

# Southend University Hospital NHS Foundation Trust

## Quality Report

Prittlewell Chase, Westcliff-on-Sea,  
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Date of inspection visit: 12-14 January and  
unannounced 24 January 2016  
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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.

## Ratings

### Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Good



Are services at this trust caring?

Good



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



# Summary of findings

## Letter from the Chief Inspector of Hospitals

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

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

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

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

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

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

Our key findings were as follows:

- The increase in the number of beds at the trust had put additional strain on the services, but in particular a strain on the staff.
- Staff nurse to patient ratios were insufficient, particularly in medicine and musculoskeletal surgery.
- High numbers of elective surgery cancellations were seen in addition to clinic cancellations all relating to the alert status, capacity and congestion within the hospital.
- Good patient outcomes were evidenced in particular the stroke service.

- Staff went the extra mile for patients and demonstrated caring and compassionate attitudes.
- The trust scored above the England average for Patient-led assessments of the Care Environment (PLACE) consistently for all categories assessed. (2013-2015)
- Cleaning undertaken by nurses and technicians for November and December 2015 of high risk equipment was 95% and 97% compliance rates. There were no MRSA cases reported and lower than the England average rates of C.Diff.
- Mortality and morbidity meetings took place but they did not follow a consistent format, and actions to support learning lacked timescales.

We saw several areas of outstanding practice including:

- We rated well led for the emergency department as outstanding. The local leadership and team worked well to deliver the service. There governance practices ensured risks were identified and managed. They engaged staff to ensure they remained motivated.
- Stroke service patient outcomes received the highest rating by Sentinel Stroke National Audit Programme. CT head scanning was delivering a 20 minute door to treatment time which was a significant achievement.
- The trust had implemented an Early Rehabilitation and Nursing team (ERAN). The ERAN Team supported the early discharge of primary hip surgery and knee surgery patients.
- The 'Calls for Concern' service, allowing patients and relatives direct access to the Critical Care Outreach Team (CCORT) following discharge home.
- The learning tool in place within Radiology allowing learning from discrepancy in a no blame environment.
- The Mystery Shopper scheme that actively encouraged people to regularly give their feedback on clinical care and services.

# Summary of findings

- Safe @ Southend was a new daily initiative to allow staff to share day to day clinical and operational issues with executive Directors for rapid action. An open invitation to all staff to share concerns and challenges in an open environment which often resulted in prompt action.
- In Outpatients a patient ambassador group met to look at issues raised by patients. Solutions to issues raised had been implemented.

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

Importantly, the trust must:

- Ensure staffing ratios comply with NICE guidelines, to ensure both patients and staff are not at increased risk.

- Ensure duty of candour regulations are fully implemented, the trust was not able to demonstrate that they had met all parts of the requirements.
- Ensure that clinical review is part of the process for cancelling elective surgical patients.
- Ensure the duty of candour regulation are being met through improved root cause analysis investigations, and robust apology to patients.

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

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

# Summary of findings

## Background to Southend University Hospital NHS Foundation Trust

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

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

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

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

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

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

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

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

## Our inspection team

Our inspection team was led by:

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

**Head of Hospital Inspections:** Tim Cooper Care Quality Commission

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

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

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

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

## How we carried out this inspection

1. We analysed data available from national data sets. We received information directly from the trust as part of the provider information request. During and following the inspection we requested further documents for review. We reviewed documents on site; spoke to staff, patients, carers, relatives and visitors.

2. We visited on 12-14 January announced and 24 January 2016 unannounced.

3. Prior to the inspection received feedback from CCG's, Monitor, Health Education England and NHS E. We also conducted public listening events and a number of staff focus groups to get their opinions of the hospital.

# Summary of findings

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

Friends and family test results was 90-92% (Aug 14 - July 15) would recommend the trust as a place for care.

Response rates for November / December 2015 FFT were 18% and 17% respectively.

The CQC Inpatient survey found;

- Maternity services (December 2015) were about the same as other trusts.

- Children and young people services (July 2015) performed about the same as other trusts. However some of the questions had no data associated with it.
- Inpatient services (May 2015) were about the same as other trusts.
- Accident and emergency services (Dec 2014) were about the same except for waiting times which was worse when compared to other trusts.

## Facts and data about this trust

### Staff:

3,714 staff – including:

- 494 Medical
- 1,950 Nursing (Inc. HCAs, scientific and technical staff)
- 1,270 Other

### 2014/15

**Revenue:** £ 273,656,000

**Full Cost:** £ 283,490,000

**Deficit:** £ 9,834,000


### Activity summary (Acute) 2014-15

- Inpatient admissions: 53,712.
- Outpatient (total attendances): 530,750
- Accident & Emergency attendances 95,217: (Oct 14 – Oct 15)

Please note that the figures quoted here were reviewed for factual accuracy by the trust prior to our inspection.

# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p>Southend University Hospital Foundation Trust requires improvement for the safe domain.</p> <p>Because;</p> <ul style="list-style-type: none"><li>• Staffing ratios were not adequate to meet patients' needs. The trust did respond promptly including an action plan to address the shortfalls when we identified this.</li><li>• There was mixed evidence of learning relating to incidents and feedback was not routinely given to the person who raised the incident to update them at the end of the investigation.</li><li>• There were 16 serious incidents relating to ophthalmology; and the learning from this appeared to be limited within other areas of the trust.</li><li>• RCA investigations were not uniform; some contained much more details than others; also templates were different. This exposed the trust to the risk of not identifying all the learning points and not having a fully robust investigation process.</li><li>• Duty of candour was not fully implemented within the trust.</li><li>• Staff did not achieve the recommended level of training relating to safeguarding in line with the multi-agency partnership the trust is affiliated to.</li><li>• The mortality and morbidity meetings needed to improve to ensure good understanding of areas for improvement were identified and acted on.</li><li>• Safeguarding practices were not robust to ensure that all staff received the level of training required for their roles.</li></ul> <p>However;</p> <ul style="list-style-type: none"><li>• The WHO (World Health Organisation) Five Steps to safer surgery checklist compliance was poor but following our inspection in the unannounced period the trust demonstrated a 98% compliance from a previous 73% rate.</li><li>• We saw trust wide awareness and learning from the previous never events.</li><li>• The 'Safe @ Southend' initiative was dealing with concerns raised by staff in an effective way.</li></ul> <p><b>Incidents</b></p>	<p><b>Requires improvement</b></p> 

# Summary of findings

- The trust had two never events during 2015/16 at the time of our inspection. In April 2015 there was a retained swab and July 2015 there was a medication error. Both of these occurred in theatres.
- The trust had 8,528 notifiable incidents reported via National Reporting and Learning System (NRLS) April 2015 to Feb 2016.
- The trust had 105 serious incidents (STEIS) reported April 2015 to Feb 2016.
- Hospital wide learning from never events occurred. We confirmed this from focus groups and interviews of various staff groups. We confirmed that learning occurred outside of the immediate area where the incident took place.
- However, there were 16 serious incidents relating to ophthalmology and the development of a backlog. These 16 patients eyesight had deteriorated during the delay in treatment and review. We found that the learning from these incidents was limited. We saw that a similar set of circumstances had occurred within respiratory clinics, with a waiting list backlog build up. One serious incident had occurred due to the delay at the time of the inspection. Learning from the ophthalmology incidents and the detrimental impact on patient wellbeing had not been communicated to the respiratory service.
- Incident reporting was accessible via the trust intranet, telephone reporting and paper, however and the biggest impact on staff raising incidents was wards being short staffed. Staff sometimes did not have any time to do this. Also we noted that feedback to the person who raised the incident was poor and this too did not encourage staff to raise incidents.
- Learning from incidents was variable; some areas had better systems in place to share learning than others. However the trust did have many communication methods which is used to share information. Radiology was notable for the excellent process it had in place for learning.
- Incidents were subject to investigations including root cause analysis (RCA). We noted of the 18 RCA's submitted to us via document requests, that the format of the forms were not uniform. This was particularly noticeable in the medicine directorate's forms. This demonstrated a lack of consistency of reporting which ran the risk of comparability of themes and lack of robustness of investigation.
- Associated action plans showed completions of actions where shortfalls were identified. Learning was shared as part of the process and this was documented within the forms.

# Summary of findings

- Results from the 2014 staff survey showed staff scored below the national average for agreeing they would feel secure raising concerns about unsafe clinical practice. The trust told us they were aware of the issues identified in the staff survey
- Safe @ Southend was an initiative designed to allow staff to share concerns on safety with the trust. Whilst not replacing the trusts incident reporting system; executives were available first thing each morning in the staff area of the canteen for staff to share concerns. These were collected on a grid, actioned and the grid available on the intranet. Staff were able to see where issues they had raised had been dealt with. Examples we saw included staffing, delayed discharges, number of outliers and bed closures. Each issue raised had an action, person responsible and date completed on it.
- The medical director confirmed that mortality reviews took place. However, these were variable within each directorate. National guidance had been rolled out by the trust for the meetings to follow. The records of mortality and morbidity meetings showed variable levels of discussion especially around patient mortality cases. Although we saw some discussion around learning from practice, we did not see allocated responsibility or time scales to ensure the actions were completed.

## Duty of Candour

- Duty of Candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to the person.
- Staff understood the principle of being honest and offering an apology, but no further evidence of understanding of Duty of Candour. However, in Surgery staff were in possession of information leaflets regarding the regulation.
- Staff understood their responsibility to be open and transparent. Within root cause analysis reports we saw that not all parts of the regulation were followed for 14 RCA's. We received 18 RCAs, one was a duplicate and three others did not appear to trigger the duty of candour. The remaining 14 did not meet all the requirements of the regulations. For instance within RCA's there was place to indicate if the Duty of Candour had been actioned, these were not completed in full, or where they were completed the information contained did not demonstrate compliance with the regulation.
- A letter to a patient following a SI signed by the medical director lacked detail regarding the incident and what the trust knew at



# Summary of findings

the time. Apologies were not given in all cases or followed up by letter. Where it was noted that duty of candour had not been followed it was not present as an action in subsequent actions plans.

- When asked to show the 'being open policy' on the intranet, the search opened a NPSA poster from 2005. The trust did have an Incident and Serious Incident policy last updated May 2015. It contained advice for staff regarding the duty of candour.
- Governance leads when reviewing RCA's said they could not see the full explanations associated with Duty of Candour.

## Records

- The World Health Organisation 'WHO surgical safety checklist' was launched in June 2008. The checklist should be used for every patient undergoing a surgical procedure. During our inspection we saw that the WHO checklist was inconsistently used in the Interventional Radiology service. We raised this with the trust who completed an audit on 15 January 2016 this showed that the WHO checklist was completed for only 48% of procedures.
- A repeat audit was undertaken on 25 January 2016 and compliance was found to have improved to 98%. The trust advised us that compliance with WHO checklist completion would in future be reported monthly to the executive team at the Directorate Performance Review meeting

## Safeguarding

- The trust failed to meet its target for safeguarding adults training level 1. Compliance was 73%, against the minimum target of compliance at 85%. Limited staff were identified as having attained level 2 adult safeguarding (Jan 2016). The exception was midwifery and critical care.
- Safeguarding adults' level 1 broken down by staff groups showed: Medical staff compliance was 46%, nursing and midwifery staff was 69% and allied healthcare professional was 77% (Nov 2015).
- The trust failed to meet its target for child safeguarding training in levels two and three. Compliance was; level 1- 86%, level 2- 72% and level 3- 77% (Jan 2016). The trust minimum target of compliance was 85%. This was an improvement on the trust position June 2015.
- The policy for Adult safeguarding (draft Oct 2015) did not identify the levels that staff needed to attain for competence; other than to state all staff who care for adults must 'complete relevant mandatory training in relation to Adult Safeguarding

# Summary of findings

according to their role'. The policy was aligned to the LSBC (Local Safeguarding Children's Board) and SAB (Southend Adults Board) training strategy. Here this strategy identifies the type staff and the levels of training they require.

- The LSBC and SAB training strategy document identified staff that should have been trained to level 2 which included but was not limited to the following; qualified professionals in health and social care and all frontline managers who manage or supervise staff providing services directly to the public. Their responsibility included; ensuring service users / carers are supported, understand how best evidence is achieved, understand when to use emergency systems to safeguard adults and maintain accurate, complete and up-to-date records. This meant that the trust was failing to offer the correct level of training to staff despite being aligned up to the multi-agency strategy.
- The number of referrals for both adults and children had increased over the last two years. However if staff were not trained to an adequate level the trust ran the risk of not identifying all safeguarding concerns or alerts.
- Safeguarding Adult and Children committees convene regularly to review referrals and trends and compliance with training targets. The trust had safeguarding teams in place; they reported to the trusts clinical assurance committee and worked closely with external partner agencies.

## **Cleanliness, infection control and hygiene**

- Good practice was evident across the trust with compliance with the trust infection control policy.
- Staff were bare below the elbows in clinical areas and the vast majority of the clinical areas were visibly clean.
- Within the mortuary due to capacity (the fridge's were in regular use) staff said it was difficult to access them for cleaning.
- We did observe some staff (for example within paediatric services) entering and leaving a clinical area without washing their hands.
- In a report to the board, we noted in November 2015 the average nursing cleaning audit score was 95% (51 audits) and in December 97% (41 audits).

## **Environment and equipment**

- During the inspection we saw some equipment which required maintenance or replacing. The area in which equipment presented the most issue was within Outpatients and Diagnostics.

# Summary of findings

- For example within Outpatients ophthalmology service 'slit lamps' and 'head lamps' had not been serviced for over 12 months. The ophthalmology manager was not sure if there was a rolling service programme for equipment.
- Within diagnostic imaging, out of 18 pieces of equipment eight were past their replacement due dates. This included both MRI (Magnetic Resonance Imaging) machines which were due to have been replaced in 2012/13 and the interventional procedure equipment which was due to have been replaced in 2009/10. There was a service configuration strategy but it was in draft format. This detailed the replacement programme in line with the Royal College of Radiologists recommendations; however these had not been met.
- Paediatricians informed us that they were concerned about the viability and efficiency of the ultrasound scanner in use within Radiology. They understood that the equipment required replacement.
- However, the therapy department gym was well equipped. All the equipment was clean and well maintained.
- We noted that there was a PET-CT (Positron Emission Tomography - CT scanner) which was not available for patient use as Southend. However due to a commissioning issue the scanner was not able to be used until this was resolved.
- Staff working on AMU told us about their frustrations about changes to the location of the ward. They told us that the move away from A&E and x-ray units meant that staff may be away from the unit for up to 40 minutes. Due to the location of stairs between AMU and accident and emergency and x-ray, patients would have to be moved in two separate lifts and from one end of the hospital to the other. This meant staff were away from the unit area and extended the time that patients were in transit.

## Medicine

- On Princess Anne ward a medicine alert dated April 2015 was displayed in the medicine storage room reminding staff about the importance of medicine security. However, we found that medicines were not always stored securely. Although the medication storage room had a secure keypad access we found the door was not secured or locked at the time of our visit. We saw that medicines that should have been locked away were out on the countertop.
- We noted that because the trust ran two medication systems concurrently this put patients at risk. The two prescribing systems were paper and electronic. In particular when patients were transferred from a ward using the paper-based system to a ward using the new Electronic Prescribing (EP) system and vice

# Summary of findings

versa. Staff working in AMU told us their concerns about these arrangements. They told us that there had been a recent incident when a medicine had been administered twice which had put the patient at risk of harm. There had also been other incidents on wards due to patients moving from other areas where the different system was used.

- On Princess Anne ward although arrangements were in place for recording the administration of medicines using the new electronic prescribing system, an error had occurred. An incorrect code had been recorded on the system which resulted in one patient missing a dose of a pain relief medicine for three days. This had resulted in the doctor prescribing a higher dose to help control the patient's pain. On informing the doctor of the error they changed the prescription. This was reported as a medicine incident.
- Following our inspection the trust's presented an action plan which acknowledged our concerns about there being both a paper and an electronic prescribing system. Options were reviewed and a decision made at the January 2016 Executive's meeting to fast track the roll out of the electronic prescribing system once the training, equipment, computer systems and staffing issues had been addressed.

## Mandatory Training

- The Trust had not met its compliance with mandatory and statutory training, which (at Jan 2016) was 75%. The compliance target rate was 85%.
- Staffing shortages may have had an impact on staff ability to attend training. The trust being on alert status with high activity meant that non-essential meetings and training were postponed.
- Junior doctors reported having problems accessing some of the mandatory training due to the format of training schedules being half day block bookings, which were not compatible with junior doctor's rotas.

## Assessing and responding to patient risk

- Early warning observations were undertaken within the trust. We saw the process was well embedded and escalation of patients identified as deteriorating was seen by medics.
- VTE assessments were utilised to identify high risk patients, having a target of 95% or above which was maintained for the previous 12 months.

# Summary of findings

- Within ED (Emergency Department) triage times were met. With the use of the South Essex Emergency Doctors service which provided a urgent care and triage service. 100% of patients received an initial assessment within 15 minutes.
- There was good practice with the use of the WHO checklist within Surgery which we observed. Documents supplied by the trust also demonstrated a near 100% compliance with sign in, time out, sign out and site marking.(January- May 2015) However this was not the case for Diagnostic Imaging, where audit demonstrated 73% compliance where the target is 100%.The Breast unit did not use the WHO surgical safety check list when conducting invasive procedures such as biopsy.
- Medical handovers took place twice a day in the Nerve Centre every day with an extra one at 4pm on Friday for weekend planning. .They shared information about the previous nights and days admissions.The meeting was well attended and the quality of information was good.However, discharges were not always discussed.
- Bed management meetings took place with senior nursing staff two to three times a day.We observed that staffing including staffing moves and planned admissions were discussed and patients requiring one to one nursing. Discharges were not discussed at this meeting; however individual discharge problems were discussed on teleconferences twice a day.Elective cancellations were discussed outside of the room and at the meetings later in the day.

## Staffing

- The trust had an overall vacancy rate of 8% (December 2015).
- The trust monitored fill rates and presented them to the board.The reports demonstrated the actual versus planned and the use of bank and agency.We compared the summer period of July and August with November to February 2016, this therefore included the inspection period. We noted an improvement for both qualified and unqualified staff fill rate from the summer to the winter.However there was a 86% fill rate for qualified staff which was the same as the summer level (daytime), therefore it had improved and then deteriorated.We noted that in the main nurse fill rates ranged from 86% which was low to 95% against the planned.This meant that the trust had to utilise additional staffing resource such as bank and agency.For the same time period agency use had increased.For instance eight and seven percent of the qualified staff were agency for July and August 2015.This increased to 24% (January 2016) and 29% (February 2016).There were also increases for HCA agency use too.

# Summary of findings

- The attrition rate in the trust was high. Data from October 2015 showed ED was the worst directorate with a rate at 2yrs of 65% of staff having left, surgery and medicine was 45% and 40% after a 2yr period. A review was undertaken of exit interview across 3 directorates which demonstrated 56% compliance rate for exit interviews. This meant the trust was losing the opportunity to identify themes for half of leavers. The report did not give the detail of reasons for leaving but the trust committed to a further more extensive review.
- The trust stretch target was 9.7% for total staff turnover; for December 2015 they failed to reach the target achieving 14%.
- Most of the core services were experiencing staffing shortages which were either impacting on care or ran the risk to do so. A notable exception was general surgery where staffing appeared to be adequate. Where the impact of staffing shortages was most noticeable was in medicine, this also had an impact on end of life care (EOLC) as patients who were placed on medical wards where there were staff shortages could not receive the level of care they required. Within outpatients and diagnostic imaging we saw eight full time radiologists carrying a vacancies from 10-12 staff.
- The trust confirmed that the review of acuity and dependency of patients was being done six monthly. As this fed into the establishment figures and we saw staff shortages we asked the trust about this. The Chief Nurse confirmed that from the end of January 2016, daily acuity and dependency would be reported to address this. The Chief Nurse also confirmed sign off to recruit additional nursing staff. We saw within an action plan sent to us by the trust following the inspection that the board had approved the recruitment of an additional 61 WTE nursing staff.
- The trust was working to a 1:8 ratio (registered nurse: Patient) in non-specialist areas; however we saw that this figure was exceeded within the hospital notably within the medical wards. Following the inspection the trust shared with us the planned and actual figures for the wards and the escalation plans they had put in place to address these. They had sought support from the wider healthcare system. We saw that although the ratio had reduced more was required to get all the wards to an appropriate ratio.
- The trust cared for patients on a stroke unit which they described as a Hyper Acute Stroke Unit (HASU), but the staffing ratio was not in line with best practice guidelines. For the first 72 hours Level 2 patients require nursing staff numbers to manage the acute stroke patient (2.9 WTE nurses per bed). Thereafter a level of 1.2 WTE nurses per bed is appropriate (British Association of Stroke Physicians, Stroke Service Standards, set

# Summary of findings

by the Clinical Standards Committee and published in June 2014). We saw a ratio on the stroke unit during the inspection period ranging from 1:6 - 1:12. Following the inspection the trust confirmed that the unit was not a HASU, but was aiming for a ratio of 1:4 (registered nurse: Patient). We saw that when escalation was applied they were able to achieve a ratio of 1:6 for some of the shifts.

- The trust was in Black alert (its highest state of escalation) at the time of the inspection, and had a process in place where senior management reviewed the plan for patients and staffing requirements for that day and planning for upcoming days. The trust shared with us their Standard Operating Procedure of actions to be undertaken when in an alert phase. The trust also adopted, used and reported red flags relating to staffing as per NICE guidelines.
- Following the inspection we were sent an action plan by the trust which contained actions to be taken relating to staffing. This included the plan to reduce the bed base, the introduction of daily acuity and dependency reviews especially on the stroke units, respiratory HDU, MSK and ED.
- Health and Social Care Information Centre data showed variances in the medical staffing skill mix against the England average. Consultant staff made up 37% which was lower than the England average of 41%. Registrars and middle career medical staff made up 48% of the medical staffing skill mix, which was higher than the England average of 48%.
- Pharmacy cover was not available on all the wards within the trust. There were not enough pharmacists when compared to similar size trusts. The trust had benchmarked itself, identifying the correct pharmacist to inpatient ratio. Six pharmacy staff had accepted offers but they had not commenced working at the time of the inspection. However, in the short term locums were being used to support. There were plans to evaluate the need for a further four and a half whole time equivalent (WTE) pharmacists. Locum cover was to be used in the interim until pharmacist posts were fully recruited to. The trust was also considering the outsourcing of Outpatient pharmacy to allow permanent members of trust pharmacy staff to focus on in-patient ward cover.
- The trust had increased the number of speech and language therapists from two to nine over the year leading up to our inspection, following benchmarking exercise.

## Major incident awareness and training

# Summary of findings

- Senior nursing staff told us they did not receive any major incident training and an electronic copy of the mandatory training matrix for staff confirmed this.
- There was a major incident plan mounted on the wall within the store room within paediatric outpatients. However, the Nurse in Charge told us staff received no training; either e-learning or face-to-face scenario based, to prepare for a major incident, but we were assured that this would be escalated by the Nurse in Charge.

## Are services at this trust effective?

We rated the effective domain as good.

Good



Because;

- National guidelines were well embedded, used and demonstrated. For instance end of life care was being delivered in line with the Leadership Alliance five priorities for care 2014.
- A simulation suite was available for staff to practice and improve skills.
- Stroke services demonstrated good outcomes for patients.
- Audit activity was widespread and where improvement was required associated action plans were implemented.
- Seven day services were offered in the majority of areas. However, end of life care was notable for lack of access to senior medical cover.
- Multidisciplinary working was demonstrated in many areas of the hospital and resulted in good outcomes for patients.

However;

- Paediatric diabetic readmission rates were higher than the England average.
- Appraisal rates were below the trust target at 74%.
- The endoscopy unit was not Joint Advisory Group (JAG) accredited or had a similar quality benchmark.
- Mental Capacity Act & Deprivation of Liberty safeguards training was mandatory; but the trust compliance rate was below the target achieving 59%.

## Evidence based care and treatment

- We saw during the inspection good evidence of national pathways being used to ensure good quality evidence based care was delivered to patients.
- Within ED there were good pathways for both stroke and sepsis patients which we saw were well implemented and delivered. However staff highlighted orthopaedic and back pain



# Summary of findings

pathways as an area of concern and the clinical lead had tried to resolve this with a new treatment protocol. A resolution had not been agreed, which resulted in on-going delays for referring patients to this medical specialty.

- Cardiotocography (CTG) was used to monitor the fetal heart within midwifery. Staff demonstrated that they complied with NICE Intrapartum Care 2014 by the use of stickers to document the assessment had taken place at the required time and frequency.
- The paediatric service demonstrated good practice following historic nasogastric (NG) tube children's clinical incidents. NG tube guidelines and competency frameworks were introduced both being based on the National Patient Safety Agency (NPSA) guidelines.
- Care plans and records of intervention for end of life care were in line with best practice from the Leadership Alliance five priorities for care 2014 'One Chance to Get it Right' guidelines and NICE 2015 Care of the Dying Audit.
- Physiotherapy within the outpatients department had patient protocols which supported patient outcomes and also improved the skills of the practitioners, which adhered to national guidelines.

## Patient outcomes

- Audit activity was undertaken by the trust to ensure that patient outcomes were assessed and improved. Enabling both local and national benchmarking. We saw evidence of plans for improvement via action plans when shortfalls were identified.
- The ED took part in Royal College of Emergency Medicine (RCEM) audits. There was a lead doctor identified who ensured areas for improvement were identified, audited and findings presented.
- The trust delivered stroke services which in the 2014 audit (Sentinel Stroke National Audit Programme (SSNAP)) was rated level A this is the highest (best) level with E being the lowest (worst). To enable the service to be benchmarked and assessed it had to be classified as a HASU by SSNAP. The trust informed us they were never a operational HASU, but were seeking classification as such with support from commissioners and stakeholders and were using the benchmarking as one of the rationales to gain the classification.
- Endoscopy had not achieved Joint Advisory Group (JAG) accreditation. At the time of the inspection the manager thought they would not be applying due to the unit being too small.

# Summary of findings

- The surgical directorate participated in national audit activity with mixed results. We saw that action plans were produced and actions discussed. For example, in a 12 month period between 2014 and 2015 the readmissions rate for elective surgery were better than the national average for trauma and orthopaedics (89) and urology (98), however the readmissions rate for general surgery (125) was worse than the national average. For non-elective surgery the readmissions rate was better than the national average for urology (70) and general surgery (97), however worse than the national average for trauma and orthopaedics (125).
- Re-admission rates for paediatric diabetics were higher than the England average every year since 2012, and there had been multiple emergency re-admissions associated with diabetes. The trust took part in the 2014 National Diabetes Paediatric audit and identified learning points. An action plan was devised to manage implementation recommendations. Initial local re-audit has demonstrated a reduction the number of re-admissions.
- Critical care unit (CCU) uploaded data into Intensive Care National Audit and Research Centre (ICNARC), to allow them to benchmark patient outcomes. The unit also took part in peer review with another NHS trust. This resulted in an action plan which we reviewed and saw all the actions had been met.
- ARCU did not submit data to ICNARC as the trust told us they misunderstood the rationale. However, they do understand it is used as a benchmarking tool and as such are looking to submit data in the coming months.
- Within maternity we saw mixed results for births compared to the England average. For example the caesarean section rate was higher (worse) than the England average, but the home birth rate was higher (better) than the England average.

## Competent staff

- The appraisal rate for the trust for December 2015 was 74% the target was 85%. Doctor appraisal rate for 2014/15 was 90% and the revalidation for the same timeframe met target. The trust had up to date policies relating to both appraisal and revalidation.
- Within the staff survey staff reported that the appraisal helped them to agree clear objectives for their work; this was lower than the England average of 79% (NHS Staff Survey 2014).
- Medical revalidation was linked to appraisals but not to personal development e-learning programme.

# Summary of findings

- Outpatient staff had met the trust target for appraisal rates. An education programme was available and delivered to referrer staff to ensure staff understood their responsibilities under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R.
- Within CCU, some staff members including nurses of senior levels, consultants and doctors expressed concerns about the efficiency of staff in other areas of the hospital regarding reporting triggering patients. Therefore, regular training became available for all staff and senior staff members had opened a simulation training room where staff could be trained based on different scenarios to support nurses and doctors to care of a deteriorating patient. Records had demonstrated that there had been an increase in referrals to the critical care outreach team (CCOT) since NEWS had been adopted in the trust.
- The trust had a simulation suite which a senior critical care contributed to. We were shown the simulator suite, which had opened a few weeks before our inspection and was identical to a real critical care clinical environment. It contained equipment including a clinical manikin which could be controlled remotely by trainers to mimic clinical conditions. Trainers could use a remote microphone to make the manikin 'speak' to staff, and were able to alter its breathing rate, blood pressure and pulse along with other physiological responses. Staff using the suite could practice essential skills. Training was facilitated by senior nurses from CCU. The training provided by this facility met the recommendations of section 1.7 of NICE guideline CG50: Acute illness in adults in hospital: recognising and responding to deterioration.
- The specialist palliative care team had identified that staffing issues had negatively impacted on the number of staff accessing End of life training. This course was not mandatory.
- The process put in place in ED (emergency department) to identify staff with required competencies was simple and effective. It allowed senior staff to identify staff with the correct competencies at a glance as they wore badges with the training completed. In addition in an emergency situation this also allowed the lead to identify appropriate staff to support.

## Multidisciplinary working

- The trust had multidisciplinary team (MDT) working well embedded into the hospital. We saw good practice across all the core services. Also healthcare staff worked with other appropriate professionals in the community to ensure that patient experience and pathways were improved.

# Summary of findings

- Within outpatients the musculoskeletal clinical assessment and treatment service was a project set up in conjunction with the local clinical commissioning group. This offered a single point of referral from GP's. Historically referrals were not always being sent to the most appropriate practitioner but through the introduction of this pathway decisions about patient review could be made in accordance with the appropriate clinical pathway. This improved the patient experience, reduced waiting times and maximised limited resources.

## Seven-day services

- One of the strategic priorities was 'excellent patient outcomes'. The trust identified that to achieve this one of the actions is to have a seven day service with senior medical cover and diagnostics available for all in-patients.
- There were good access to seven day services, this included, pharmacy, physiotherapy occupational therapists, psychiatric liaison nurses, supervisor of midwives and consultant cover.
- X-ray services were available at all times in the hospital, being on call out of hours.
- Paediatric accident and emergency department employed paediatric trained staff. Although open seven days a week the department was open between 8:00am to 9:00pm. Outside of these hours children would need to present to the adult accident and emergency department.
- Speech and language therapists and dieticians did not offer a seven day service and were available six days a week.
- The notable exception was End of Life Care. Consultant on site cover was not available seven days a week. Out of hours an on call South East palliative medicine consultant was available. There were five consultants available to cover the whole of South Essex for 24 hours a day, seven day a week. These consultants were available to offer advice to all hospices, community hospitals and the acute trusts. Clinical nurse specialist for palliative care cover operated over five days on site in the hospital.

## Access to information

- Information was widely available for staff to access via the intranet.
- Patient records were both paper-based and some were in electronic format.

## Consent, Mental Capacity Act & Deprivation of Liberty safeguards

# Summary of findings

- MCA DoLs Level one was mandatory for staff, information sent to us prior to the inspection identified that 59% of staff had undertaken this training. The trust working target was 85%.
- There was a good level of understanding when staff were asked to explain MCA and DoLs. We saw mixed completion of assessment of mental capacity, some units were better than others. ED were particularly good. We reviewed the records for ten patients receiving EoLC. Eight of the ten records did not have an MCA assessment recorded for their do not resuscitate decision.

## Are services at this trust caring?

We rated caring within this trust as good;

Because;

- We saw committed caring and compassionate examples of care, delivered by all grades of operational staff.
- Feedback from patients, relatives, carers and visitors was positive about the care given.
- Patients were aware of their treatment plans and had sufficient information.
- Patient and relative groups were on offer, to support both with any questions or ongoing issues.
- Psychological support was available; the bereavement service was flexible to meet the needs of deceased families.
- The privacy, dignity and wellbeing PLACE score was above the England average and had increased by 10%.

However;

- Friends and family test responses and results were lower than the England average.
- 

## Compassionate care

- Friends and family test results was 90-92% (Aug 14 - July 15) would recommend. This was lower than the England average for every month. Although the trajectory was rising. The trust when asked about this said the reason for the consistently low score was because they did not support patients to complete the questionnaire.
- There was a drop in responses November / December 2015 18-17%, the trust attributed this to the number of admissions 'which dilute the ratio of responses'. 2014 response rates for the same months was 29-34%. The recommender rate remained the same at 91%.

Good



# Summary of findings

- The PLACE score for privacy, dignity and wellbeing was 88 which was above the England average of 86 (2015). This was a 10 point increase on the previous year..
- The trust performed consistently above the England average for 2013 - 2015 for all categories assessed within PLACE.
- Patients, carers and relatives we spoke with gave positive feedback regarding the care they or their relatives received. We observed care which was dignified and compassionate on the whole. One patient on a medical ward told us that nurses “try very hard” despite being “well and truly overworked”.
- We saw one incident where care was not compassionate; we brought it to the attention of senior staff who assured us they would address the behaviour.

## **Understanding and involvement of patients and those close to them**

- Staff kept patients up to date with information about their current treatment plans.
- There was a weekly relatives’ forum on one of the medical wards (Benfleet) which aimed to give the patient’s family an opportunity to discuss the patient’s progress.
- Women we spoke to in midwifery confirmed that staff gave them ample information to prepare for birth of their child.
- Within EoLC staff ensured that families had as much time as they required to spend with their deceased relative before they were taken to the hospital mortuary.
- Within outpatients they had a ‘Patient Ambassador’ group. Members of staff would bring patient feedback to the group and they would discuss how services could be improved. Positive results of this group included additional fold away seating for the main outpatients. Also additional refreshments points and dignity briefs for patients undergoing intimate examinations.

## **Emotional support**

- Psychological support and counselling was available for patients.
- Support groups were available for some patients such as the group called PACERS which supported patients with pacemakers and met every three months.
- Within diagnostic imaging in outpatients a member of staff described how they invited a person living with learning disabilities into the department to familiarise them with the unit. If they then ever required treatment in the department they hoped that this would reduce their anxiety.

# Summary of findings

## Are services at this trust responsive?

We rated the responsive domain within this trust as requires improvement;

Because;

- Large numbers of elective surgery was being cancelled too often, which would cause distress and additional risk to patients.
- Cancelled outpatients clinics was an issue due to the capacity and congestion within the hospital, outpatient staff were required to work on the wards. This negatively impacted on those waiting for appointments.
- As the trust was in alert status, they had multiple outliers which were impacting negatively on patients who should have been cared for within wards of their speciality.
- Discharges were not taking place in a timely fashion; this was having a knock on effect. We saw this in critical care, where patients ready for discharge were delayed as they were waiting for beds on the wards.
- Complaints were not always responded to quickly enough. Some directorates were missing their key performance indicators for response times.

However;

- The stroke service was extremely responsive and swift.
- There was evidence of good planning with regard to the impact of the closure of a local urgent care centre.
- The trust had good support processes in place for vulnerable people.

## Service planning and delivery to meet the needs of local people

- The ED had identified patient cohorts where additional actions were required to either support the person or maintain patient and staff safety. For instance clear processes were in place for patient escorted by the police. We saw that additional support was offered via the alcohol liaison team to patients under the effects of alcohol abuse.
- The planned closure of a nearby urgent care facility and the likely impact this would have was mitigated by the implementation of a 'navigator' role to redirect patients appropriately within ED.
- The stroke emergency service and was delivered both in ED and continued within the medical directorate and diagnostic imaging. The pathway was well embedded with good outcomes for patients requiring thrombolising.

Requires improvement



# Summary of findings

- The CT department provided a service for stroke patients requiring CT head scanning having a 20 minute door to treatment time which was a significant achievement.
- In accordance with NICE guideline CG83: Rehabilitation after critical illness in adults, CCU now offered patients a follow-up clinic appointment within three months of their discharge from the unit. This was a new initiative in place six months prior to our inspection.
- Maternity services undertook many initiatives to meet the needs of local people, for example the additional support offered to mothers who wanted a natural birth having previously had a caesarean. We noted the empathetic service offered parents who had lost a child. In particular there was a cold cot which enabled parents to take their child home for a brief period to aid the bereavement process.
- Within paediatrics Diabetes, Cystic Fibrosis and Oncology all had transition services. Clinics were available specifically for adolescents who have diabetes and rheumatology where both a paediatrician and adult clinician attended.
- We saw an improving picture of the number of patients who wished to die at home and required fast track discharge (within 24 hours). At the time of inspection 50% of those wishing to die at home due to deterioration were able to do so in 24 hours. The aim was for the majority of patients wishing to die at home should be discharged within 24 hours.

## Access and flow

- At the time of the inspection the hospital was on Black Alert (highest alert category) due to the number of patients in the hospital at the time. The trust had an escalation policy and process in place. This included three bed management meetings daily. These were attended by senior staff to discuss the bed blockers and staffing issues they had on each unit. Staff in attendance would identify areas of capacity and share resource to try and alleviate the pressure. The later meetings in the day would look at the expected elective patients due the next day, the number of discharges and the planned staffing to help plan for the next day.
- There were 189,193 occupied bed days in 2014/15. (An occupied bed is an available bed where there is a patient physically in the bed or the bed is being retained for a patient). This included critical care and maternity beds
- Medical outliers occurred due to the number of medical patients admitted. This impacted on the number of available surgical beds. During the inspection we found that several patients had moved wards on three or more occasions.



# Summary of findings

Information provided by the trust identified that the number of medical patients who have had three or more bed moves during the last 6 months was 1,359. We were told by senior management that when two or more moves occurred this should be associated with a risk assessment. We reviewed records and found this did not always occur.

- The senior CT radiographer attended the bed meetings. If a patient was required to undergo a scan prior to discharge, the radiographer was bleeped and the patient was brought to the department to improve flow.
- Gynaecology wards had medical outliers due to winter pressures. All outliers were assessed for suitability to be transferred to the gynaecology ward.
- January to December 2015 demonstrated the highest incidence of paediatric patients being admitted to adult wards was to the delivery suite, which accounted for 60% (114/191) of cases for 14 to 17 year olds, and inpatient admission to the gynaecological ward was at 22% for the same age range and time period.
- Due to medical patient capacity the trust was required to cancel elective surgery. Between July 2015 and December 2015 there were 1,512 cancellations in surgery with 802 of those cancellations in trauma and orthopaedics.
- Average theatre utilisation for elective surgical admissions in September 2015 was 73%; however, main theatre five, and eye theatre two, had low theatre utilisation rates of 37.1% and 51.3% respectively.
- Gynaecology cancelled 95 operations between September 2015 and December 2015 due to bed pressures. Eight of those were cancer patients.
- The congestion / capacity issue also had an impact for discharges from CCU, with around half delayed by over four hours to be accommodated on a ward.
- Patients requiring palliative and EoLC were usually cared for on speciality wards such as oncology/haematology, renal, respiratory and other medical wards. However, some of the beds in the specialist wards were 'flipped' to care for general medical patients when the hospital was congested. We saw one bay comprising of four beds in the haematology ward was functioning as a 'general medical' ward on the day of our visit. Staff told us this had happened seven previous times recently. Staff were distressed because this had caused an incident for one haematology patient. We raised our concerns about this with the trust.
- The ophthalmology department had a waiting list for follow up appointments of 17,880 patients which had resulted in 16

# Summary of findings

serious incidents where patient's sight had deteriorated due to lack of follow up care. The respiratory service also had a rolling waiting list of around 2000-3000 patients waiting for follow up appointments also due to capacity. Mitigation has been put in place where an external company has triaged patients to identify those most at risk. Additional weekend clinics were being run and the external company was also undertaking surgery on a defined cohort of patients to reduce the back log.

- The trust cancelled of outpatient clinic sessions as part of the trusts escalation policy to manage capacity. This meant that when the hospital was very busy outpatient clinics were cancelled to allow staff to be allocated to different ward areas to ease patient flow. From 1st October 2015 to 31st December 2015, 3,830 clinics had been cancelled out of a possible 33,055 which was 11.6%.
- The trust exceeded the Referral to Treatment (RTT) 18 week standard for Non-Admitted and Incomplete Pathways for the whole of 2015 and has been better than the England average.
- The ENT (Ear, Nose and Throat surgical speciality) had the lowest RTT figure with 68% of patients being referred receiving treatment within 18 weeks.
- The ED met or exceeded the four hour admission, transferred or discharge national target four times in the 12 month period August 2014-15.
- The trust exceeded the England target of 90% of referred patients should start consultant-led treatment within 18 weeks of referral. Between September 2014 and August 2015 the trust achieved 97.5% or higher for this standard for medical services with the exception of December 2014. Geriatric medicine and neurology had achieved 100% figures for patients who were admitted.

## Meeting people's individual needs

- Services in place within the ED met the needs of both adult and children with mental health needs. There was a mental health assessment suite located in ED; this was developed in partnership with another local trust.
- The trust had a flagging system to identify people living with dementia or a learning disability, so staff interacting with them would do so appropriately.
- CCU and ARCU had learning disability link nurses who assisted with staff education and advice about care of any patients who

# Summary of findings

were living with learning disabilities. On admission to the hospital, any patients living with learning disabilities were flagged on the hospital's electronic records system and the learning disability clinical lead was automatically made aware.

- The trust employed a lead learning disability nurse who engaged with people in the community to ensure the hospital was not an intimidating place to attend. In addition to this information including videos was easily accessible on the trust website.
- The trust planned to make the training course dementia awareness mandatory for all front line staff.
- The bumble bee pin was used to in ED on curtains to demonstrate that difficult conversations were taking place within the cubicle.
- The trust had widespread dementia awareness and processes in place to support people and their carers.
- Specialist midwives were available for women with specific problems such as: infant feeding, drugs and alcohol, teenage pregnancy and bereavement.
- A school was available for in patient children of school age staying on the unit longer-term, and was available between 9:15am and 12:00pm on weekdays during term time.
- Young people with learning difficulties were transitioned to adult services in liaison with the clinical teams involved in their care. This would include paediatricians, specialist school nurses, community nurses, rehabilitation staff and social care staff. The age for transition would be decided by the team involved dependant on the severity and needs of the young person and their family. There is an adult learning difficulty clinical nurse specialist who would be involved in the transition process along with the relevant adult teams.
- The trust provided around up to 12 beds for patients requiring palliative or end of life care. There were identified wards where these beds were available. The number of beds varied dependant on need.
- Patient information in the ophthalmology unit was printed on yellow paper to make it easier for those with visual impairment to read.
- The trust had translation services available for patients. Patient information sheets were available and could be translated into other languages if required.
- Within diagnostic imaging there was no paediatric waiting or play area available, also bariatric patients could not be accommodated at the trust for MRI scans but were sent to other trusts.

# Summary of findings

## Learning from complaints and concerns

- The number of complaints was rising from 2012 to April 2015. April to December 2015 the trust had received 727 formal complaints. This was a drop from the previous 2 months. 84 were in the quality assurance process at the time of our inspection.
- Information was available to make patients aware of their right to make complaint.
- Staff confirmed they would use local resolution to try and resolve issues before they became formal complaints.
- All complaint responses went through a process which was updated December 2015. A member of the senior management team confirmed that complaint handling was missing internal KPI's. The directorate which received the most complaints was the medical directorate. A weekly report of complaints and the time to complete was shared with the chief nurse. The delays were due to the quality of the complaint responses, the ownership of complaint handling by the directorates and the timeliness of the completion response.
- The trust had implemented a 'Mystery Shopper' system. Leaflets encouraged patients and visitors to feedback their experiences by registering to be a mystery shopper. The leaflet showed the benefits to both service users and staff of learning from feedback. Patients would be sent a pack of forms and prepaid envelopes to complete each time they used the service. Patients were assured of anonymity. This was coordinated by the patient experience team.

## Are services at this trust well-led?

Southend University Hospital Foundation Trust requires improvement for the well led domain.

Because;

- The strategy to open escalation beds which increased the hospital bed base numbers had put increased pressure on the whole of the hospital, such as staffing, outliers, and cancelled elective procedures.
- The decision to cancel elective surgery was taken by non-clinical staff which was not appropriate and increased risks for patients.
- Within the detail of the trust strategy some of the actions were not consistently delivered.
- The risk register and BAF required further development; both lacked some detail such as action by dates.

**Requires improvement**



# Summary of findings

- Some mitigation relied upon with the BAF were not effective mitigation because they were not consistently delivered.
- There appeared to be a lack of joint working and learning for the back-log of patients in both ophthalmology and respiratory services issue.

However;

- The trust had a vision and strategy in place, staff and the public had had input into it.
- Board and governors took part in ward visits regularly.
- Staff had good access to the leadership.
- Escalation process was in place and well embedded during the times that the trust was in an alert status.
- The leadership were visible and accessible to staff.

## **Vision and strategy**

- The vision of the trust is 'high quality care for every patient every time'.
- The trust had launched a strategy for 2015-19 to achieve the vision in November 2015. The strategic goals are:
  - Excellent patient outcomes
  - Excellent patient experience
  - Engaged and valued staff
  - Financial and operational sustainability
- Within the strategic priority 'excellent patient outcomes', we saw good outcomes in a number of places, stroke services were of particular note. However the detail defining what the trust needed to do to demonstrate this priority was not being achieved, which included '.....and deliver care in the right place, first time, every time'. This was not achieved for high numbers of patients who were outliers on incorrect wards.
- The strategic priority 'excellent patient experience' included in the detail delivering the six C's (nursing values), which we saw staff demonstrated, for instance commitment and compassion. Feedback from patients and visitors mentioned these voluntarily. However the PLACE score for privacy, dignity and wellbeing was 88, which was above the England average, this was a drop on the previous two years for the trust.
- The strategic priority 'engaged and valued staff', detailed within this was 'everyone to receive appraisal...'; the trust was not achieving this with a 74% completion rate for December 2015 when the target was 85%. We did get feedback from staff relating to easy access to senior and executive team members, which is also identified in the detail relating to this strategic priority.

# Summary of findings

- The strategic priority ‘financial and operational sustainability’; within the detail is improve theatre utilisation. From December 2015 the trust increased the number of trauma lists from seven to 12 per week; to ensure that MSK patients were not cancelled so often. Short notice cancellations had been an issue for an extended length of time. We saw in documents presented to the board that from April 2012 to December 2015 for the vast majority of the time the trust had failed to meet the target and exceeded the number of short notice cancellations.
- Each directorate was able to produce its own vision and strategy in line with the trusts strategy. Within CCU we saw this was taken on board through beginning to produce their own vision. This was to be presented to the board first to ensure it aligned the trust vision. Following this it was to be presented to staff for their suggestions and input before the final version was produced.
- The governors had an input in the new trust strategy and had led public meetings to share the trust goals.
- The human resources strategy was out of date and the department was drafting the workforce strategy, this was to reflect the five year strategy already in place for the trust.
- Trust had an Information technology strategy in place. This had representatives from each directorate, which met ‘most’ months to review compliance with the strategy.

## **Governance, risk management and quality measurement**

- The trust was in the process of reviewing the whole governance structure following a report by an external body.
- The governance structure in place. Each directorate leadership had a governance manager in place. However, there was a lack of parity in this role. Medicine was the busiest directorate and had the highest number of incidents, but this directorate was supported by a band 5 governance lead who worked part time. Whereas diagnostics and screening the role was fulfilled by a band 8 working full time.
- There were discrepancies with the directorates in the handling of complaints, some had appointed individuals to lead on complaints and coordinate locally whilst others had not and so did not perform so well. A high level flow chart had been produced to help with the process of complaints in January 2016.
- The directorates produced a monthly report on the incidents raised to identify themes and learning. There are key performance indicators (KPI’s) set for the completion of investigations of incidents Women and children’s’ and ED directorate consistently met these.

# Summary of findings

- The Governance team produced reports about the directorate performance which included NICE compliance, freedom of information (FOI) requests, legal services and incidents. NICE guidance was reviewed as part of governance, to ascertain if they are relevant to the trust and the work they undertake.
- Staffing shortages were not routinely reported via the risk system. Incidents raised via the electronic incident software for November and December 2015 were 30 in total. This was below the number of times that staffing was below planned rotas. We spoke to senior staff within governance who confirmed they did not get many incidents raised relating to short staffed areas.
- The board of governors took part in board to ward rounds, these were on a rota basis, staff on the units visited were aware as the visits were announced beforehand. The governors felt this activity was useful to meet with both patients and staff and hear their accounts first hand. A report was produced and shared at the board of their findings.
- Governors and Non-Executive directors had quarterly meetings.
- Senior staff admitted that retention was an area of concern for the trust and was looking at strategies to improve this. They were considering using an external company to help with this in particular, compliance with exit interviews, for which they were achieving 56% compliance.
- With regard to equality and diversity the trust employed 18% BME. This staff group felt that career progression opportunities needed to improve.
- The ophthalmology waiting list issue was identified via a complaint received by the trust. We spoke to a number of senior and executive staff who gave differing explanations regarding how the number of people who had been affected by this came to light. What was clear was that it was not picked up via a risk register. The risk had been identified by the department but was low risk. The governance team reviewed all of the medium and high risks identified by the directorate leads on their risk register but not the low risk. The low risks were reviewed at directorate level. This meant that the system of review at the time of the inspection meant that a similar incident could happen again. The trust was considering re-instating the risk management committee.
- The respiratory service also had a rolling waiting list of around 2,000-3,000 patients waiting for follow up appointments due to capacity constraints. Management told us that this had been an issue since 2012. Learning from the ophthalmology incident and the detrimental impact on patient wellbeing had not been communicated to the respiratory service. To date one serious

# Summary of findings

incident had resulted from the delay in respiratory follow-up appointments resulting in long term morbidity for a patient.

Senior management thought that learning was not shared due to the services were divided up between different directorates.

- The Chief Executive Officer (CEO) thought that the learning from ophthalmology had been disseminated across the trust. However, a similar issue had arisen within respiratory and it was not clear that learning had been utilised to diminish the impact for patients.
- The risk register was managed by the risk team this was part of the governance team; they attended risk meetings and reviewed RCA's. They also checked that staff who undertook RCA's were trained to do so. Training was planned to be delivered to 150 staff this year. The risk team viewed all the incidents added to the electronic incident system. This team worked closely with the medical director and chief nurse. Whereas the governance team worked closely with the chief nurse.
- The Board assurance framework was produced by the trust secretary, however the risk team were not aware how the information contained was produced and where the link was with the risk register.
- The CEO was aware of the main issues on the risk register including the deteriorating financial position. The cancellation of elective surgery was having a negative impact on finances in the trust. The CEO was in discussions with the CCG's to request support with the possibility of having an elective and cancer centre in the future. This would help to improve the financial and operational sustainability within the trust.
- We reviewed the corporate risk register provided which only had the high level risks most of which have been identified in our reports. The BAF also had similar risks within it. Both documents did not have completion dates for the resolution of risks. The BAF was not aligned to the trust strategies.
- We also noted that some of the mitigations on which the trust relied upon were failing, therefore not true mitigation. For instance 'Poor patient experience' was identified on the BAF, some of the mitigation in place which the trust relied upon was the Organisational Development strategy, staff training, and the appraisal process. During the inspection we noted both the staff training and appraisal rates were not meeting the trust targets. Also the human resources strategy was out of date and a workforce strategy was being produced.



# Summary of findings

- The equipment within diagnostic imaging which required replacement was placed on the departments risk register. However we saw some equipment which was in need of replacement and was past their recommended replacement dates.
- The process for cancelling elective surgical patients did not have clinical input. The decision was taken by the associate director operations (ADO's) who is part of the leadership of each directorate. This person does not have a clinical role and was not seeking clinical oversight or validation of their decisions to cancel. During the inspection we spoke with the Chief Operating Officer (COO), who felt that the safeguards in place were sufficient. We were given the example of a patient who was likely to breach 18 weeks so the trust outsourced their treatment to the private sector.
- The assistant director of operations who cancelled patients were not required to produce a report so that their decisions could be evaluated by clinicians or the COO. We asked the CEO about this who was not aware that this was a role undertaken by the ADO's
- Following the inspection the trust sent an action plan assuring us that this practice would be stopped and all elective cancellations would have a clinical review as part of the process.
- Some of the leadership had been concerned about silo working when the previous structure was business units. The trust now had directorates with a triumvirate leadership structure. Most of the directorate's clinical director role was held by a medic, with the clinical associate director being a nurse and the other associate director an operations manager. The only exception was the women and children's directorate where the clinical director was the head of midwifery.
- The trust had seen an increase in the numbers of visits to ED, with medical patients accounting for the large majority of the admissions. The trust response had been to increase the bed base and put the trust in alert escalation status. Elective surgical patients were regularly cancelled as a result and medical patients were being placed on wards outside of their speciality. The increased bed base along with the vacancies put an additional strain on the staff in post. This resulted in low (worse) nurse to patient ratios which put patients and staff at additional risk. There were incidents which had occurred due to this strategy. In addition to this where the staff to patient ratios were low (worse) there was a need for additional staff both bank and agency which incurred additional unplanned costs.

# Summary of findings

- Following our inspection with the support of the lead commissioners the trust was supported to close 28 beds. Of these, 18 were escalation beds and included six stroke beds of which two were acute stroke beds.
- The regulator Monitor identified a licence breach and took enforcement action Feb 2016 following investigation.
- Managers we spoke to praised their staff for the commitment during the times of high workloads. They described times when they had delivered sandwiches to staff who could not leave the ward for breaks due to work load.
- Information governance breaches were a risk of which the trust was aware. They had put processes in place to minimise the incidents. This included reminder signage and confidential waste bins on units for handover sheets. Information governance training was mandatory the trust; the compliance rate was 79%, the target was 95%.
- There were discrepancies relating to figures we received from the trust via the provider information (PIR) request prior to the inspection. These did not tally with national data sets. We explored this further with the trust who were thought the discrepancies had occurred due to varying definitions. For instance medicine admissions for one year were reported nationally as 30,000 episodes, but the trust PIR stated 35,000. For serious incidents reported within Surgery nationally 20, but via the PIR 31 were reported. We saw varying figures for the bed base too, between 539 and 725.
- We saw outstanding leadership in practice within the Emergency Department, which engendered a good team, which delivered a service that most patients were happy with.

## Leadership of the trust

- The CEO felt that the leadership team was now stable, with the recent addition of the chief nurse.
- Board development was available however from our interviews with senior management and the executive team it required further development. The HR director confirmed that they were planning an away day for the executive team.
- A development programme was in place for the clinical directors, which the trust wanted to roll out for the next clinical management tier.
- We held a governors focus group. They confirmed their induction programme was comprehensive as well as the development programme. The governors also attended statutory and mandatory training.

# Summary of findings

- The trust leadership held a daily meeting called 'Safe @ Southend'. This was held in the canteen for anyone who was able to attend including the public. We reviewed minutes of these meetings and saw that follow-up actions were undertaken and reported in this forum.
- A ward manager said the Chief Nurse was "inspiring and approachable".
- Some senior managers told us that they felt well supported by the executive team, however felt that on some occasions there were delays in actions being implemented during change processes across the trust.
- Within maternity services, some medical staff told us they were not adequately supported by senior doctors. The senior team were aware and shared a plan that was being implemented to address this problem. The medical director confirmed that junior medical staff felt they were not getting the quality of training in the acute medical unit. Especially when it came under increased pressure. The MD addressed this with the training lead consultant.
- The relationship with local hospitals was being developed further with the Success Regime. This was a programme to plan the future of healthcare in the area and what hospitals were best placed to offer specialisms. The Executive felt that more clinician engagement was required.

## Culture within the trust

- At the vast majority of the focus groups, staff talked about the hospital being friendly and having a strong culture of team work. People described being proud of working at the trust.
- Staff reported that their colleagues were supportive of them.
- We found that staff were focussed on patient experience despite how hard they were working.
- Within medicine which had the highest nurse to patient ratios, we found staff were hard working and committed to providing the best possible care they could however, managers said that staff were "tired" and there was "low morale" because of staffing shortages.
- Some staff has worked in the hospital for long periods of time. Within children's and young people's services some staff within the eye unit told us senior members of staff within the unit had been there in excess of 20 years.

## Fit and Proper Persons

# Summary of findings

- The trust 'Pre and Post Employment Checks policy' was out of date requiring update 2014; and therefore makes no reference to Regulation 19 Fit and Proper Persons; and Regulation 5 Fit and Proper Persons at Director level..
- The Chair had the responsibility to ensure that the FPPR was actioned within the trust, but at the time of the inspection the process was not fully implemented. It was the responsibility of the Human Resources executive to manage on a day to day basis.
- During the two week unannounced period the trust updated their FPPR process. We returned and reviewed a cross section (six) director records of our choosing. We found they met the requirements of the regulations in full. The revised policy had been approved by the board and implemented by the trust during the inspection period. The process had been extended to the associate director level.

## Public engagement

- There was a period of consultation during the development of the trust's five year strategy in which the public were engaged and invited to provide feedback. Communication to the public was undertaken in a number of ways including, stakeholder engagement events, publication of the consultation document on the trust's website, the use of local media and social media to raise awareness.
- The FFT response rates were below the England average, within medicine we noted that within ward meetings staff were reminded to encouraged patients to complete the FFT feedback.
- CCU had produced its own survey to gain patient opinions.
- The trust recruited members of the public to undertake the roles of mystery shopper. Their role was to share their experiences of services as another feedback mechanism.
- There was a Maternity Service Liaison Committee (MSLC) group which was undertaking a woman to woman experience audit which was on-going at the time of our visit. Children's and Young People's services completed an outpatient's department survey sampling 100 patients in September 2015. Results demonstrated that 89% of respondents said the environment was welcoming and courteous (for which the 'very likely' option was selected).
- Patients could also give feedback via the trust website. One of the ways the patient experience team gained an understanding from the patient perspective was via a mystery shopper scheme.

## Staff engagement

# Summary of findings

- Following the inspection we were contacted by a two staff including one in a management position. Both felt concerned regarding the activity being undertaken by the executive team to resolve the alert status. It was clear from their concerns they did not fully understand the situation at the time of the inspection and the rationale for the executive team decisions. This raised the question regarding staff engagement and communications to ensure that staff fully understood the impact of the plans.
- The staff survey results 2014 demonstrated that the overall indicator for engaged staff was in the lowest (worst) 20%. Examples where the trust performed worse than the national average related to work related stress and staff likelihood to recommend the trust as a place to work or receive treatment. Examples where the trust performed better than the national average; percentage of staff feeling the pressure to attend work when feeling unwell and percentage of staff working extra hours was slightly better than the England average.
- In the NHS Staff Survey, 27% of respondents agreed that communication between senior management and staff was effective. This was below the England average of 31%.
- In the NHS Staff Survey, 39% of respondents agreed that they would recommend the trust as a place to work. This was below the England average of 40%.

## **Innovation, improvement and sustainability**

- The trust had a research unit which supported the units to identify and deliver results to change best practice for patients.
- The use of taping of cannulas, known as 'chevron' in the renal unit which kept the needle more secure and reduced the risk of displacement and blood loss. The renal unit were also using an alarm for high-risk patients that alerted staff quickly to the presence of any moisture (which may be blood loss).
- The trust had implemented an Early Rehabilitation and Nursing team (ERAN). The ERAN Team supported the early discharge of primary hip surgery and knee surgery patients. The team visit patients in their own home either on the day of discharge or the day after discharge, and continue to support the patient and their carers with their recovery from surgery. We spoke to patients using the service who told us that they felt the service had had a positive impact on their recovery following surgery.
- The renal department had received negative feedback about the amount of time patients needed to wait for transport to the hospital. Therefore staff reviewed current arrangements and discussed how these could be improved. By grouping patients together by geographical locations and offering them

# Summary of findings

appointments on the same day the waiting times were dramatically reduced and patient satisfaction increased. By grouping patients together for transport a saving of £183,000 was made.

- The gynaecology sister received an improvement award for setting up a manual vacuum evacuation day clinic to enable women to get timely treatment of miscarriages under local anaesthesia.
- There was a culture within IT of 'We are here to help you'. For last six months IT staff had been invited to join ward rounds, this enabled them to see first-hand how IT was being used by staff and what the obstacles were and assist staff to understand what can be done to improve systems.
- The Nerve centre was an electronic hospital wide system which included E-observations; at the time of our inspection it was being trialled on a number of wards. In addition to this the trust were trialling access to deteriorating patient data on consultants' personal phones as part of the system capability. Senior nurses from CCU were instrumental in the ongoing roll-out process of a wireless electronic observation recording and alerting system. Nurses using the system in wards across the hospital would record patients' observations, such as pulse and breathing rate, blood pressure, level of consciousness and temperature on a hand-held device similar to a smartphone. The device linked to a central co-ordination area in the hospital and if any patient's observations exceeded set levels on the National Early Warning Score (NEWS) an alert would automatically be sent to the manager of the ward where the patient was being nursed, and to the CCORT. The system also allowed ward managers and the CCORT to remotely view real-time information on patients across their department or the hospital respectively and to work proactively if patients whose condition was deteriorating were identified. This was a significant improvement on 'traditional' methods of monitoring 'track and trigger' scoring systems such as NEWS, which relied on the individual nurses escalating patients to senior nurses, doctors and outreach teams manually. It also reduced time spent locating patients' notes and provided a robust audit trail.
- The trust were aiming at being paperless by 2020. A project manager had been employed on a fixed term contract to achieve this.
- There was a system in place which enabled access to radiology and pathology results. This enabled widespread access to results including G.P's.
- The trust had implemented a 'Mystery Shopper' system. Leaflets encouraged patients and visitors to feedback their

## Summary of findings

experiences by registering to be a mystery shopper. The leaflet showed the benefits to both service users and staff of learning from feedback. Patients would be sent a pack of forms and prepaid envelopes to complete each time they used the service. Patients were assured of anonymity. This was coordinated by the patient experience team.

# Overview of ratings

## Our ratings for Southend University Hospital NHS Foundation Trust

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

## Our ratings for Southend University Hospital NHS Foundation Trust

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

### Notes



# Outstanding practice and areas for improvement

## Outstanding practice

### Trust wide:

- The Mystery Shopper scheme that actively encouraged people to regularly give their feedback on clinical care and services.
- Safe @ Southend was a new initiative to allow staff to share day to day clinical and operational issues with executive Directors for rapid action.

### Medical Services:

- The alarm used by the renal unit for high risk patients to alert staff of presence of moisture (that may be blood loss) during dialysis.
- The renal unit used a new standardised taping technique (chevron) to secure needles during dialysis to prevent dislodgement of the needle which can result in considerable blood loss.
- The hospital had received an innovation award for the seven-day transient ischaemic attack (TIA) clinic that GPs could access electronically. The system assessed patient risk and gave priority of appointments in order to improve timeliness of medical intervention for TIA patients.
- The trust provided emergency treatment (thrombolysing or clot-busting and thrombolectomy or clot retrieval), 24 hours a day, seven days a week for stroke patients.

### Surgery:

- The Early Rehabilitation and Nursing Team (ERAN) supporting the early discharge of patients following primary hip and knee surgery with recovery in their own homes.
- Consultant led Emergency Surgical Ambulatory Care ensured that patients with certain conditions were seen and treated quickly and reduced the number of inpatient admissions

### Critical Care:

- Use of the 'All about me' document.
- Levels of planning, governance and staff engagement and satisfaction on CCU.
- Introduction and ongoing rollout of an electronic, wireless patient observation and escalation trigger system.
- The 'Calls for Concern' service, allowing patients and relatives direct access to the CCORT following discharge home.
- The proactive, enthusiastic management team on CCU and ARCU.

### Maternity and Gynaecology:

- The number of specialist clinics available to meet the needs of the population using the service.

### In OPD:

- Physio Direct was a new physiotherapy assessment, advice and triage service. It was introduced to provide fast and easy access to physiotherapy assessment and advice, reducing patient wait times, reduces 'did not attend' (DNA) rates and missed appointments. It promoted patient empowerment and self-management.

### Diagnostic imaging

- An exemplary system was in place for capturing radiology discrepancies and learning arising from them which has been designed and implemented by a Trust radiologist. It captured all discrepancies in a friendly and efficient manner and is seen as an excellent tool for learning.

## Areas for improvement

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

**Trust wide Services MUST:**

# Outstanding practice and areas for improvement

- The duty of candour regulation were not being met, there was a lack of records to demonstrate that the regulations were within root cause analysis investigations. We saw that letters did not always have an apology within it.
- Improve the response rates of FFT.

## **Emergency Department Services MUST:**

- Improve the response rates of FFT.
- Improve the security arrangements to ensure that staff and patients are protected.

## **Medical Services MUST:**

- There must be sufficient and appropriate staff available to provide care and treatment for patients.
- The trust must review the arrangements and effectiveness of morbidity and mortality meetings.
- A daily record is made of the temperature of medicine storage rooms and for medicine refrigerators to ensure that medicines were stored within safe temperature ranges.
- A review of the safe and effective use of two medicine prescribing systems is undertaken.
- Patient records must be fully and appropriately completed.
- The trust must ensure that all staff have the required and identified level of 'both adult and children's safeguarding training.
- The use of whiteboards/ handovers in public place that include confidential patient information should stop.
- Ward staff must all be aware of procedures to review patients who are 'outliers' and when required able to escalate any concerns.
- Staff must have appropriate and suitable training opportunities to develop their practice and knowledge.

## **Surgery MUST:**

- The trust must ensure that governance systems with pharmaceutical oversight are in place to ensure that patients are protected from the risk of harm resulting from medication errors on the wards.
- The trust must ensure that there is clinical input into decisions to cancel operations.

## **Critical Care MUST:**

- The trust must take action to ensure sufficient numbers of suitably qualified and experienced nurses are deployed on ARCU to meet standard 1.2.2 of the Faculty of Intensive Care Medicine's Core Standards for Intensive Care Units.

## **CYP MUST:**

- Review and improve the robustness of complete, comprehensive, legible, chronological hard copy notes for children and young people. - Regulation 17 (2c)
- Ensure that there is an emergency plan for all children's and young people's areas, and that regular training is completed for awareness and preparation. – Regulation 12 (2e)s
- Develop and introduce a robust system for holding discussions with patients or their families where appropriate, in relation to consent and ensuring that this is documented appropriately within the patient notes. – Regulation 11 (1)
- Ensure that staff are adhering to the trust's infection control policies in terms of hand sanitisation. – Regulation 12 (2 h)
- Ensure that staff are sufficiently trained to be able to correctly severity grade clinical incidents, providing timely duty of candour where necessary. – Regulation 12 (2b)

## **EoLC MUST:**

- The trust must take action to ensure mortuary facilities are secure and suitable for the purpose for which they are being used.
- The trust must take action to ensure all mortuary equipment in use is safe for use and capable of effective cleansing.
- The trust must take action to ensure sufficient numbers of suitably qualified, competent, skilled and experienced nurses are available at all times on wards caring for palliative and end of life patients and there are sufficient end of life care consultants available to the trust.
- The trust must take action to ensure that risks presented by the flexible use of beds in specialist wards caring for palliative and end of life patients are managed to avoid patients missing regular treatments or being displaced to wards without the skilled staff to care for them.

# Outstanding practice and areas for improvement

- The trust must take action to ensure all DNACPR Orders state whether the patient had the capacity to make decisions.
- The trust must take action to ensure deceased patient's need for dignity and the reasonable expectations of relatives are met by the environment of the mortuary.
- The trust must take action to ensure it improves the quality and safety of palliative and EoLC services by identifying all risks and mitigating all identified risks in a timely way.

## **OPD MUST:**

- The trust must take action to ensure that learning from serious incidents in ophthalmology is shared with all outpatient departments.
- The trust must take action to ensure that the back log patients waiting for follow up appointments in ophthalmology and respiratory services are managed in a timely manner.
- The trust must take action to improve compliance of the WHO checklist in diagnostic imaging.

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

### **Medical Services SHOULD:**

- Staff should receive training in the principle of duty of candour and procedures that relate to it.
- A review of the environment on the AMU should be undertaken to ensure that there is sufficient space to safely access and exit the ward.
- Care pathways are in place for endoscopy procedures.
- The competencies required of staff to work in AMU staff should be reviewed.

### **Surgery SHOULD:**

- Full implementation of the electronic prescribing system should be expedited across all wards to reduce delays in the dispensing of medications and to increase safety through the removal of the dual prescribing system in place at the time of inspection.
- Encourage and act on feedback via the NHS FFT to ensure that the service is achieving the average national percentage of 95% for those who would recommend the service.

- When surgical operations are cancelled and a patient is not treated within 28 days of the cancellation, the trust should investigate the causes and implement actions to address them.

### **Critical Care SHOULD:**

- The trust should ensure data from ARCU is submitted to the Intensive Care National Audit and Research Centre (ICNARC) or similar national audits.

### **Maternity and Gynaecology SHOULD:**

- The trust should review medical presence on the labour ward to meet best practice recommendations.
- The trust should improve attendance at mandatory training.
- The trust should have a maternity and gynaecology strategy.
- The trust should store medical records securely and are not accessible to the public.
- The trust should inform the people using the service how to complain.
- The trust should review and reduce the amount of operations that are cancelled.
- The trust should display maternity outcomes for staff to see.
- The trust should improve the completion of risk assessments on the gynaecology ward.
- The trust should review the gynaecology ward handovers.
- The trust should ensure patients are not identifiable on boards that are in view of the public.

### **CYP SHOULD:**

Ensure that bathroom cleaning schedules are adhered to, in order to promote health and well-being. – Regulation 12 (2h)

- The service must be able to assure itself that all reasonable steps are being taken to minimise paediatric waiting lists, ensuring there is a robust and fair system implemented for trust decision changes to patient appointments. -
- Provide assurance that children's and young people's staff members are all familiar with both Gillick competence and Fraser guidelines. – Regulation 11, (1, 3)

# Outstanding practice and areas for improvement

- Be able to provide assurance that having surgical adult patients located within the children's ward for recovery purposes does not cause a safety issue for children on the unit. - Regulation 12 (2b)

## **EoLC SHOULD:**

- The trust should consider improving assessment of the spiritual needs of patients, relatives or friends.
- The trust should ensure end of life patients can be discharged quickly to their preferred place of death.
- The trust should ensure the practice of 'flipping' areas of specialist wards to care for general medical patients when the hospital is under pressure is put under review.

- Arrangements for attendance by a consultant haematologist to the weekly multidisciplinary palliative care meetings should be reviewed.

## **OPD SHOULD:**

- The trust should take action to improve the levels of medical staffing in respiratory and ophthalmology services.
- The trust should take action to improve the level of radiographer and radiologist staffing levels.
- The trust should take action to ensure equipment in the diagnostic imaging service equipment is replaced in a timely manner.
- The trust should improve uptake of audit within the departments of outpatients and diagnostic imaging.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p><b>For Medicine, Critical Care and EoL:</b></p> <p><b>Regulation 18(1) 18 Staffing</b></p> <p>Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.</p> <p>In that:</p> <p>There were insufficient numbers of nursing staff on all medical wards which compromised patient safety.</p> <p>Insufficient numbers of nurses were planned and deployed on ARCU to meet standard 1.2.2 of the Faculty of Intensive Care Medicine's Core Standards for Intensive Care Units.</p> <p>There were insufficient nurses on duty on the Princess Anne ward to support 28 medical patients including some patients with end of life care.</p> <p>There were insufficient palliative/end of life care consultants working for the trust.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>For Surgery and Emergency Department:</b></p> <p><b>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</b></p> <p>12(2)(b) doing all that is reasonably practicable to mitigate any such risks</p> <p>In that:</p>

This section is primarily information for the provider

## Requirement notices

There was no ward-based pharmaceutical oversight for MSK or surgical wards. Prescription charts were not reviewed or checked by a pharmacist.

Within ED staff and patients were put at risk with the current arrangements for security.

### Regulated activity

Diagnostic and screening procedures  
Nursing care  
Surgical procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

#### For EOLC:

#### 15 Premises and Equipment

1. All premise and equipment used by the service provider must be-
1. Clean,
2. Secure,
3. Suitable for the purpose for which they are being used,
4. Properly maintained

In that:

Mortuary facilities were not all secure and suitable for the purpose for which they were being used.

Not all mortuary equipment in use was safe for use and capable of effective cleansing.

Water was flowing into the tunnel connecting the main hospital building to the mortuary body store room and the lift to the mortuary premises, used for transporting deceased patients.

One mortuary store room could be accessed only by a footpath open to general public use.

The security and night surveillance arrangements for the mortuary facilities were inadequate.

### Regulated activity

### Regulation

## Requirement notices

Regulation 17 HSCA (RA) Regulations 2014 Good governance

### **For Trust wide, ED and EoLC:**

#### **17 Good governance**

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to:

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

In that:

Friends and family response rates were low across the trust; ED was an area of note. The trust would benefit from gaining feedback from patients using the services to make improvements.

Some risks to patient safety posed by flexible bed/ward use arrangements were not identified and risks identified as posed by the mortuary arrangements were not all mitigated in a timely way to protect patients, staff and the reputation of the hospital

and

Not all DNACPR Orders recorded whether the patient had the capacity to make decisions.

## Requirement notices

Diagnostic and screening procedures

Nursing care

Surgical procedures

Treatment of disease, disorder or injury

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

### **Trust wide**

Treatment for disease, disorder and injury

Diagnostics and screening

Surgery

Nursing care

### **20 Duty Of candour**

20.— (1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in

carrying on a regulated activity.

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(3) The notification to be given under paragraph (2)(a) must—

(a) be given in person by one or more representatives of the registered person,

(b) provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the

incident as at the date of the notification,

(c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

(d) include an apology, and

(e) be recorded in a written record which is kept securely by the registered person.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided under paragraph (3)(b),



## Requirement notices

(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),

(c) the results of any further enquiries into the incident, and

(d) an apology.

In that:

The trust were not able to demonstrate the records of conversations that took place. There was a lack of evidence of apologies in writing. The letters lacked detail of the incident and what the responsible person knew at the time.

There was no evidence of sharing the outcome of the investigation with a follow-up letter containing another apology.