayer room that offered a peaceful environment and facilities for prayer, worship and contemplation, close to the main hospital reception making it easily accessible. The chaplaincy service

provided spiritual and pastoral care for patients, relatives and staff on site during working hours and through an on-call chaplain at other times. There were a number of weekly services for multiple faiths that people could attend. The Department of Spiritual and Pastoral Care (DSPC) had a responsibility to provide support to people of all faiths and of none. We saw an operational procedure folder that provided guidance with using multi-faith contacts to facilitate the religious support of patients and their relatives.

## Vulnerable patients and capacity

Support was available for patients with learning disabilities or physical needs. There were numerous information leaflets and posters available on Orsett ward to provide information about diagnosis, treatment and care to patients and visitors.

## Leaving hospital

End of life discharge planning documentation supported the rapid discharge of patients who wanted to end their lives in their own home. There was a terminal pathway for patients with an end of life prognosis of 24 hours or less.

The goal of this pathway was to discharge patients within four hours who wanted to die at home. There was also a fast track pathway for palliative patients with an end of life prognosis of three months or less. Its goal was to discharge patients within 24-48 hours with the required healthcare services in place. We saw evidence on the days of our inspection this service had worked well and the team had supported the rapid discharge of one patient within three hours. This had enabled the person to leave the ward and end their life in the comfort of their own home.

Staff on all seven wards we visited were aware of how to implement the pathways. Community teams, medication and equipment were arranged prior to discharge to ensure patients received the care, treatment and support they needed at the end of life and try to prevent unplanned hospital admissions. All of the staff we spoke with reported

excellent relationships and liaison with other agencies, such as integrated care teams and Macmillan nurses. It also included cross boundary working with physiotherapy and occupational therapy staff from the hospice team.

Staff told us that they were in regular contact with community teams to facilitate discharges and we saw evidence of discharge notification forms that allowed patient treatment information to be appropriately shared with community teams.

We were unable to speak with any patients on the pathways. All of the staff we spoke with were highly motivated and committed to meeting patients' references about where they ended their life. This was an example of outstanding end of life practice.

## Learning from experiences, concerns and complaints

Reported complaints were handled in line with the trust policy. Staff encouraged patients and relatives to speak to them about concerns. If a patient or relative wanted to make a formal complaint staff were aware to direct people to the Patient Advice and Liaison Service (PALS).

We looked at the number and type of formal complaints received about end of life services from August 2013 to February 2014. There had been four complaints about the service during that time. Each complaint had been investigated and most related to issues around patient property rather than care provided.

The ward manager told us that they received all of the complaints relevant to the ward and these were shared with staff to learn from them at meetings. We found mixed feedback from patients; some knew how to make a complaint and others were unsure. There was information available in the hospital to inform people of the process.

## Are end of life care services well-led?

Good



The majority of staff we spoke with were positive about the service they provided for patients. They felt that they worked well as a team and were well supported by management. Staff told us that they received annual appraisals but that they had no or little clinical supervision.

# End of life care

There was emotional support available for staff from the chaplaincy service and Macmillan counselling service. The specialist palliative care team had a comprehensive education programme in place for the team and the hospital. We saw that more work was needed to make sure there was forward planning for the service that involved audit and research involvement.

## Leadership and culture

Staff we spoke with talked positively about the service they provided for patients and felt that they worked well as a team. One staff member told us that, “We always go the extra mile for patients”. One sister told us that they had been a student on the ward and had enjoyed working there so much they had returned, they commented, “I feel very honoured to work here”. Staff we spoke with told us that they were well supported by the management team.

The chaplaincy team offered staff support in coping with the situations they encounter on a day-to-day basis, offering individual support, spiritual direction and a listening ear. In addition to this they provided staff training and orientation. There was a Macmillan counselling service that provided support and debriefing sessions for staff. This meant that staff were supported and could talk to trained professionals about any issues they had.

Staff told us there was a clear progression pathway on the ward and that there was always the potential of being promoted. Staff were encouraged to attend the trust leadership programme that was being piloted to enhance their leadership skills. Staff told us this was, “Brilliant”, and demonstrated, “Leading in practice”. This meant that senior staff were being given the opportunity to have appropriate professional development in order to lead services.

Ward staff told us that they had annual appraisals but there was room for improvement with no or little clinical supervision. Staff told us, “I feel well supported”. We did not find that the lack of clinical supervision had a negative impact upon patient care.

## Patient experience and Staff involvement

We saw a CNS core competency booklet that new palliative care CNSs were encouraged to complete to ensure that had adequate knowledge and skills to fulfil their role. They were required to produce various pieces of evidence to demonstrate how they met the learning objectives of the competencies. Staff were assigned mentors and were encouraged to meet with them monthly to discuss their progress. Two palliative care CNSs were accredited non-medical prescribers and we were told that the intention was that all palliative care CNSs would work towards this status. This meant that staff in specialist posts received appropriate training, professional development and support to provide care and treatment to patients using their service.

## Learning, improvement, innovation and sustainability

We were told by mortuary staff that they provided an on-call service that was rotated between the four staff members. Staff told us that to ensure safe manual handling they would always have a second person on-call.

Mortuary staff told us that there had been incidences where the mortuary had received from wards the inappropriately prepared body of the deceased. They gave examples of the deceased having no identification wrist band or no documented confirmation of an implantable device. This could have compromised safety of the deceased and staff. We saw that the service had highlighted this issue to ward staff in recent ‘hotspots’ trust's newsletter. As a result guidance and care plans had been updated to remind staff about the care of the deceased patient.

# Outpatients and diagnostic imaging

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

## Information about the service

Basildon and Thurrock University Hospitals NHS Foundation Trust offers outpatient services across two sites, Basildon University and Orsett Hospitals, with a compliment of 54 staff including a lead nurse, four senior sisters, 18 registered nurses and 31 health care assistants.

There were 49 clinic rooms - 30 at Basildon University Hospital and 19 at Orsett Hospital. Clinics provide an outpatient service for a variety of specialties. This included pain, general medicine, surgery, rheumatology, ear nose and throat (ENT), urology and gastroenterology. Minor procedures were carried out in ENT, urology and oral surgery. At Basildon Hospital over 334,000 people had an outpatient appointment during 2012 and 2013; this was an increase of 20,000 on the previous year.

We inspected the outpatient department and imaging department at Basildon University Hospital over two days. We spoke with patients, relatives and staff. We also reviewed the trust's performance data in relation to outpatients.

## Summary of findings

### **We did not inspect outpatient services during our inspection in March 2015.**

In 2014 the outpatient's department was clean and safe for use. Equipment was well maintained but storage could have been more secure in order to prevent theft, damage or misuse occurring.

Patients were treated with compassion, dignity and respect. The outpatient survey in August 2013 showed that the majority of patients felt the care they received in the department was excellent, very good or good. We identified some good practice in the way the service responded to patient feedback and planned care to meet individual patient needs.

The outpatient service was responsive to the needs of the patients and was meeting the 95% target for referral time to treatment.

The outpatient service was well led because staff felt supported and received appropriate professional development. Meetings were held across the service to improve performance. There were innovative ways to gain patient feedback that were considered in planned service developments.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



### Safety in the past

Data on reported outpatient incidents at the hospital between July 2013 and January 2014 showed that there were two serious incidents recorded. One where confidentiality was breached and a root cause analysis concluded this may have been a result of interim additional administrative support provided by temporary staff. The trust had taken action and put measures in place to minimise the risk of this happening again. The other incident was currently still under investigation and could not be reported upon.

### Systems and processes

The environment in the outpatient and reception areas was clean, tidy and fit for purpose. We saw evidence of monthly infection control audits and action plans being completed to ensure the safety and cleanliness of the environment and equipment. An electronic outpatient survey in August 2013 indicated that 84% of patients found the outpatients department clean, 16% of patients thought the department was not very clean or not at all clean. Patient comments included, "Improve your cleaning staff", and, "Could clean around the outpatients a little more".

There was clear signage in the department to encourage people to use the alcohol gel dispensers located closed by.

There were hand washing facilities in all the clinic treatment and consultation rooms we inspected, along with liquid soap, paper towels and alcohol gel dispensers.

We saw staff use these to try and prevent the spread of hospital acquired infections. One patient told us that, "The doctors wash their hands before they examine me".

We found that diagnostic equipment was appropriately checked and cleaned regularly. There was adequate equipment available in all of the outpatient areas. The resuscitation equipment we inspected was clearly labelled for people to locate, it was clean and single use items were sealed and in date. We saw that the equipment had been serviced and that staff documented daily equipment testing to ensure it was fit for purpose. This meant the equipment was safe for use in an emergency.

We found that equipment was calibrated daily within the imaging department to ensure that it operated safely.

During our inspection we found an equipment store room door open within a patient area. We were concerned that unauthorised personnel could get access to equipment such as needles, syringes and surgical packs. We reported this to a senior nurse, who told us that this had not been previously highlighted as a risk and that they would ensure a lock was fitted as soon as possible.

### Learning and improving

We saw staff meeting standing agendas and minutes that showed staff were encouraged to report incidents and received direct feedback from senior staff. Staff also confirmed this when we spoke with them during focus groups and in the outpatient department.

### Monitoring safety and responding to risk

The outpatient lead nurse told us that staffing levels were safe. When additional clinics were provided outpatient staff were generally used, the service rarely relied upon agency staff. This was reflected in the trusts agency spend, which was below the median within the East of England Strategic Health Authority. We were also told by commissioners that at times some clinics were cancelled at short notice so that medical staff could provide care on the wards.

Staff we spoke with understood their responsibilities for people regarding safeguarding and how to report this. The outpatient lead nurse told us that staff received mandatory safeguarding training and that in addition, senior staff received advanced safeguarding training. This meant that staff knew how to identify and manage safeguarding incidents.

### Anticipation and planning

The majority of the service was delivered Monday to Friday 9am to 5pm. A number of 'ad hoc' clinics were provided as required during evenings and weekends to help meet the 18 week referral to treat (RTT) targets. There were no plans in place to offer regular out of hours clinic appointments or move towards seven day working at the time of our visit.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The outpatient services were effective because there were systems in place to identify, investigate and learn from incidents to enhance the service. Outpatient services worked together as part of the productive outpatient programme to improve patient experience and that there was some multidisciplinary working within clinics.

In the reception area there was an information desk that provided material such as hospital maps and leaflets regarding Patient Advice and Liaison Service (PALS) and feedback forms. There was a large area dedicated to Macmillan Cancer Support that displayed a vast range of information about their service and the support available for patients and relatives. This meant that the service provided patients with appropriate information and support in relation to their care and treatment.

### Evidence-based guidance

Imaging staff we spoke with told us that they followed the 'Ionising Radiation (Medical Exposure) Regulations 2000 to ensure patient safety. We found that equipment was operated in line with 'As low as reasonably possible' (ALARA) rules, which meant that every reasonable effort was made to maintain exposures and ionising radiation as far below the dose limits as practical, to safeguard patients and staff. This meant that care and treatment was delivered in accordance with current national standards and regulations.

### Monitoring and improving outcomes

We saw the results of a monthly outpatient 'Error Capture' audit that was started in July 2013. Common issues reported were related to medical staff arriving late to clinic, no medical staff available in clinic due to an error, and clinics over running their allocated time. Patient appointments could be delayed or cancelled due to poor time management or availability of medical staff if they were needed on the wards. The hospital was working with the clinical commissioning group looking at ways to improve this.

We saw minutes from a registered nurse forum meeting in February 2014, where staff nurses received feedback of the

audit. It was highlighted that double booked clinics were a regular occurrence and that staff should complete incident forms in these circumstances. This meant that for every appointment time there were two patients booked and would again delay appointment times.

The outpatient lead nurse told us that there had already been firmer guidance released that related to clinic changes to prevent late clinic cancellations and that the audit data would be presented to clinicians to emphasise the need for improved time management.

### Sufficient capacity

During our inspection we witnessed the electronic patient system fail. This type of event had been logged on the outpatient risk register. We saw that staff were not perturbed by this system malfunction and an alternative paper system was in place. Patient care was not disrupted.

There was a system in place to escalate this issue so that the trust board would be aware of it.

### Multidisciplinary working

We were told by staff that teams involved in outpatient services worked together as part of the productive outpatient programme to improve patient experience. We saw evidence that the programme had specific teams dedicated to enhance the patient environment that focused on patient information, environmental and estate issues.

We were told that several clinics had consultants and specialist nurses, including breast and dermatology clinics.

Allied health professionals (AHPs) told us that they worked very closely with consultants to provide a multidisciplinary approach. Physiotherapists told us that they supported some patient group sessions that provided education and treatment for patients about managing and living with their condition.

## Are outpatient and diagnostic imaging services caring?

Good

Results from the outpatient survey in August 2013 showed that the majority of patients felt the care they received in the department was excellent, very good or good.



# Outpatients and diagnostic imaging

## Compassion, dignity and empathy

On entering the outpatient department there was a volunteer to greet patient and help them with concerns.

During our inspection we witnessed people being treated with compassion, dignity and respect. We saw people being guided to their required destinations and helped into transport by staff.

We spoke with seven patients in the imaging department, who all told us that they felt safe and well cared for in the service. We saw in-patients that received treatment were accompanied by a ward nurse who understood how to care for them.

Outpatient services did not perform well in the August 2013 patient survey in terms of informing people about waiting times. Patient's feedback indicated that 59% of people were not told how long they were expected to wait for their appointment. In response to this, the service now had boards outside of each clinic room with the expected waiting time clearly displayed. We saw boards that showed waiting times from five to 30 minutes. None of the people we spoke with had been waiting for longer than the expected waiting time. This meant that the service had responded to feedback and clinics kept patients informed of delays with realistic estimated waiting times.

## Involvement in care

There were several systems in place for people to feedback their experience of the outpatient service. In the reception area there was an electronic system for people to use and provide feedback. Staff we spoke with told us that the system was not that popular with patients and was not used as often as it could be. Staff also told us they did not know why this was the case.

Patients were encouraged to feedback to staff verbally.

Comments and actions were displayed on a board in the waiting area under the title, 'You said, We did'. This presented comments such as, "There are not enough tables in the reception area", with a response from the service stating what they did to resolve the issue, "Eight small tables were purchased for the reception area". The outpatient lead nurse told us that this project showed, "Patients they have a voice and that patients feel more listened to and can visually see the results of their

comments." Patients were able to express their views as to what was important to them in relation to their care and treatment, and that where appropriate these views were considered by the service.

There was also a listening activity called 'Here 2 Hear', where Governors of the trust provided a face to face opportunity to listen to people's experience of the service.

This provided Governors with opportunity to engage in direct contact with people who used the hospitals services.

We saw a report from March 2014 that showed the activity, "Positive and worthwhile". The outpatient lead nurse told us that this was generally a monthly activity that was discussed at Governors meetings to share what had been learnt.

## Trust and respect

The August 2013 outpatient survey showed that 70% of patients felt that staff explained tests or investigations in a way they could definitely or to some extent understand.

Comments included, "Explained everything", and, "You did well at answering my questions".

Patients we spoke with told us that staff explained their tests and treatment to them. One patient commented that, "Doctors explain things very well, clearly and in an understandable way", and another, "Clinical nurse specialists explained treatment plans to us". This meant that patients were given information to make decisions about their care and treatment.

Patients were asked to rate the care that they received in the outpatient department, 42% of patients felt this was excellent, followed by 11% and 16% for very good and good, respectively.

## Are outpatient and diagnostic imaging services responsive?

Good



## Meeting people's needs

We saw evidence that an 18 week referral time to treatment (RTT) performance management group, chaired by the Deputy Chief Operating Officer, had been established in January 2014 to improve performance by encouraging safe 18 week pathways. The data highlighted areas of excellent



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practice where some clinics had managed to get a 100% 18 week RTT rate in general medicine and geriatric medicine, whilst others were below the 95% target such as trauma and orthopaedics and ear,nose and throat (ENT). However the trust was meeting their overall 95% target.

Concerns about the lack of capacity to meet the 18 week RTT in some clinics was noted on the outpatient risk register. We were told by the service unit manager for patient access that the oral surgery and trauma and orthopaedics clinics had specific 18 week RTT targets set by Outpatients the local clinical commission group (CCG) that they were required to meet to ensure improvements had been made later this year. We were told that the group will monitor performance at speciality level and share best practice to improve the overall trust performance.

Data on the number of people who did not attend (DNA) their booked appointments showed that the overall trust rates ranged from 9.5% to 10.8%, between December 2013 and February 2014. Rates were consistently above the upper target of 5%. Some Allied Health Professionals (AHPs) told us that their individual services had implemented strategies to reduce the number of DNA clinic appointments, such as a one strike policy, but staff were unsure of how successful these strategies were because no evaluation of the process had yet taken place.

The service unit manager for patient access told us that proposals were being developed to reduce the DNA rates in the future via the electronic patient record system and text message reminders.

## Access to services

The service unit manager for patient access explained to us that outpatient appointments were booked via the national Choose and Book service. This meant that patients were able to choose the date and time of their appointment from allocated appointment slots.

One patient we spoke with told us that they had use this service, they commented that they would have liked a confirmation letter with a map to clarify which department they needed to attend, as they felt this was not clear on booking the appointment and made it confusing when they had arrived at hospital. The service unit manager for patient access told us that confirmation letters and maps

were only sent to people if appointments were organised by internal booking services. This meant that the appointment arrangement did not always meet individual peoples' needs.

The imaging department had an arrangement with local GPs for direct referrals, which meant that the service was able to respond in a timely manner to patient's needs. The imaging department delivers out patient and GP appointments for ultrasound, CT and MRI examinations seven days a week. The walk in GP x ray service is five days a week currently.

Senior staff in the imaging department told us that they have an arrangement with local GPs for direct referrals.

Patient can attend the service without a planned appointment to receive care. We spoke with two patients that had followed this pathway who told us that it usually did not take long to be seen by a clinician. This meant that the service was able to respond in a timely manner to the needs of patients.

There was a staff member available to help patients use the self-check-in kiosks that were implemented in December 2013. This meant that patient received appropriate help and the service was effective at reducing cues at the reception desk.

There was a volunteer coffee shop in the main reception area with a range of snacks and hot and cold drinks. There were also refreshments available from vending machines for people to use.

## Vulnerable patients and capacity

We saw a trust policy that outlined the outpatient journey for vulnerable people. This gave staff guidance about how to care for vulnerable people and provided contact numbers if they required further advice. This included people with a learning disability and people living with dementia.

Staff told us that they regularly met with a patient representative, to gain feedback and ensure that service facilities were appropriate for people with physical disabilities. As a result appropriate adaptations to the facilities had been made. We saw that toilets had been adapted for use for people with physical disabilities. There were waste bins with knobs on the top for people to use their hands if they were unable to use their feet to open the bin. This promoted people's independence.

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We spoke with one person who had difficulty walking, they told us that there were no wheelchairs left available at the reception area for them to use. We asked reception staff if this was a frequent problem, they told us that it regularly happened and that wheelchair users did not always return the wheelchair to the reception after use, but no action had been taken to resolve the problem.

We saw a detailed plan relating to wheelchair access at the self-check-in kiosks to ensure that those wheelchair users could efficiently use the service. We saw that the font size of the display could be changed at the kiosks to help people with a visual impairment read the information. We were told by staff that there was no specific equipment for bariatric patients within the outpatient service, however, appropriate seating had been ordered. The staff had identified an area in the endoscopy department, close to outpatients, that was appropriate for the care and treatment of bariatric patients and clinicians would see patients there. We saw evidence of this arrangement and comments from a keyworker, "The appointment went really smoothly. The patient did not become anxious or distressed due to the organisation". An example of how the service made reasonable adjustments to deliver care to meet people's individual needs.

## Learning from experience, concerns and complaints

In the staff room we saw 'Listening Posts'. Staff used these boards to record patient's comments they had overheard, these were discussed at staff meetings with the aim of improving the service. For example, a nurse overheard one female patient anxiously commented that they required sanitary items but none were available within the toilet facilities. As a result there are now sanitary items available from staff and the implementation of contracted sanitary resources were being investigated. This meant that the service made reasonable adjustments to reflect patient needs.

We looked at the number and type of complaints reviewed about outpatients' services at the hospital from August 2013 to February 2014. There was only one complaint concerning the outpatient department relating to a waiting time not being met for a suspected cancer patient. Staff told us they had been involved in the investigation into the complaint. The complaint had been investigated in line with the trust's policy.

## Are outpatient and diagnostic imaging services well-led?

Good



Staff felt supported and received appropriate professional development.

Governance meetings were held within the imaging department and all multidisciplinary staff were encouraged to attend, improvements had been made to reduce waiting times and improve efficiency within the department.

## Vision strategy and risks

All of the staff we spoke with and those who attended our focus groups told us the trust board was visible, were enthusiastic and had a clear vision about the direction of the trust. Staff told us about the 'stepping up' meetings where they had the opportunity to talk about issues and risks in their department. They told us the senior management team were frequently seen in the department and were very approachable. All of the staff we spoke with knew the trust's vision for improved patient care. Staff told us they felt proud to work in the hospital and were valued as employees.

## Leadership and culture of service

The outpatient lead nurse told us that they had attended the McKinsey Leadership Development programme that focused on patient experience and that they had started to implement what they had learnt within the department to improve the service.

We saw minutes of weekly registered nurse forum meetings that informed staff about forthcoming events as well as reminding them to complete forms such as incident reports and 'Error Capture' audit data. Staff told us they attended monthly staff meetings, we saw the standing agenda for the meeting that included health and safety, infection control, governance, complaint and feedback, education and training. This meant that staff received appropriate information to support the care and treatment that they delivered to patients.

## Patient experience and staff involvement and engagement

Service level staff survey data was not available directly for outpatient staff, but all of the staff we spoke with spoke

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positively about the service they provided for people and reported that they felt well supported. Quality and patient experience was seen as a priority and everyone's responsibility. There was an 'Outpatient employee of the month', nominated by patients to highlight staff that exceeded patient expectations and acknowledged good practice.

There was a, 'You said, We did'; board in the staff room for staff to raise issues and have visual feedback about what had been actioned to improve these. Senior staff were visible within the service for staff to raise any concerns.

## Quality and performance

Monthly governance meetings were held within the department and all multidisciplinary staff were encouraged to attend to ensure that there was a collaborative approach to care and treatment.

## Learning improvement, innovation and sustainability

Areas of innovation could be seen around the department gaining patient feedback, for example the 'Listening Posts', the 'You said, We did' boards and the 'Here2Hear' activity. We saw that the service considered patient views and experiences when planning and delivering their care and treatment.

We found there was a continuous drive to improve. We were told by the audit lead that the service had reduced waiting times by extending the service to evenings and weekends. This meant that the needs of patients were met.

We were told that a voice recognition system had reduced the production time of radiology reports and as a result the system was more effective for staff. This meant that the service was being led to improve efficiency.

# Outstanding practice and areas for improvement

## Outstanding practice

- We found the innovation around development of medical staff in the A&E service with career progression to consultant level to be a very innovative response to a national shortage of emergency department medical staff.
- The preparedness of staff for major or emergency incidents in the medical care areas was outstanding. Staff were very aware of their responsibilities and were engaged with the trust's processes.

## Areas for improvement

### Action the hospital **SHOULD** take to improve

- Improve the management of medicines across the medical care directorate. There is a particular need to improve the recording of medicines administration and storage and prescription of oxygen.
- Improve the governance from the top at executive level to the local wards and departments and ensure that risk assessments and service plans are available to staff providing direct patient care in escalation areas.
- Continue to work and improve on the skill mix and staffing levels throughout the hospital.