

# Southend University Hospital NHS Foundation Trust

## Quality Report

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This report describes our judgement of the quality of care at this trust. 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.

# Summary of findings

## Letter from the Chief Inspector of Hospitals

Southend University Hospital is an established 700 bed general hospital and provides a range of services to a local population of some 338,800 in and around Southend and nearby towns. The trust provides a range of acute services and is the South Essex centre for cancer services.

We inspected this hospital on 7 August 2014 in response to concerns of stakeholders and information of concern received into the CQC. Southend University Hospital NHS Foundation Trust was found to be in significant breach of its terms of Monitor authorisation since 2011-2012 due to their failure to demonstrate that there were appropriate arrangements in place to provide effective leadership and governance. There were also concerns around the trust's failure to meet cancer and C. Difficile targets.

This was a responsive review undertaken by six inspectors from CQC and two specialist advisors in A&E and governance practices. Only the services within the A&E department and the governance structures at Southend Hospital location were inspected. We have not given the trust a rating as this was a focused review, a further comprehensive inspection will be undertaken in the future to determine ratings of all services within the trust.

Our key findings were as follows:

- In all areas inspected, we found that staff were kind, caring and compassionate towards patients.
- Good progress had been made in strengthening the executive capacity of the board and establishing a pace of change towards improving quality.
- Evident support for the CEO's style and influence across the trust, engendering a commitment to change and improvement.
- Staff were proud to work for the trust.
- The trust had worked well to improve the performance within A&E to achieve the 95% target to see patients within four hours more consistently.
- Management of medicines, including storage was not always in accordance with national guidelines within A&E.
- Whilst the trust was actively recruiting nursing and medical staff, we found that the levels of permanent medical and nursing levels were not sufficient.
- Environmentally, there were concerns with the A&E not having a dedicated paediatric A&E.
- Infection control standards and practices around cleaning and equipment in A&E were not sufficient with some items and waiting rooms found to be unclean.
- The quality of serious incident investigations was poor and required improvement. There was also no quality assurance process in place to review investigation findings or outcomes.
- The staff who were undertaking serious incident investigations were not all trained investigators.
- Learning from incidents was slow and reactive.
- Maternity services policies and procedures on the induction of labour were not reflective of current clinical practice. However the clinical practice we observed did reflect current clinical practice in this area.

Whilst we saw areas of good practice there were also areas of poor practice where the trust needs to make improvements.

- Importantly, the trust must:
- Improve its cleaning schedule within the A&E department.
- Improve the security and storage of medicines within the A&E department.
- Increase the number of permanent trained nurses, paediatric nurses and consultants within the A&E department.
  - Ensure that policies and procedures reflect current clinical practice within maternity services.
  - Improve the quality and processes of the incident investigation process and ensure that lessons are learnt at the earliest opportunity.

During this inspection we found that the essential standards of quality and safety were not being met in some areas. As a result of our findings we have issued the trust with compliance actions. We have asked the provider to send CQC a report that says what action they are going to take to meet these essential standards.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Background to Southend University Hospital NHS Foundation Trust

Southend University Hospital NHS Foundation Trust is situated in the south of Essex, providing services to a population of approximately 338,800 people within Southend on Sea and surrounding areas in Essex. The trust provides a range of acute services including acute medical and surgical specialties, general medicine, general surgery, orthopaedics, ear, nose and throat, ophthalmology, cancer treatments, renal dialysis, obstetrics and gynaecology and children's services. Southend University Hospital is the south Essex surgical centre for uro-oncology and gynae-oncology surgery. The trust achieved Foundation Trust status in 2006.

We inspected this hospital on 7 August 2014 in response to concerns of stakeholders and information of concern received into the CQC. Southend University Hospital NHS Foundation Trust was found to be in significant breach of its terms of Monitor authorisation since 2011-2012 due to their failure to demonstrate that there were appropriate arrangements in place to provide effective leadership and governance. There were also concerns around the trust's failure to meet cancer and C. Difficile targets.

## Our inspection team

Our inspection team was led by:

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

The team included six CQC inspectors and two specialists in A&E medicine and Governance processes.

## How we carried out this inspection

During the planning of this inspection we spoke with key stakeholders such as Monitor, the local Clinical Commissioning Group and the Essex County Council local authority. When we visited we spoke to members of the executive team and to staff working in the A&E department, medical wards and maternity staff. We spoke

to a number of managers of these areas in order to address the information of concern that CQC had received. We spoke to patients, relatives and visitors attending the trust and reviewed previous NHS Friends and Family ratings.

## What people who use the trust's services say

The NHS Friends and Family Test was implemented to assess if patients and their friends and family would recommend the ward to their loved ones. The trust was performing above the England average in A&E with a score of 72 from 54 responses.

The inpatient survey showed that the trust was performing in line with other trusts during 2013. The A&E service was also performing in line with other trusts

according to the survey. However, there was one question where the trust performed worse than other trusts when it came to patient's being provided with enough notice about when they would be discharged from hospital.

We spoke with 38 patients, relatives and visitors during our inspection. All informed us of their positive experiences of using the A&E services. Patients reported that the staff had been caring, their questions had been answered and their concerns alleviated.

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## Facts and data about this trust

Southend University Hospital was opened in 1932 with 221 beds. The service now operates 700 inpatient beds, serving a local population of 338,800.

The hospital is currently the only centre in Essex to offer high dose brachytherapy treatment to prostate cancer patients.

The trust employs 4,528 staff comprising 181 consultants, 309 other doctors, 1,214 nurses, and 2,824 support staff.

During 2013/14 the trust admitted 91,391 inpatients, including:

- 9,119 elective inpatient admissions
- 42,513 day case admissions
- 42,622 emergency admissions

There were:

- 544,565 outpatient attendances.
- 89,965 attendances in the accident & emergency department

# Summary of findings

## Our judgements about each of our five key questions

### Are services at this trust safe?

Whilst the trust had taken action to address identified issues within the hospital these actions were not always completed. Examples of this include the recent investigation into a potential incorrect administration of a medicine where whilst staff had taken action to ensure that the incident was not repeated the policy was still awaiting ratification one year on. Further examples include the identification of a requirement for paediatric nurses in A&E. Whilst the required action was known, the shortages of staff on the paediatric ward made the practical working of the action impossible. At a senior level we discussed a number of issues which had identified actions in place but there was a lack of follow up on the outcome of these.

The senior management team had put systems in place to assure themselves of a line of sight into daily issues within the trust. The 'Comms Cell' was a weekly meeting for acute business units to review what was happening in their area and to share this with other business units. This encouraged positive challenge from other areas of the trust. The trust has to date recruited 50 Spanish nurses to complement their workforce although significant vacancies remained. However the trust senior team were aware of these and were taking steps to address the issues faced in the county.

### Are services at this trust effective?

Whilst we only reviewed the A&E department in depth we found that this service did not have audits to support the identification of outcomes for patients. The A&E department and maternity unit did not have up to date policies and procedures. The trust is required to make improvements so that patients can be assured that staff are following protocols which enhance their outcome and experience. We found that departments did not work cohesively which impacted upon outcomes for patients. Senior managers were aware of the difficulties with communication issues with the medical consultants but did not appear to have a coherent plan as to how to deal with these.

### Are services at this trust caring?

Staff, in the areas inspected, were caring, compassionate and treated patients with dignity and respect. Senior managers were aware that complaints were declining and were keen to improve the experience of patients.

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## Are services at this trust responsive?

Staff in Maternity were responsive to the review of the serious incident and had taken appropriate action to ensure patient safety and responsiveness. A&E four hour wait targets had improved since April 2013. Staff were working hard to ensure that patients did not wait and the introduction of a GP service within A&E had impacted significantly on achieving this target. The trust had recently undertaken the “perfect week” which is an exercise that strives to ensure that each department functions to its optimum capacity. The trust had an action plan to address the learning highlighted following this.

## Are services at this trust well-led?

The trust was well led however local areas of management and structures of the business unit required improvement to demonstrate clear leadership throughout the trust. The senior management team were able to articulate the strategy behind the vision.

Serious incident investigations were not always completed to an acceptable standard. For example the root causes that were identified were not the root cause of the incident that occurred. One investigation into a patient’s care identified contributory factors around the incident rather than what actually caused the incident. We also found that the trust was slow to implement the required changes to policies, guidelines and procedures following incidents.

We found in maternity services that the clinical practice was different to the policy which was in place. A new policy which reflected current practice was awaiting ratification. Whilst the care being provided was safe we were concerned that this conflicting information could be confusing to staff and meant that they may risk not following trust protocol.

## Vision and strategy for this trust

- The trust has a vision and strategy which was displayed throughout the hospital. The senior management team were able to articulate the strategy behind the vision.

## Governance, risk management and quality measurement

- All senior managers we spoke to highlighted the same or similar key risks to the organisation overall. This means that the trust was cohesive and aware of these risks.
- Learning from incidents was not always fed back to staff.
- Systems for closing the loop on quality improvements were not always in place. A number of staff at all levels could tell us of actions that were to be taken but there appeared to be no ownership of ensuring that these were actually taken. Examples

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of this included the recent incident in A&E where two teams of specialists were to be working on greater integration. Follow up meetings had not occurred. Similarly protocols in maternity had required amendment and whilst staff were working to these the documents, these documents had not been ratified.

- We found that the trust does not use nor has it implemented a recognised early warning score (EWS) or process to identify and respond to adult patients who have deteriorating condition. We were informed that a new system is due to be implemented in November 2014 because the trust had learned lessons from an incident where previous processes had not been effective. Throughout the visit no one was clear on when this new process would be implemented. On speaking with staff we found that generally nursing, support and medical staff were aware of the enhanced process to monitor deteriorating patients.
- We examined five serious incident investigations completed by investigators throughout the trust. We found that these investigations were not always completed to an acceptable standard. For example the root causes that were identified were not the root cause of the incident that occurred. For example one incident's root cause was 'External Source' another was 'Inadequate interpretation of the CTG' which were contributory factors and did not comprehensively detail why the event occurred. We also found that no consideration had been given to human factors and behaviours in each incident. For example staffing levels, competence and working capacity within a service. We spoke with the governance team who informed us that they would review their investigation processes.
- We found that the trust did not have an updated or current list of trained investigators. We spoke with a governance team member about this who informed us that training on investigating using the root cause analysis technique was currently being planned. It was acknowledged that some investigations were not being undertaken by trained investigators and as a result the quality of the investigation had been affected.
- We found that lessons learnt from incidents were not identified or actioned at the earliest opportunity. For example in Maternity following a serious incident a policy change did not take place until 11 months post incident. This meant that learning from incidents was slower than would be expected.

## Maternity Governance

- Prior to this inspection we received notification from the Coroner's office of Essex about an incident where care had

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been provided to a mother and the baby subsequently died. The incident involved the use of the medicine 'Propess.' Propess is a medicine used to induce labour. As part of the inspection we followed up on the concerns raised to us by the Coroner.

- During the inspection we found that the trust had stopped the use of Propess and staff had been informed that it could no longer be prescribed. We were informed that more research on the product was required before it would be used in the service again.
- We observed a staff poster in the central delivery suite which alerted all staff about recent changes to the trust's induction of labour protocol. These changes had been made in relation to women who had previously had uterine surgery. Four midwives confirmed that they knew about these amendments and that practice had been changed accordingly. We were assured that staff were following this new guidance and that mothers and babies were receiving appropriate care.
- New checklists were in place which prompted doctors to discuss the risks and benefits associated with induction of labour with patients. Patients told us that prior to treatment their consultant had discussed these issues with them thoroughly. We observed patient leaflets which supported these discussions.
- Whilst staff we spoke with confirmed that they were adhering to the trust's new protocol in relation to induction of labour, which reflected national guidance, we found that the trust policy available to staff did not reflect this practice. The serious incident had occurred almost a year prior to the time of our inspection and policy was in draft format for revision. This meant that the policy was not up-to-date and accurate. We were concerned that this conflicting information could be confusing to staff and meant that they may risk not following trust protocol.
- Following a recent serious incident which related to the induction of labour for women with previous uterine surgery, we were concerned that the service did not determine the root cause analysis of the incident or implement appropriate changes in practice in a timely way. For example no human factors, staffing, skill mix or other concerns had been considered as part of the investigation.

## Leadership of service

- We were informed that the communication within the business units was variable and that succession planning could be difficult.



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- The trust is divided into six business units which had a unit director manager and head of service. However at times there are issues for the unit manager in terms of challenging practice when this person is not clinical. Senior managers have proposed and agreed a different structure so that the head of the unit is a clinical lead. This had yet to be implemented at the time of our inspection but was a recognised issue for the trust and it was noted that they were taking action to resolve the issues.
- The senior team are visible within the hospital and staff email the CEO directly with issues of concern.
- The senior team are relatively new in terms of permanently appointed members of the board. We were informed that the board are collectively working together to build their working relationships to help drive change through the organisation.
- Staff engagement has improved with regular briefings and walkabouts by the senior team.
- The medical director is part time within their role, supported by two associate medical directors, maintaining a clinical practice. Whilst this facilitates a clinical perspective it may constrict the time available for planning and implementing strategic vision.

## Culture within the trust

- The senior management team were cohesive and shared a vision for the trust. They were aware of the issues and had plans in place to address these.
- The senior managers welcomed challenge by the board members but felt that this was not always as rigorous as it could be.
- We found no evidence of a bullying culture within the service during our inspection. We spoke with seven members of staff across three wards as well as 24 members of staff in A&E. Only one staff member informed us that they felt there was a bullying culture. No other concerns of this nature were raised. Staff throughout the services told us that they felt the culture was 'open' and that any concerns they had, they could share and they would be listened to.

## Public and staff engagement

- Senior managers described that communication with staff had improved through team brief and walkabouts by senior members of the trust.
- Managers were also clear that more needed to be done to improve relationships with key stakeholders to improve outcomes for patients.

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- A significant number of staff were aware that interdepartmental relationships with some consultants was poor and that this impacted on patient care.
- Some consultants were not engaged in the management of the services they provided.

## **Innovation, improvement and sustainability**

- The trust had recently undertaken “the perfect week” scenario which had raised some issues which the trust needed to be addressed. Despite this being held we saw little movement towards sharing and embedding these issues.
- The trust continues to recruit into the vacant nursing and medical posts but recognise the challenges in doing this. The CEO is on the workforce planning board so is ideally placed to agree with local trusts how to move this issue forward.

## **Wards visited as part of this inspection**

- We received information of concern from the public with regards to care and practice on Eleanor Hobbs ward, Kitty Hubbard Ward and Caestlepoint Ward.
- We spoke with 14 patients across the wards. All patients we spoke with found the staff to be caring and respectful of their needs. Patients told us that their care was, “excellent” and that the staff were “kind” and “caring.” However one patient said that although they recognised that it was good to give feedback they did not like being texted each day while in hospital to be asked about their experience in outpatients. The patient said they had not agreed to being texted.
- We examined nine sets of patient records across the three wards and found that risk assessments had been completed about skin condition and of developing blood clots. One patient who had been identified as at risk of skin soreness had appropriate care plans recorded and the risk was reviewed each day.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the trust **MUST** take to improve

- Improve its cleaning schedule within the A&E department.
- Improve the security and storage of medicines within the A&E department.
- Increase the number of permanent trained nurses, paediatric nurses and consultants within the A&E department.
- Ensure that policies and procedures reflect current clinical practice within maternity services.
- Improve the quality and processes of the incident investigation process and ensure that lessons are learnt at the earliest opportunity.

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

- Take prompt action to ensure that the children's A&E department is in line with national guidance.

- Review working with the psychiatric liaison services to improve the care provided to patients within the department.
- Ensure that there are robust systems in place for checking stock to ensure it is in date and safe to use within the A&E department.
- Review the management and directorate structure which supports A&E to improve clinical excellence.
- Improve on the overall achievement rate of doctors attending mandatory training.
- Ensure that all doctors within the A&E department have received children's safeguarding level 3 training.
- Review the process for equipment reported as faulty within the service, ensuring it is repaired or replaced in a timely manner.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

#### Regulated activity

Accommodation for persons who require nursing or personal care

#### Regulation

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

People who use services and others were not protected against the risks associated with infection because of inadequate maintenance of appropriate standards of cleanliness and hygiene within the A&E department.

Regulation 12 (2) (c)(i) HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and Infection Control.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

People who use services and others were not protected against the risks associated with the unsafe use and management of medicines because the medicines were not stored securely and were not always disposed of appropriately within the A&E department.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

There were an insufficient number of suitably qualified, skilled and experienced trained nurses and consultant doctors within the A&E Department.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

## Compliance actions

People who use services were not protected against the risks associated with staff following outdated internal policy guidelines regarding the induction of labour in maternity. Staff clinical practice was found to be safe however policy guidelines were not yet ratified.

The provider is inadequately analysing the quality of serious incident investigations that resulted in, or had the potential to result in, harm to a service user because the investigations were completed by investigators who were not always trained, the investigations missed key items of information and there was a lack of quality assurance processes to determine if the investigation report was completed to an acceptable standard.

Regulation 10 (2) (c)(i) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.