This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Southend University Hospital NHS Foundation Trust (SUHFT) provides acute services from its main Southend Hospital site and outlying satellite clinics across Southend-on-Sea, Castle Point and Rochford. The trust employs over 4,500 staff, serves a population of over 350,000 and has a higher combined percentage population over 65 years of age (20.2%) than the England average (16.95%).

The trust provides a comprehensive range of acute services including acute medical and surgical specialties, general medicine, general surgery, orthopaedics, ear, nose and throat, ophthalmology, cancer treatments, renal dialysis, obstetrics and gynaecology and children's services. It is the South Essex surgical centre for uro-oncology and gynaecology surgery and has a dedicated stroke unit. Also offered are breast screening, ophthalmology and orthodontic services to the wider South Essex population.

The current hospital site opened in 1932 with additional extensions added throughout the existing site, the major extension of the tower block was opened in 1966. In 1997, the trust was officially designated cancer centre status and in 2006 opened the centre for clinical oncology. The trust has 544 acute inpatient beds, 31 maternity beds and 26 critical care beds.

From July 2016 to June 2017 there were:

- 90,849 inpatient admissions
- 625,109 outpatient attendances
- 101,120 emergency department attendances.

The trust is a part of the Essex Success Regime launched in 2015 with the aim of addressing the pressures on the local health and care system by tackling the gaps in clinical staffing, meeting the
growing health demands of the population and enabling the system to achieve financial balance. In December 2016, the boards of the three acute trusts (SUHFT together with Basildon and Thurrock University Hospitals NHS Foundation Trust, and Mid Essex Hospital Services NHS Trust) decided to enter into a formal collaborative governance framework and contractual joint venture. This allows the organisations to plan services and make decisions together, whilst remaining three independent statutory organisations with their own boards and councils of governors (or equivalent). This followed a period of board-level collaboration as part of the Acute Joint Working Project Steering Group between April and December 2016. In November 2017, a public consultation started that included the option of the potential merger of all three acute trusts, this is due to end March 2018.

The Essex Success Regime is one of three national initiatives designed to support the most challenged health and care systems across the country. It covers hospitals and NHS providers in the south of the county plus the CCGs that commission the services. The two to three year programme will see hospitals, GP surgeries and other NHS service providers work together to address deep-rooted pressures and secure high quality care.

The overall aim is to improve health and care in areas managing financial deficits or issues of service quality or both. The Success Regime will bring managerial and financial support to the region. It will help facilitate the developments of local plans that will set out how partners will transform care in a sustainable way. Key elements of focus include a closer working relationship across the area and improvements of provision and access to urgent and emergency care.

Is this organisation well-led?

Leadership

There were clear processes in place to ensure that the trust board and senior leadership team had the skills, knowledge, integrity and experience that they needed on appointment and throughout their employment. However, at the time of our recent inspection the trust was going through a period of transition that included an evolving leadership team to meet the needs of a changing organisation.

The trust was part of the Essex success regime and in line with the Sustainability and Transformation Plan (STP) had formed a partnership with Basildon and Thurrock University Hospitals NHS Trust and Mid-Essex Hospital Services NHS Trust. This partnership was formalised as of 1 January 2017 and was overseen by the Joint Working Board (JWB), which was made up of nine executive members and six non-executive directors from all three trusts. Claire Panniker, Chief Executive Officer (CEO) for all three trusts, led the JWB. The chair of the JWB was also joint chair for all three trusts. There was also a Joint Executive Group (JEG), which worked with the JWB and consisted of nine executive directors with joint responsibility for oversight of specific areas across all three trusts. For example, the chief human resources director was responsible for the overall delivery of the organisational development strategy across all three trusts; they also sat on the JWB.

Senior leaders acknowledged that the trust board was not representative of the workforce or the local population, they were working with the equality, inclusion and diversity advisor and HR and OD team to understand what was needed to address this.

Board members

- Of the executive board members at the trust, 12% were BME and 67% were female.
- Of the non-executive board members, none were BME and 25% were female.

<table>
<thead>
<tr>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 RPIR – Universal: Board tab
### Executive vs. Non-executive

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive</td>
<td>12%</td>
</tr>
<tr>
<td>Non-executive</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>12%</td>
</tr>
</tbody>
</table>

At each trust in the Essex success regime there was a site level senior leadership management team (SLT) responsible for the day-to-day management team of the hospital and reporting to the relevant director at JEG level.

The site level senior leadership team at the trusts were working on fixed term contracts until March 2018 when a decision will be made either to extend the JWB period or to disband the partnership working. A public consultation process started in November 2017 to consider these options and included the potential merger of all three trusts.

The site level senior leadership team at SUHFT consisted of nine directors including a managing director who acted as overall site leadership and reported directly to the CEO. The managing director at SUHFT had been in this post since December 2016. Prior to this, they had been the chief nurse at SUHFT since October 2015. Other members of the SLT included the medical director who had been in post since 2012 after 16 years as surgical lead for the trust. The director of nursing had been in post since December 2016 and was previously associate director of nursing at the trust since October 2015.

Our interviews with all of the directors at SUHFT confirmed that leaders understood the unique qualities and needs of their teams. There was a clear understanding of the challenges to developing and implementing a leadership team that would meet the needs of the changing organisation. Leaders that we spoke with acknowledged that the current leadership structure was complex and in a state of transition which was unsettling for all staff.

The trust reviewed leadership capacity and capability on an on-going basis, however there was no formal succession plan or process in place at the time of our recent inspection. The CEO informed us that ensuring that the leadership team had the capability and capacity to deliver strategic objectives was an integral part of the organisation’s ‘journey’. A process had started in December 2016 to map the critical roles needed for the current and emerging organisational form. This would inform a long-term succession planning strategy across all three trusts. The process had enabled the trust to identify key roles within the current structure that would require emergency cover if individuals left or were absent for a period, however, this was still a work in progress. Our interviews with the HR team confirmed that the development and implementation of a robust succession planning and talent management programme was a priority of the ‘Human Resources and Organisational and development strategy, 2016-2019’.

Our review of personnel files and policies demonstrated that the trust had a comprehensive Fit and Proper Persons Requirement (FPPR) process in place to ensure that directors were fit to carry out their responsible roles in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The process included comprehensive pre-employment checks that included enhanced Disclosure and Barring Service (DBS) checks, insolvency and bankruptcy checks, disqualified director register checks and occupational health checks. There were further checks on appointment through self-declaration and on-going assurance through an annual declaration and an audit process conducted by the chair of the JWB.

The leadership team had a comprehensive knowledge of current priorities and challenges and identified actions to address them. For example, one of the main risks identified to the board was the ability to meet key performance indicators (KPIs) such as ED four-hour performance target and referral to treatment (RTT) in all specialities including ophthalmology. The trust had been managing a backlog of follow-up appointments for this speciality since an improvement plan for this area was implemented in April 2016; (this is covered more fully in Outpatients report in ‘Safe’ and ‘Responsive’ sections). The trust had a comprehensive recovery action plan for RTT performance, which covered all specialities and was monitored by the trust’s dedicated improvement director. However, there was still variable performance and more work was needed to improve performance in specific areas. The trust was working with commissioners and other
stakeholders to develop care pathways and implement processes to prioritise care and treatment for patients waiting for treatment, which included reviewing and adapting internal and external processes. The trust acknowledged that they had significant challenges including an aging estate and the need to ensure financial stability. All senior leaders we spoke with were acutely aware of the challenges of local commissioners and the wider health and social care systems and what actions the trust was taking to deliver services in a challenging climate. For example, the finance director (at both JEG and SLT level) explained that they had regular meetings with other stakeholders such as the clinical commissioning groups and NHS Improvement to discuss trajectories, cost improvement programmes and priorities for funding and capital investment. The director of nursing was leading on the ‘Red to Green days’ programme that had been implemented in January 2017. During our interview with the director of nursing they confirmed that the introduction of the programme was to both measure the amount of days patients stayed at hospital and did not have any positive interventions (i.e. treatment, diagnostics or nursing care) ‘red days’ and to think about what that meant to the patient’s experience.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The trust had developed a ‘Human Resources (HR) and Organisational Development (OD) Strategy’ with equality, inclusion and diversity forming an integral part of the plan to develop leaders. A leadership development programme had been introduced to the trust in November 2016. All senior staff at band seven or above were required to complete a mandatory leadership course and were encouraged to explore leadership development opportunities.

During our core services inspection, most staff told us that the site level senior leadership team were visible and approachable. There was a programme of board visits to services and staff feedback that leaders were approachable. For example, the chief HR director explained how they had visited various areas of the trust during October 2017 to promote ‘Black history month’ and staff awareness of diversity. The SLT had introduced a fortnightly visibility walk-round process to visit wards and departments and make themselves available for feedback from staff. Non-executive directors conducted monthly walk-rounds with governors, matrons and department leads.

At our Well-led inspection, we had the opportunity to have interviews with five of the trusts clinical directors from different directorates. Our interviews with these local leaders demonstrated that they were committed to ensuring quality patient care and determined to be involved in shaping the future of the organisation to achieve the trust’s vision. This included providing constructive challenges to senior leaders to enable them to participate to the delivery of the strategy.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust’s vision was ‘To be a leading provider of seamless healthcare that will support every person who needs our services, whether in our out of hospital to achieve their best health possible’. This was reflected in their mission statement, which was to ‘Deliver high quality care to patients every time’. The vision was underpinned by four goals, which were to attain:

- Excellent patient outcomes
- Excellent patient experience
- Engaged staff
- Financial and operational sustainability

The values had been developed in conjunction with staff and during our recent inspection, staff that we spoke with told us about the trust’s values. The values were:

- Care with compassion
- Working together
- Professional and accountable
The trust’s current and future overall strategy was aligned to local plans in the wider health and social care economy and was being developed with external stakeholders. For example, during our Well-Led inspection the trust held a workshop to discuss the options for the partnership between the three trusts. The workshop was attended by most of the executive team and external stakeholders such as commissioners and NHS England. The trust had published their ‘Five year strategy 2015-2019’, (http://www.southend.nhs.uk/about-us/media-centre/news-archive-2015/nr-42-(2015)/) which had been developed prior to the formalised partnership with the other two NHS trusts. Senior leaders told us that although the strategy was developed prior to the formalised partnership the main objectives to achieve the vision remained the same. For example, one of the objectives was to ‘Provide better access for patients and where possible reduce their need to come to hospital’. The trust worked with commissioners and local partners in care to develop networks to enable patients to receive more care in the community. Underpinning the overall strategy were a series of other strategies developed to achieve the vision. For example, one of the objectives was to ‘Make sure our buildings are fit for purpose by modernising existing facilities and developing new ones’. A comprehensive estates strategy was in place that clearly set out the trust’s plan to modernise key areas such as the ophthalmology unit and mortuary. Our conversations with the directors of estates and review of records confirmed that the estates strategy was monitored and reviewed regularly.

Staff, patients, carers, external partners and other stakeholders had the opportunity to contribute to the development of the strategy. A public consultation document was published on 30 November 2017 (http://www.nhsmidandsouthessex.co.uk/) which was developed by members of the Mid and South Essex STP. The document outlines proposals for reconfiguration of services within the STP footprint including the three acute NHS trusts. Interested parties were invited to provide feedback via the public website. Senior leaders at Southend Hospital had organised a series of public engagement events at various locations to enable people to ask questions and provide feedback. The CEO was holding a number of briefings with staff at all levels to discuss the proposals and give staff the opportunity to provide feedback and contribute.

Our review of trust board papers, annual reports and operational plans demonstrated that progress against delivery of the strategy was appropriately monitored and reviewed.

Most staff we spoke with understood the vision and values; however, some staff were not sure of the strategy for their own areas and the future of the trust. Senior leaders acknowledged that they had to improve communications with staff at all levels and this had been started with the CEO briefings. The HR team were actively developing further resources such as blogs and staff engagement events to improve communication related to the strategy development.

All the senior leaders that we spoke with demonstrated their commitment to achieving the vision through a collectively developed strategy. Leaders were positive about the proposals for the transfiguration of services and passionate about enabling staff and other stakeholders to contribute to the development of services.

Culture

Most staff that we spoke with described an open culture where concerns could be raised and they felt supported, respected and valued by their team and the organisation. However, some staff felt that the communications between the executive team and the local teams was ineffective. This meant that they were unable to contribute and participate with plans for their area, which in turn made them feel undervalued. The NHS staff survey results reflect this (results in table below) however, the trust scores are slightly worse than the national average.

**NHS Staff Survey 2016**

The trust has no key findings where they are in the top 20% similar trusts in the 2016 NHS Staff Survey and two where they are in the bottom 20% of similar trusts.

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2 NHS Staff Survey 2016
The trust had developed a comprehensive corporate action plan in response to the NHS staff survey 2016 and building on from the previous staff action plan. This was structured so that each directorate developed their own individual action plans to meet the needs of their teams and to encourage different ways of exploring engagement methods. There were five main areas identified for improvement in the corporate action plan. These were:

- Improving manager communication
- Involvement in decisions around change
- Staff feel valued
- Positive health and well-being of staff
- Recruitment and retention action plan

Senior leaders openly acknowledged that they needed to improve communication and methods for staff to provide feedback on plans that could affect them. The HR and communications team had developed an action plan to address the concerns, which included introducing blogs, increasing senior leadership visibility and encouraging staff to raise concerns and provide feedback.

Throughout our core service inspection, staff told us about the ‘Safe at Southend’ meetings which were held weekly and was an opportunity for staff to speak with the site level senior leadership team about any concerns related to service provision. Our interviews with directors and review of documents demonstrated that the senior leadership team recognised the importance of staff contributions to achieve the vision and strategy.

There were processes in place to empower staff and encourage them to raise concerns both internally and externally. For example, a ‘Freedom to Speak Up (FTSU)’ guardian who was from an external organisation had been appointed in January 2017. The FTSU guardian was helping the trust introduce FTSU ‘champions’ throughout the organisation. There was information available throughout the hospital and on the internal trust website encouraging staff to raise concerns openly or anonymously. There were policies in place to support staff raising concerns such as the ‘Incident reporting policy’ and ‘Whistle-blowing policy’.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. There were clear processes in place to ensure that the trust met the requirements of duty of candour. The medical director had overall responsibility for compliance with duty of candour, which included ensuring that staff at all levels were aware of the requirements and their responsibilities. The trust’s risk and patient safety team managed and monitored the process through the electronic incident reporting system. The trust had developed guidance that was available on the internal website (intranet) and staff were provided with bespoke training by the trust’s legal department. Our conversations with staff during the core service inspections demonstrated that staff were aware of the duty of candour regulation and their responsibilities. From July 2016 to June 2017, the trust applied duty of candour 110 times.

Senior leaders were open about discussing concerns related to bullying and harassment, which had been highlighted in the NHS staff survey (see table below). All leaders we spoke with articulated that there was ‘zero tolerance’ in relation to bullying and harassment and they were exploring the results with staff to understand how to improve the culture. For example, the trust had conducted an internal staff survey relating to bullying and harassment from June 2017 to

<table>
<thead>
<tr>
<th>Key Findings where trust is in bottom 20%</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation and management interest in and action on health and wellbeing</td>
<td>3.55</td>
<td>3.6</td>
</tr>
<tr>
<td>Percentage of staff able to contribute towards improvements at work</td>
<td>68.0</td>
<td>70.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.55</td>
<td>3.6</td>
</tr>
<tr>
<td>68.0</td>
<td>70.0</td>
</tr>
</tbody>
</table>
August 2017. The survey had two elements consisting of an online survey and face-to-face focus
groups. Recommendations from the survey included identifying a trust wide lead, raising staff
awareness around the differences between ‘bullying and harassment’ and ‘fair management’ and
ensuring that staff were aware of the methods of raising concerns both internally and externally
without fear of reprisal. At the time of our inspection, the Joint Executive Group (JEG) were
discussing the results and recommendations.

NHS Staff Survey 2016 – Performance on questions relating to harassment, bullying and
equal opportunities

The scores presented below are the un-weighted question level score for question Q17b and un-
weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority
Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key
Finding and question numbers have changed since 2015.

<table>
<thead>
<tr>
<th>KF25</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>23%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KF26</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>23%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KF21</th>
<th>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>86%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q17b</th>
<th>In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>5%</td>
</tr>
</tbody>
</table>

The response from BME and White staff at the trust was significantly different for Q17b.

Staff diversity

- The largest proportion of staff at the trust is from a white background (68.5%). A breakdown
  of all ethnic background can be seen below:

| A – White – British | 68.5% |
| B – White – Irish   | 1.3% |
| C – Any other white background | 6.1% |
| D – Mixed White and Black Caribbean | 0.3% |
| E – Mixed White and Black African | 0.1% |
| F – Mixed White and Asian | 0.3% |
| G – Any other mixed background | 0.4% |
| H – Asian or Asian British – Indian | 5.9% |
| J – Asian or Asian British – Pakistani | 1.2% |
| K – Asian or Asian British – Bangladeshi | 0.3% |
| L – Any other Asian background | 3.0% |
| M – Black or Black British – Caribbean | 0.4% |
| N – Black or Black British – African | 3.0% |

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3 NHS Staff Survey 2016
4 RPIR – Universal, submission P107 Care Organisation Stock Take
The Workforce Race Equality Standards (WRES) were introduced in 2015. WRES provides a framework for NHS Trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality, and to ensure that employees from BME backgrounds receive fair treatment in the workplace and have equal access to career opportunities. As of 2016, all NHS providers are required to implement the WRES and the trust had a comprehensive WRES action plan in line with requirements. The action plan included ensuring that all leadership programmes had equalities training as a mandatory module. The Equality, Diversity and Inclusion Committee (EDIC) regularly reviewed the WRES action plan and progress was reported to the board on an annual basis.

There were clear processes in place to promote equality and diversity within the organisation and in relation to patient care and equal access. This included an Equality Delivery System (EDS2) action plan in line with national guidance. The EDS2 is designed to help local NHS organisations, in discussion with local stakeholders, review and improve their performance for patients, communities and staff in respect to all nine characteristics protected by the Equality Act 2010. A non-executive director of the board chaired the EDIC. The trust had a dedicated Equality, Diversity and Inclusion advisor. The EDIC set out equality objectives on an annual basis and monitored the trust’s EDS2 action plan. The trust had diversity network groups in place and had introduced equality champions for each directorate. There were trust wide lead nurses for patients living with dementia and patients with a learning disability.

The trust had identified the ‘Positive health and well-being of staff’ as an area to focus on as part of the corporate staff survey action plan. This was also a part of the overall HR and OD strategy and the objective to have a ‘Healthy organisation culture’. The strategy incorporated a ‘Health and well-being’ strategy that focused on providing appropriate support for staff. This included developing awareness about smoking cessation support, alcohol management and flu vaccination programmes. Staff had access to occupational health services and an employee assistance programme and the trust had signed up to health and well-being pledges including the ‘Mindful employer’ scheme to support the mental well-being of staff.

Sickness rates

The trust’s sickness levels from July 2016 to May 2017 were lower than the England average, with rates increasing in line with the England average over the winter period and falling again in 2017.

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5 Source: NHS Digital
There were not effective mechanisms in place to ensure that staff at all levels received the development they needed including high quality appraisal and career development conversations. In the last financial year 2016/17, the trust did not meet their target of 90% of staff receiving an annual appraisal and achieved 72% completion rate. At the time of our recent inspection, the trust had improved on the previous year’s performance and had achieved 74% completion rate with an expectation that each directorate would meet the trajectory of 90% completion rate by the end of the 2017/18 financial year. During our inspection of the core services, staff at different levels told us that they felt that the lack of staffing in certain areas affected their capacity to complete appraisals. The trust had developed an overall action plan to improve appraisal completion rates. This included the HR team monitoring appraisal rates on a monthly basis and supporting directorate leads to develop individual action plans for their areas and asking staff for feedback on how they felt the process was working. Through this process, the HR team had identified that some staff groups felt that the appraisal document was not relevant to their roles. At the time of our inspection, the trust were reviewing the document to see how it could be adapted to meet the needs of all staff groups.

Throughout the core service reports, local teams we spoke with described a patient-centred culture. Staff were proud of the work that they did in their local teams and achieving the best outcomes for the patients. Our interviews with executive directors and non-executive directors (NEDs) demonstrated that the leadership team had processes in place to ensure that delivery of services was patient-centred. This included the NEDs we spoke with being committed to their roles as ‘critical friends’.

**Governance**

There were effective processes and systems of accountability to support the delivery of the strategy and good quality sustainable services, including sub-board committees, divisional committees and team meetings. Since our last inspection in 2016, the trust had reviewed their governance structure and implemented changes including recommendations from an external review. There were clear processes in place to review the governance structure and to align the structure to the partnership model that the three trusts had now formed; this included regular review at trust board meetings.

The trust was developing their policies and processes to ensure that all levels of governance and management functioned effectively and interacted appropriately. Our interview with the chief nurse and director of nursing who had overall responsibility for governance at Southend Hospital, demonstrated that ensuring that the governance systems remained cohesive through the transitional period for the organisation was a priority for the trust. Governance systems were now being integrated across all three trusts in a measured and timely manner to minimise the risk of
gaps in quality controls. For example, some policies and strategies such as the FPPR policy and the HR and OD strategy were developed to align processes across all three trusts and monitored by relevant committees and teams.

There were processes in place to ensure that staff were aware of their responsibilities and what they were accountable for. This included a financial scheme of delegation and a directors and committees reports in the trust’s annual quality account.

The Quality Assurance Committee (QAC) had overall responsibility for reporting to the board on agreed quality measures based on local and national priorities. The QAC consisted of a responsible executive and non-executive director and senior representation from the directorates. Four committees reported to the QAC, these were the Quality and Safety Committee (QSC), Clinical Governance Committee (CGC), Corporate Governance Group (CGG) and Corporate Management Team (CMT). Each of these committees received information and reports from various other management and sub-committees, which included the audit committee, charitable fund committee and the mortality surveillance group.

The governance structure provided appropriate sources for information to be reported to the board and provide assurances that controls were working to manage the risks outlined in the board assurance framework (BAF). Our review of the trust BAF demonstrated that appropriate information including risk owners, sub-committee review, mitigating actions and gaps in control was reported to the board. The audit committee was responsible for providing assurances to the board that the systematic programme of internal and external auditing of processes including governance systems was being delivered. Our review of audit committee meeting records demonstrated that the non-executive directors and executive directors provided appropriate challenge when audits identified areas for improvement or were delayed.

Board Assurance Framework

The trust has provided their Board Assurance Framework (BAF) which, for 2017/18, contains eight risks and action details. The four risks with a current risk score of 20 or above are listed below:

<table>
<thead>
<tr>
<th>Risk I.D.</th>
<th>Risk Title</th>
<th>Strategic Objective</th>
<th>Current Risk Score (Q2) (2017-18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Failure to provide adequate patient safety, quality of care and patient experience due to capacity, demand and external agent stakeholder engagement</td>
<td>Excellent patient outcomes; Excellent patient experience</td>
<td>20</td>
</tr>
<tr>
<td>2</td>
<td>Failure to meet constitutional and national performance targets</td>
<td>Excellent patient outcomes Excellent patient experience Financial and operation sustainability</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>Trust not being financially sustainable</td>
<td>Finance and operation sustainability</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>Inability to recruit and retain staff</td>
<td>1, 2, 3 &amp; 4</td>
<td>20</td>
</tr>
</tbody>
</table>

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems. There were clear processes in place to identify risks and escalate them appropriately through the risk management process, which included the electronic incident reporting system and internal and external audits.

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6 RPIR – Universal – submission P113 All BAF Risks
The trust utilised a red, amber, green (RAG) rating system to categorise identified risks. There was a corporate risk register and each directorate had a local risk register. Our review of the risk registers and the BAF confirmed that all risks were triangulated and the BAF contained links to the corresponding corporate and local risk. Risk registers were discussed at local and corporate governance meetings and reviewed at board level via the BAF. However, we were concerned that appropriate actions to mitigate identified risks were not always taken in a timely manner due to financial constraints. For example, the issue regarding the security of children’s emergency department (ED) and staffing (see Urgent and Emergency ‘Safe’ section for details) had been raised at our previous inspections in 2016 and 2017. This was identified as a risk on the corporate and divisional risk register and linked to an associated risk on the BAF (see table below – provider level risk register). We raised our concerns again with the trust at this recent inspection and after our inspection, we were told that a business case had been approved to fund a 24-hour children’s ED to mitigate the risks. Our interviews with the director of finance, director of nursing and local leaders confirmed that the trust had completed a number of actions to mitigate the risk. For example, a programme of training had been introduced to provide adult nurses with appropriate skills to assess and treat children in line with national guidance and there was a standard operating procedure in place that included co-ordination with the children’s wards to help provide support to the main ED when the children’s ED was not appropriately staffed. Other risks identified related to the ophthalmology backlog and infection, prevention and control systems and processes. Whilst there were comprehensive action plans in place to mitigate these risks actions taken to address were sometimes delayed or slow due to the need to prioritise capital investments and/or lack of funding available.

Provider level risk register

The trust has provided one document listed as their risk register which details 13 corporate risks and the controls in place to manage them, along with additional tabs covering other services.

Corporate risks with an extreme risk level and current rating of 20 or above are listed below:

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description</th>
<th>Directorate</th>
<th>Link to Board Assurance Framework</th>
<th>Current Risk Score (Q2) (2017-18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>In-year demands on the Capital programme exceed the funding available</td>
<td>Finance</td>
<td>Risk 4 – Trust not being financially stable</td>
<td>25</td>
</tr>
<tr>
<td>2808</td>
<td>Staffing shortages may lead to compromised patient care or experience and failure to meet safer staffing requirements</td>
<td>Corporate</td>
<td>Risk 1 – Failure to provide adequate patient safety and quality of care; Risk 2 – Poor patient experience (linked to poor patient outcomes as per risk 1); Risk 5 – Inability to recruit and retain staff</td>
<td>20</td>
</tr>
<tr>
<td>1823</td>
<td>Failure to stay within Department of Health targets for MRSA bacteraemia</td>
<td>Corporate</td>
<td>Risk 2 – Poor patient experience (linked to poor patient outcomes as per risk 1); Risk 3 – Failure to meet performance targets</td>
<td>20</td>
</tr>
<tr>
<td>1949</td>
<td>Risk to patient safety due to</td>
<td></td>
<td>Risk 5 – Inability to recruit and retain staff</td>
<td>20</td>
</tr>
</tbody>
</table>

---

7 Provider information Requests - P113 – Risk Register
shortage of medical staff across the medicine directorate

<table>
<thead>
<tr>
<th>2854</th>
<th>Medicine</th>
<th>Corporate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to meet national performance targets for care and treatment may lead to patient harm resulting in reputational damage</td>
<td>retain staff</td>
<td>Risk 3 – Failure to meet performance targets</td>
</tr>
</tbody>
</table>

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. The trust used a RAG rating system to prioritise financial investments required to improve services. Our interviews with the directors of finance, managing director, medical director and director of nursing confirmed that the finance and remuneration committee and the quality and safety committee reviewed all business cases. Senior leaders told us that when service improvements were being considered, the process for securing funding was designed to allow appropriate input and oversight to minimise the risk of financial constraints affecting patient safety and quality care.

Finances overview[^8]

<table>
<thead>
<tr>
<th>Financial Metrics</th>
<th>Previous Financial Year (2 years ago)</th>
<th>Last Financial Year (2016/17)</th>
<th>This Financial Year (2017/18)</th>
<th>Next Financial Year (2018/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income (deficit)</td>
<td>£283,232</td>
<td>£303,858</td>
<td>£310,592</td>
<td>£314,412</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(-£15,912)</td>
<td>(-£11,080)</td>
<td>(-£15,469)</td>
<td>(-£11,848)</td>
</tr>
<tr>
<td>Full costs (deficit)</td>
<td>(-£299,144)</td>
<td>(-£314,938)</td>
<td>(-£326,061)</td>
<td>(-£326,260)</td>
</tr>
<tr>
<td>Budget (deficit)</td>
<td>(-£7,014)</td>
<td>(-£15,760)</td>
<td>(-£15,469)</td>
<td>(-£11,848)</td>
</tr>
</tbody>
</table>

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, which was monitored by local management teams and the audit committee.

Information management

The board received information on quality and sustainability through committee reports and the review of the integrated performance dashboard at trust board meetings. Our review of trust board papers, meeting minutes and committee reports confirmed that quality and sustainability was discussed at all levels.

The trust had an IM&T strategy that included developing systems to allow effective information sharing with the other two acute trusts in the Success regime and the wider health care community.

The trust had processes in place to ensure that the information used to manage, monitor and report on performance and quality was accurate, reliable and validated. This included internal and external processes.

The director of nursing was appointed as the trust’s Caldicott guardian and had overall responsibility for ensuring that the seven Caldicott principles related to information sharing and patient confidentiality were being adhered to. The senior information risk owner (SIRO) had overall responsibility and accountability for information governance within the trust. Information asset owners reported directly to the SIRO and worked with information asset assistants on a daily basis to ensure that risks related to information governance were being managed. The information governance committee was responsible for providing assurances to the board and worked closely

[^8]: RPIR – Universal – Finances tab
with the audit committee to ensure that internal audits such as the annual Information Governance (IG) toolkit were being completed.

**Engagement**

The trust had processes in place to seek, gather and collate feedback from public and staff. This included social media networks and public events.

Senior leaders told us that the priority continued to be seeking feedback and views about the plans for the organisation within the Success regime. For example, a series of public engagement events had been arranged across the region to coincide with the publication of the consultation document in November 2017.

There was a patient and service user improvement focus group that met on a regular basis and conducted independent patient experience and satisfaction surveys.

The trust operated a ‘Hospital Heroes’ awards programme, featuring the ‘Patient’s Choice award’. Members of the public and patients were invited to take part in the nominations and voting process. The details of winners were published on the trust public website and internal newsletters.

The trust actively engaged with commissioners, regulators and other stakeholders to receive feedback about plans for the future and current challenges.

There were action plans in place in response to the NHS staff survey. This included a series of staff engagement events to improve communications between senior leaders and local teams.

**Learning, continuous improvement and innovation**

There was a clear focus on learning, continuous improvement and exploring innovative ways of working. The trust actively participated in national audits to benchmark services, highlight best practice and identify areas for improvement. For example, the trust was highlighted as an outlier for mortality rates (unexpected deaths in specific groups) based on the national Summary Hospital-level Mortality Indicators (SHMI) and Hospital Standardised Mortality Ratio (HSMR) from January 2016 to December 2016. Whilst the SHMI and HSMR is only one measure and does not necessarily indicate poor performance, a ‘higher than expected’ rate of deaths should prompt further scrutiny. The trust had implemented an improvement plan that included a review of the coding system and working in partnership with the other two acute trusts to develop a wider platform for sharing learning and best practice. The trust also used the Copeland’s Risk Adjusted Barometer (CRAB) as a tool to identify potentially avoidable deaths, which were then subjected to a retrospective case note review. CRAB data was reviewed at the trust’s mortality surveillance group and discussed at trust wide mortality and morbidity meetings to identify opportunities for learning.

Senior leaders welcomed the opportunities to have external reviews of processes and systems. Our review of reports and action plans demonstrated that the trust was responsive to recommendations made from external reviews and sought to find ways to address concerns. For example, Health Education England (HEE) raised concerns regarding support and training for junior doctors after a site visit in December 2016. The trust implemented an action plan to address the concerns and the medical director oversees this. HEE have since undertaken a number of site visits and the trust have taken a number actions including; adjusting junior doctors rotas, improving communications between teams and increasing provision of out of hours teams to provide greater support for junior doctors on call. Senior leaders acknowledged that this was still an area of significant concern and further improvements were necessary.

The trust had processes in place to identify learning opportunities and areas for improvement through their complaints management processes. The trust had a Patient Advisory Liaison Service (PALS) team located on the hospital site and an ‘open-door’ policy Monday to Friday between 8.30am and 4pm. The trust had introduced a rapid review process for complaints in April 2016; the aim was to manage complaints within five working days without the need to escalate to a formal
complaint. The rapid review process was managed by the complaints team with support from PALS and if there was no local resolution within five days this was escalated within the relevant directorate by the PALS team. Our review of complaints data demonstrated that changes to practices and processes were made because of learning from complaints. For example, changes had been made to pharmacy staffing levels and processes because of complaints relating to delays at discharge.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>99% (July 2017)</td>
</tr>
<tr>
<td>35</td>
<td>72 complaints outside this timeframe</td>
</tr>
</tbody>
</table>

If you have a slightly longer target for complex complaints please indicate what that is here.

<table>
<thead>
<tr>
<th>No fixed amount of days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extensions to complaint response deadlines are agreed on a case by case basis</td>
</tr>
</tbody>
</table>

* The trust qualified completing the complaint is defined as closing the complaint, having been resolved or decided no further action can be taken.

Complaints

- The trust received 813 complaints between August 2016 and July 2017
- Outpatients received the most complaints with 351 (43% of all complaints)
- 679 of the 813 complaints (83.5%) were either closed within the 35 working day agreement or closed within an agreed extension deadline (29 complaints (3.6%) were re-opened with six complaints ongoing)
- 134 complaints remained open

In the same period, the trust received 1,460 compliments from patients and their relatives. The main themes were related to the caring manner of staff specifically during busy periods.

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust participate in several schemes however the table below shows which services within the trust have been awarded an accreditation together with the relevant dates of accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme</th>
<th>Details of accreditation and date (if available)</th>
<th>Related core service</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHKS Accreditation for radiotherapy and oncology services</td>
<td>Radiotherapy CHKS ISO 9001 2008 accredited 07/12/2016</td>
<td>No</td>
</tr>
<tr>
<td>MacMillan Quality Environment Award (MQEM)</td>
<td>MacMillan information and support service – accreditation in June 2015</td>
<td>No</td>
</tr>
</tbody>
</table>

9 RPIR – Universal – Complaints tab
Acute services

Urgent and emergency care

Facts and data about this service

The Emergency Department (ED) at Southend University Hospital provides a 24 hour, seven day a week service.

The main ED consists of 10 minors’ cubicles and 16 majors cubicles, one of which can be flexed into majors step down area. The resuscitation area has four bays, which can stretch to five. The Paediatric Emergency Department has four cubicles and three side rooms and is open 0800-2100, seven days per week. There are approximately 200 doctors, nurses and other practitioners.

Walk-in patients are streamed by an ED consultant or experienced triage nurse 0800-2000 Monday to Friday with senior nurse led triage at all other times. There is an on-site GP from 1000-2300 daily for re-directing non-acute patients.

There is a Rapid Assessment and Treatment (RAT) multidisciplinary team (running for up to 13 hours per day) led by a Consultant or middle grade doctor and assisted by a junior doctor (FY2), nurse and emergency department assistant (EDA).

The Clinical Decisions Unit has capacity for six patients transferred under strict protocols and managed under the care of the Emergency Department medical team.

(Source: Trust Provider Information Request)

Activity and patient throughput

Total number of urgent and emergency care attendances at Southend University Hospital NHS Foundation Trust compared to all acute trusts in England

There were 100,454 attendances between April 2016 and March 2017 at Southend University Hospital NHS Foundation Trust as indicated in the chart above.
Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased between 2015/16 and 2016/17. In 2016/17, rates were similar to the England average.

Urgent and Emergency Care attendances by disposal method

Is the service safe?

Mandatory training
The trust had a policy for mandatory training completion. The ‘policy for the management of statutory, mandatory and professional competency training’ set out the responsibilities of all staff
members and staff groups in the completion of training. The policy had version control and a review date of July 2019.

The emergency department did not meet the trust’s target for mandatory training. The emergency department had a recovery plan for the completion of mandatory training. We spoke to the practice development nurse who told us that the department was on track to make marginal gains of 0.5% improvement each month for the completion of mandatory training. The department aimed to reach the trust’s target for mandatory training by January 2018. The table below demonstrates the mandatory training completion rates for emergency department.

The trust set a target of 85% for completion of mandatory training modules, with the exception of information governance and safeguarding children level 1 where the target was 95% and Prevent (Levels 1-2) where the target was 69%.

A breakdown of compliance for mandatory courses from April 2016 to March 2017 for medical/dental staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>85%</td>
<td>29</td>
<td>39</td>
<td>74.4%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>85%</td>
<td>34</td>
<td>40</td>
<td>85.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>85%</td>
<td>7</td>
<td>40</td>
<td>17.5%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>26</td>
<td>40</td>
<td>65.0%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>85%</td>
<td>31</td>
<td>40</td>
<td>77.3%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>85%</td>
<td>24</td>
<td>39</td>
<td>61.5%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>34</td>
<td>39</td>
<td>87.2%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>32</td>
<td>39</td>
<td>82.1%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>37</td>
<td>40</td>
<td>92.5%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>34</td>
<td>39</td>
<td>87.2%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>85%</td>
<td>29</td>
<td>39</td>
<td>74.4%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>85%</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>CPR - Adults</td>
<td>85%</td>
<td>27</td>
<td>39</td>
<td>69.2%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85%</td>
<td>31</td>
<td>40</td>
<td>77.5%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>85%</td>
<td>35</td>
<td>40</td>
<td>87.5%</td>
</tr>
<tr>
<td>Local Induction</td>
<td>85%</td>
<td>23</td>
<td>29</td>
<td>79.3%</td>
</tr>
<tr>
<td>MCA DOLS Level 1</td>
<td>85%</td>
<td>33</td>
<td>39</td>
<td>84.6%</td>
</tr>
<tr>
<td>MCA DOLS Level 2</td>
<td>85%</td>
<td>32</td>
<td>39</td>
<td>82.1%</td>
</tr>
<tr>
<td>Prevent (Levels 1-2)</td>
<td>69%</td>
<td>15</td>
<td>40</td>
<td>37.5%</td>
</tr>
<tr>
<td>Fails Prevention</td>
<td>85%</td>
<td>13</td>
<td>39</td>
<td>33.3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>527</td>
<td>740</td>
<td>71.2%</td>
</tr>
</tbody>
</table>

Of the 20 mandatory training modules for medical/dental staff, 14 modules did not achieve the trust target. The six modules that did achieve the trust target were: Equality & Diversity with 85% completion rate, Safeguarding Adults (Level 1) with 87% completion rate, Safeguarding Children (Level 2) with 87% completion rate, Venous Thromboembolism with 100% completion rate, Infection Prevention with 88% completion rate and MCA DOLS Level 1 with 85% completion rate, compared to 85% trust target.

A breakdown of compliance for mandatory courses from April 2016 to March 2017 for qualified nursing staff in urgent and emergency care is shown below:
Of the 20 mandatory training modules for qualified nursing staff, 16 modules did not achieve the trust target. The four modules that did achieve the trust target were: Safeguarding Children (Level 2) with 90% completion rate, Safeguarding Children (Level 3) with 88% completion rate, Venous Thromboembolism with 100% completion rate and Oxygen Therapy with 91% completion rate, compared to 85% trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust had a sepsis eLearning module for staff to complete but this did not form part of the mandatory training programme. The eLearning module for sepsis was monitored through the local sepsis reduction CQUIN (Commissioning for Quality and Innovation). CQUINs demonstrate improvements in quality and innovation in specified areas of patient care. The practice development nurse for the department told us that nursing staff did not receive protected time to complete mandatory training and eLearning.

Staff found it difficult to book face-to-face mandatory training, which caused pressures in achieving the mandatory training target set by the trust. The practice development nurse for the emergency department reported that some face-to-face trainers held two or three spaces for ED staff in each session. This meant that staff were released for training if the department was safe for staff to leave.

Staff had received external training from the local mental health team. The training included awareness of mental health conditions and care of patients with mental health needs.

**Safeguarding**

The emergency department generally had robust systems and processes in place to safeguard children and adults from avoidable harm.

There was a specific symbol on the electronic patient record system that allowed staff to highlight any patient that they had assessed as being at ‘high risk’ of abuse.
We found staff missed opportunities to have discussions with parents following child injuries to ensure that the child was safe from abuse. We observed one case where staff missed an opportunity to ensure that a child was safe from abuse, the child was also subject to a previous safeguarding alert. We raised our concerns to the trust, an immediate review of the case was conducted and assurances sought from staff that all safeguarding concerns had been considered.

The hospital used a red flag system for patients that had previously been subject of a safeguarding concern. The reception staff ensured the flags were applied to the paper records and the electronic patient records. Clinical staff completed a safeguarding assessment if any concerns were raised during the consultation or a safeguarding flag was highlighted on the paper records.

We reviewed one patient record following a safeguarding flag for a paediatric patient. We saw that clinical staff had completed a safeguarding assessment during the patient consultation.

Safeguarding adults and children formed part of the trust’s mandatory training programme. The trust required staff to complete safeguarding adults and safeguarding children levels one and two for all patient-facing roles. In addition to this, all clinical staff within the emergency department were required to complete safeguarding children level three training. The tables below show the safeguarding completion rates for medical staff and nursing staff.

The intercollegiate document ‘Safeguarding children – Roles and competencies for healthcare staff’ published by the Royal College of Paediatrics and Child Health (RCPCH) 2014 provides guidance on the level of safeguarding training required for different staff groups. The document states that ‘All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns’ should be trained in safeguarding for children levels one, two and three’.

The department had met the trusts target of 85% of the nursing staff working in the ED had completed safeguarding children training to level three. However, medical staff within the ED had not met the 85% target for the completion of safeguarding children to level three.

The trust set a target of 85% for completion of safeguarding training modules, apart from safeguarding children level 1 where the target was 95%.

A breakdown of compliance for safeguarding courses from April 2016 to March 2017 for medical/dental staff in Urgent and Emergency Care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>34</td>
<td>39</td>
<td>87.2%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>32</td>
<td>39</td>
<td>82.1%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>37</td>
<td>40</td>
<td>92.5%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>34</td>
<td>39</td>
<td>87.2%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>85%</td>
<td>29</td>
<td>39</td>
<td>74.4%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>166</td>
<td>196</td>
<td>84.7%</td>
</tr>
</tbody>
</table>

The trust did not meet the safeguarding completion target of 85% in two of the four safeguarding modules undertaken by medical & dental staff; Safeguarding Children (Level 2) and Safeguarding Adults (Level 1) were the modules that met the completion target both with 87%; Safeguarding Children (Level 3) scored the lowest with a 74% completion rate. Safeguarding Children (Level 1) did not meet the 95% target, with 93% completion rate.

A breakdown of compliance for safeguarding courses from April 2016 to March 2017 for nursing staff in Urgent and Emergency Care is shown below:
The trust met the safeguarding completion target of 85% in two of the four safeguarding modules undertaken by nursing staff; Safeguarding Adults (Level 2) scored the lowest with a 72% completion rate. Safeguarding Children (Level 1) did not meet the 95% target, with 94% completion rate.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The emergency department made 50 adult safeguarding referrals and 393 child-safeguarding referrals from August 2016 to July 2017. Staff we spoke with were clear in their responsibilities and were able to tell us the indications of suspected abuse, for both adults and children.

The trust had reviewed and updated the policy for Female Genital Mutilation (FGM). Staff received training about FGM within the mandatory safeguarding training. The policy included risk assessments to assist with the escalation of concerns about FGM. The children’s and adults safeguarding teams shared information accordingly when there were both children and adults within the family network.

The hospital had processes in place to ensure patients with mental health conditions received a mental health assessment. The hospital had a mental health assessment area located within the emergency department. An external provider staffed this assessment area; each staff member had an honorary contract with the trust. The mental health liaison team were available to review adults over the age of eighteen, 24 hours a day seven days a week to assess patients with mental health conditions.

Child and Adolescent Mental Health Services (CAMHS) were provided externally by another NHS trust. The service took patient referrals between 9am-5pm with limited or no provision outside these hours, however staff could contact the trust’s duty psychiatrist. We spoke with four members of staff about children’s mental health services and they told us the provision of the service was of concern to them. They reported they found it difficult to arrange assessment and care children and young people with mental health needs. The ED was represented at meetings to improve the CAMHS service provision. During our unannounced inspection, senior staff in the ED told us that the CAMHS service was due to provide an out of hours service to start in January 2018.

The hospital had specialist nurses to support patients living with dementia and learning disabilities. The ED had dementia and learning disability champions to support patients and staff caring for people with additional communication needs.

Cleanliness, infection control and hygiene

There were effective systems in place to ensure that standards of cleanliness and hygiene were maintained. All areas of the ED we visited were visibly clean.

Reliable systems were in place to prevent and protect people from a healthcare associated infection in line with National Institute of Health Care Excellence guidelines (NICE QS61, 2014). For example, patients received care from staff who had decontaminated their hands immediately before and after every episode of direct contact or care.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>61</td>
<td>76</td>
<td>80.3%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>55</td>
<td>76</td>
<td>72.4%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>74</td>
<td>79</td>
<td>93.7%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>68</td>
<td>76</td>
<td>89.5%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>85%</td>
<td>58</td>
<td>66</td>
<td>87.9%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>316</td>
<td>373</td>
<td>84.7%</td>
</tr>
</tbody>
</table>
The main emergency department and the children's emergency department were visibly clean and free from clutter.

The department scored between 98 – 100% in staff hand hygiene audits from June 2017 to October 2017.

Staff demonstrated good hand hygiene throughout the inspection by decontaminating their hands before and after providing patient care. All staff wore scrub style uniforms, which meant that staff observed the ‘arms bare below the elbow’ National Institute of Health and Care Excellence recommendation CG139.

The department scored 93.7% for cleanliness in the Patient-Led Assessments of the Care Environment (PLACE) for 2017.

The ED had cleaning schedules in place to ensure the ED was clean. We saw cleaning staff visible within the department. We spoke with cleaning staff who reported they had a schedule of cleaning responsibilities and were able to demonstrate how they implemented schedules during their shift.

The trust conducted monthly cleaning audits within each area of the department for example but not limited to, main waiting area, children’s ED and the treatment areas. The children’s ED and the main waiting area scored 98-100% from June 2017 to October 2017. The treatment areas scored 96% for June, August, September and October but scored 93% for July. The trust had a target of 95% for cleaning audits.

Staff cleaned equipment after its use with a patient. We saw staff cleaning items of multiple use equipment after use with a patient and place a dated ‘I am clean’ sticker on the piece of equipment.

The department had an infection control champion. This member of staff had additional knowledge and skills in order to support other staff members within the department with infection control and prevention measures.

The trust told us that they had three side rooms in the ED that could be used for patients requiring isolation due to infection. However, staff told us they also used one cubicle within the major’s area for this purpose. The cubicle was positioned within the major’s area and had walls to three sides and a curtain at the front for dignity. We spoke to one member of staff who told us that patients with suspected infections were cared for in the cubicle as the design made barrier nursing easier for staff.

Environment and equipment

The design, maintenance and use of facilities and premises generally met most patients’ needs. There were systems and processes in place to ensure that the maintenance and use of equipment kept people safe.

The ED was located next to the radiology department, which meant that they had direct access to the magnetic resonance imaging (MRI) and computerised tomography (CT). A health care assistant (HCA), porter or transfer nurse escorted patients to the radiology department.

The paediatric emergency department had four cubicles and three side rooms and was open from 8am to 9pm, seven days a week. Outside of these times, children were treated in the adults’ area.

The trust had a formal process in place to separate children from adults when the children’s ED closed. This involved using one of the minors’ cubicles as a waiting area. However, during our inspection, we saw four children waiting in the adult area. This was not in line with recommended guidance (Standards for children and young people in emergency care settings, RCPCH, 2012) or the trust’s process. We raised our concerns with the trust who told us that this was because there were no available cubicles in the minors area at that time. We spoke to a member of staff about the children in the waiting room and an area was prepared for children to wait away from adult patients. After our inspection, the trust supplied us with an updated process that stated that if there
were no minors cubicles available to separate children from adults, the situation should be escalated to the clinical site manager.

We were not assured that the security arrangements for children’s ED were robust. The children’s ED had a dedicated waiting area that was audio and visually separated from the adult’s ED (during opening hours). However, we found the entry to the children’s ED waiting area was not restricted as the door was unlocked. The door to the children’s main waiting area opened onto a non-restricted corridor, this meant that the area could be entered by unauthorised persons. There was signage displayed advising parents that children should not be left unaccompanied, however, there were minimal control mechanisms in place to prevent unauthorised access. We raised our concerns with the trust and they informed us that the door had to remain unlocked due to fire regulations.

The children’s ED had a side room for adolescent patients. Staff in the children’s ED reported that they often used the room for adolescents with mental health needs. We found that the room had ligature points and could pose risk to patients with mental health care needs as there was not a member of staff in the room at all times. This was listed as a risk on the departmental risk register and the mitigation was for staff to ensure that the ligature risks were removed when the room was being used for patients with mental health illness. The department used an enhanced observation assessment tool for patients that presented with acute mental health illness or agitated behaviour. The assessment tool had clear guidance for what steps to take based on the patient’s presenting symptoms; this included a section to remind staff to ensure that the environment was safe.

The ED had 10 minors’ cubicles and 16 major’s cubicles and four bays in the resuscitation area.

The emergency department had a mental health assessment room located next to the children’s ED. The mental health assessment room did not meet the standards set out by the Royal College of Emergency Medicine. We saw that the room had multiple ligature points however; staff told us a health care assistant was always present in the room. The room had two doors but one of the doors led straight to the car park of the hospital. We also found the room did not have an alarm system and the observation window between the interview room and the mental health assessment area was frosted meaning that all staff did not have oversight of this room. The trust told us that a risk assessment had been undertaken and this had been reviewed after we raised our concerns. The trust told us that no further actions were needed as the area was always staffed with at least one member of staff and the door that led into the car park set off an alarm when opened. After our inspection, the trust supplied us with an updated risk assessment and plan to address the environmental concerns.

Up to three patients could wait in the mental health suite area with a healthcare assistant observing. We had concerns of the risks to patients if the healthcare assistant was helping one of the patients that a vulnerable adult may leave the department or exit into the car park and potentially be at risk of injury. We raised our concerns with the trust and following our inspection the trust provided us with information that the standard operating procedure for this area had been updated to ensure that the process for managing more than one patient in the area was formalised. Whilst the risk of patients with a mental health illness absconding from the department due to delays in assessment time was listed on the risk register, the risks associated to the environment, staffing and location of the room was not. This meant that we were not assured that all safety risks were being effectively monitored to protect people from avoidable harm.

There was resuscitation equipment for adults and children readily available throughout the ED. Records showed that staff had checked resuscitation equipment on a daily and weekly basis and according to the trust’s policy.

We reviewed the paediatric resuscitation equipment within the children’s ED and found emergency drugs were unsecured and in reach of unauthorised persons including patients. We raised our concerns regarding the risk of children accessing these drugs as the area formed part of the main corridor for the children’s ED. The trust took immediate action and provided a secure resuscitation trolley for this area within one hour.
We checked 20 electrical machines within the ED and found all of these items were up-to-date with electrical safety testing. The department held certificates for all items of equipment that required electrical safety testing.

The ED had clear processes in place to manage clinical waste (including sharps such as needles) and domestic waste. We saw domestic staff checked the bins regularly and empty them if they were full.

Assessing and responding to patient risk

Comprehensive risk assessments were generally carried out for patients and risk management plans were developed in line with national guidance. Nursing and medical staff at all levels in the ED were aware of the processes to identify and respond to patient risk and there were systems in place to monitor and manage risks to patient safety.

However, reception staff had not been suitably trained to correctly identify patients with ‘red flag’ symptoms. For all patients who self-presented to ED, dedicated non-clinical reception staff took the patient’s details and a brief description of their symptoms. Staff in reception had not been trained to recognise patients with ‘red flag’ symptoms as defined by the Royal College of Emergency Medicine (RCEM, ‘Triage position statement’, 2011) such as chest pains and difficulty breathing. The reception supervisor told us that staff would benefit from receiving red flag training. All reception staff we spoke with were experienced members of the team and described instances where they had escalated patients to triage staff if they had any concerns.

There was a clear system of streaming (streaming is the process of allocating patients to specific groups and/or physical areas of a department) and triage for all patients who presented to the ED. Senior nurses with specialist training or doctors triaged all patients who presented to the ED.

Staff used a prioritisation tool called the Luton and Dunstable triage system. This tool aided staff to stream patients to the right services within the ED. The tool had been modified to meet the needs of the local patient groups attending the ED. The clinical director for the ED told us that the triage tool did not fit the needs of their local patients and had required some modification to make sure all patients including walk-in patients were seen in the right place. The triage tool was used to stream patients to areas depending on their needs. For example, patients with minor symptoms and normal vital signs were streamed to the on-site GP service. All other patients were streamed to either the minor’s area or the major’s area depending on their presenting condition.

The triage area was located next to the ED reception and reception staff had access to the senior nurse or doctor responsible for triage if they had any concerns about a presenting patient.

The ED aimed for all patients to receive an initial clinical assessment within 15 minutes of arrival in line with national guidance such as the Royal College of Paediatric Child Health ‘Intercollegiate standards for children and young people in emergency care settings’ (RCPCH, 2012). This included observation and recording of vital signs, pain score, brief patient history and immediate care plan. Of the seven patients, we tracked six patients were triaged within 15 minutes.

The department audited the time from arrival to triage for all patients. Clinical staff recorded the time the patient was triaged on the patient records. Reception staff updated triage times electronically on the ED patient booking system following the triage process.

Children who were brought into the ED were initially seated in the main adult’s ED waiting area to await triage an initial clinical assessment. After triage, they were directed to the children’s ED waiting area to see a doctor.

Senior staff told us that the standard for initial clinical assessment was also applied to all self-presenting adult patients to ensure that patients without ‘red flag’ symptoms were safe to wait and they were seeing their sickest patients first.

During our inspection, the average time to initial clinical assessment patients was between 2 and 15 minutes. We tracked seven patients through the emergency department and we saw that six patients had an initial assessment between 2 and 15 minutes. However, one child waited 35
minutes for an initial assessment with reported respiratory symptoms; we were unable to ascertain the cause of the delay.

All patients who arrived by ambulance were taken to the majors area where a handover of patients took place between the ambulance and ED staff.

The Department of Health recommends that ambulance handovers be completed within 15 minutes of arrival at the ED to ensure that an initial clinical assessment is carried out in a timely manner.

The median time from arrival to initial assessment was worse than the overall England median every month from September 2016 to August 2017. In August 2017, the median time to initial assessment was 15 minutes compared to the England average of seven minutes.

Ambulance – Time to initial assessment between September 2016 and August 2017 at Southend University Hospital NHS Foundation Trust

The median time from arrival to initial assessment was worse than the overall England median every month from September 2016 to August 2017. In August 2017, the median time to initial assessment was 15 minutes compared to the England average of seven minutes.

Ambulance – Time to treatment between September 2016 and August 2017 at Southend University Hospital NHS Foundation Trust

The department had introduced the modified Luton and Dunstable triage tool in October 2017 to improve patient streaming within the department and to the onsite GP service. The clinical director reported that the aim of the introduction of the tool was to improve the time to triage and treatment of patients.

The majors’ area had 16 bays where patients could receive a rapid assessment from a dedicated multi-disciplinary team and start of treatment for time sensitive conditions such as sepsis. The Rapid Assessment and Treatment (RAT) multidisciplinary team (running for up to 13 hours per day) was led by a consultant or middle grade doctor and assisted by a junior doctor, nurse and emergency department assistant (EDA). The RAT team moved around the department to patients to carry out patient assessments and start treatment where needed.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for five months over the 12 month period from September 2016 to August 2017.

Performance against this standard showed a trend of improvement up to April 2017 when the median time to treatment was 49 minutes compared to the England average of 56 minutes. Performance has since declined. In August 2017, the median time to treatment was 65 minutes compared to the England average of 53 minutes.

Ambulance – Time to treatment between September 2016 and August 2017 at Southend University Hospital NHS Foundation Trust
Southend University Hospital

From October 2016 to September 2017, there was a downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Southend University Hospital. In October 2016, 71% of ambulance journeys had turnaround times over 30 minutes and in September 2017, 66% of ambulance journeys had turnaround times over 30 minutes.

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From August 2016 to August 2017 the trust reported 1,903 “black breaches”. Week commencing 01 January 2017 saw the most black breaches occur (117) after which there was a downward trend over the period to August 2017.
The resuscitation area had four bays with one of the major’s cubicles that staff could use in the event that the resuscitation area was at capacity. One bay was used for children and in the event of two children, one of the adult bays could be used.

The ED used National Early Warning Score (NEWS) assessment for adult patients as a measurement tool for the deteriorating patient. A paediatric early warning system (PEWS) was used in line with NICE guidelines (CG50 Acute, illness recognising and responding to the deteriorating patient). We reviewed 15 sets of records and of these, we found that 13 of the NEWS or PEWS score had been recorded and appropriate escalation was made when required. Two of the patient records reviewed did not demonstrate nurse escalation when risk assessments were outside normal parameters. We saw one patient with a NEWS of six and a nursing documentation listed a number of tests required but did not document any process of escalation to a senior nurse or the medical team.

The trust had undertaken retrospective studies for early warning scores and escalation of patients at risk of deterioration. The study was undertaken in May 2017, which showed that 93% of patients who triggered four or more on the NEWS were escalated appropriately.

The clinical score card for the department showed that the ED achieved 100% for the completion of observation charts (NEWS and PEWS) from April to October 2017.

Staff had access to acute paediatric support for the investigation of sudden, unexpected deaths in infancy and childhood. Staff had access to senior staff on the paediatric ward if they needed support.

The ED used the Sepsis Six pathway for adults and children. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis. The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis). Sepsis is the presence of harmful bacteria and their toxins in the body. Patients with suspected sepsis were flagged on the electronic system and a sepsis sticker placed on their paper based assessments.

The ED audited the treatment of patients with suspected sepsis. The screening rate of patients with suspected sepsis varied between 63% and 92% from May to October 2017. The rate of patients receiving intravenous antibiotic therapy within one hour varied between 90% and 100% from May to October 2017.
The ED had three sepsis champions, one within the adult ED and two within the children’s ED. The sepsis champions had additional education and training to support other members of staff with the identification and management of patients presenting with sepsis.

Patients had access to the on-site psychiatric liaison team based in the ED 24 hours a day for patients 18 years old and over. There were pathways in place to arrange Child Adolescent Mental Health services (CAMHS) for all children and young people between the hours of 9am and 5pm.

Staff told us that VTE assessments were conducted for all patients with lower limb immobilisation and other patients including those who had suffered other traumatic injuries in line with national guidance (NICE CG92, 2010).

The ED used the Anderson pressure ulcer risk assessment tool to screen patients at risk of developing pressure ulcers. The ED scorecard from April to October 2017 showed that the department achieved the 90% target for pressure ulcer risk screening in May, June, June, July and August but did not achieve the target in April, September and October.

In the Emergency Department Survey 2016, the trust scored “about the same as” other trusts for all of the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the A&amp;E staff?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q6. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q7. From the time you first arrived at the A&amp;E Department, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q31. In your opinion, how clean was the A&amp;E Department?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. While you were in the A&amp;E Department, did you feel threatened by other patients or visitors?</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC - A&E Survey (01/09/2016 - 30/09/2016)

We tracked seven patients through the ED and found all seven patients had been seen within one hour of presenting within the department. We also saw that patients were reviewed by a specialist within one hour of referral. This was in line with the Royal College of Emergency Medicine recommendation that the time patients should wait from time of arrival to receiving treatment is no more than one hour.

The ED had access to six patient bays within the clinical decisions unit, which was part of a medical ward and assessment area. Medically fit patients could stay up to 48 hours while waiting for social care assessments or care packages. The unit was staffed by the medical directorate but patients remained under the care of ED consultants until their discharge. Staff we spoke with told us that patients had to meet the strict criteria; they had to be medically fit and be discharged within 12 hours.

**Nurse staffing**

We were not assured that the ED always had enough staff to safely look after patients.

We observed in adults and children’s ED during the unannounced and announced inspections that there was a good skill mix during the daytime. However, this was not the same for night shifts, and staffing for children after 9pm was variable and not in line with national recommendations.
The overall leads for adults and children’s ED were two ED matrons supported by experienced band six and seven nurses. There were no junior staff working without supervision and senior nursing staff were visible and available at all times.

The department used the ‘safer staffing’ tool to calculate their nursing staff requirements. The Safer Nursing Care Tool is an evidence-based tool that allows nurses to assess patient acuity and dependency and to use this to inform the number of staff needed. The trust told us that, senior management team reviewed collated nursing staffing levels on a monthly basis and informed the safe staffing monthly report. The monthly safe staffing reports were submitted to local trust board every two months. The reports contained the fill rate percentage by clinical area. A nursing establishment review was conducted on a six monthly basis.

The trust held ‘safer at Southend’ meetings each morning where staff could share any safety concerns, this including staffing concerns. The director of nursing facilitated these meetings, which gave staff oversight of the safety issues throughout the trust.

Staffing levels were displayed on the governance information board in the ED. Daily staffing was planned to have 10 registered nurses (RN) and five emergency department assistants (EDAs) on the early shift for the adults ED. This rose to 11 RNs and five EDAs on the late shift. The night shift planned for 10 RNs and four EDAs with an extra RN for the twilight shift between 6pm and 2am.

The children’s ED planned to have two RN (child branch) during the hours between 8am and 9pm. During our inspection, we saw that the children’s ED was staffed appropriately during these hours and rotas confirmed this. However, the provision of paediatric nurses within the ED between the hours of 9pm to 8am was inconsistent. There were not enough RNs (children’s branch) to ensure that at least one was on duty 24 hours a day in line with Royal College of Paediatrics and Child Health (RCPCH) guidance (Standards for Children and Young People in Emergency Care settings, 2012). We spoke to five members of staff during a visit to the ED at 9 PM who told us that the department did not always have a registered children’s nurse for night shifts in the department. We raised our concerns with the trust who told us that to mitigate this risk they ensured that adult nurses caring for children between 9pm and 8am had the correct competencies in line with RCPCH guidance. Specifically, adult nurses received training including recognition of the deteriorating child, paediatric pain management and paediatric immediate life support training (PILS). Our review of rotas for October 2017 confirmed this. After our inspection, the trust supplied us with an action plan and updated standard operating procedure (SOP) that outlined the staffing requirements of the ED at night to mitigate the risk to patients in the absence of a RN (child branch). This included ensuring that at all times there was a member of nursing or medical staff that had advanced training in paediatric life support (EPALS) and that agency staff induction included a record of paediatric competencies. The trust told us that a business case had now been approved in December 2017 to increase staffing and provisions for children’s ED to be appropriately staffed in line with guidance 24 hours a day.

At the time of our inspection, the ED had nine vacancies for band five nurses, four vacancies for band six nurses and three vacancies for healthcare assistants. The matron told us that the vacancy rate affected the department’s ability to complete mandatory training and appraisals. The trust acknowledged that recruiting to these vacancies was challenging, this was highlighted on the divisional risk register and linked to the corporate risk register.

From August 2016 to July 2017, nursing staff in the Accident & Emergency Department had a monthly average vacancy rate of 15.7%, compared to the trust’s overall target of 7%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The trust have reported their staffing numbers below for the period from August 2016 to July 2017. The trust reported a lower number in post compared to WTE staff during this period.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>WTE Staff</th>
<th>Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing and health visiting staff</td>
<td>80.3</td>
<td>65.9</td>
</tr>
<tr>
<td>Total</td>
<td>80.3</td>
<td>65.9</td>
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</table>
Nursing staff worked to a fixed rolling rota within the ED. This meant that staff worked the same shift pattern from month to month. Staff we spoke with told us that the rota system gave them the ability to plan their life outside of work. One member of staff told us that senior staff handled changes to the rota sensitively if changes were needed due to a change in the staff member’s circumstances.

From August 2016 to July 2017, nursing staff in Urgent and Emergency Care had a monthly average sickness rate of 4% against the trust’s overall target of 3.5%.

As at July 2017, the trust reported an overall sickness rate of 5% in Urgent and Emergency Care.

The department used bank and agency staff to fill vacant shifts either due to vacancies or staff sickness. All bank and agency staff received a local induction to the ED and were supported by senior nurses within the department.

From August 2016 to July 2017, the trust reported there were 3,840 unfilled shifts for qualified nursing staff within ED, of which 1,367 were covered by bank staff and 1,057 covered by agency staff and 1,182 shifts were left unfilled.

The turnover rate within the ED was significantly better than the trust’s target of 9.7%

From August 2016 to July 2017, nursing staff in the Accident & Emergency Department had a monthly average turnover rate of 1.7%, compared to the trust’s overall target of 9.7%.

As at July 2017, the trust reported a turnover rate of 0.8% in Urgent and Emergency Care.

We observed nursing handovers that were structured and conducted in small teams and individually. The nurses in charge of ED conducted verbal and written handovers and discussed the acuity levels of patients and capacity.

**Medical staffing**

During our inspection, the ED had medical staffing to meet the needs of patients.

The planned daily consultant cover was below national recommendations of 16 hours per day as 14 hours cover was provided per weekday. Medical staffing for middle grade and junior doctors met the needs of patients at the time of the inspection. There was a designated consultant in charge on a daily basis.

The ED had an ongoing recruitment plan to ensure consultant numbers met the needs of the department and patients.

The number of consultants within the ED was lower than the England average with a higher number of middle career doctors and registrars compared with the England average.

During June 2017, the proportion of consultant staff reported to be working at the trust were lower the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 45 whole time equivalent staff working in Urgent and Emergency Care at Southend University Hospital NHS Foundation Trust**

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</table>
The RCEM recommends that EDs seeing 80,000 plus patients annually should provide 16 hours of on-site consultant cover per day (RCEM, 2010). Consultant presence in the emergency department (acute medicine) was from 8 am to 10 pm with on call consultant cover from 10 pm to 8 am Monday to Friday. At weekends, the department had consultant cover from 8 am to 8 pm on Saturdays and Sundays with on call consultant cover from 8 pm to 8 am. The emergency department had further reduced consultant cover on Bank holidays; consultants were present in the department from 10 am to 4 pm. There was a middle grade doctor (ST4 or equivalent) available on site 24 hours a day and on-call consultant cover at all other hours. Consultants were required to be able to return to the hospital if required.

The trust reported their staffing numbers below for the period August 2016 and July 2017. The trust reported a lower number in post compared to WTE staff during this period.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>WTE Staff Planned</th>
<th>Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff</td>
<td>49.3</td>
<td>40.7</td>
</tr>
<tr>
<td>Total</td>
<td>49.3</td>
<td>40.7</td>
</tr>
</tbody>
</table>

The vacancy rate for medical staff in the ED was below the trust’s target of 9.7%.

From August 2016 to July 2017, the trust reported a vacancy rate of 7% for medical staff in Urgent and Emergency Care, compared to the trust target of 9.7%.

The turnover rate for medical staff in the ED was lower than the trust’s target of 9.7%.

As at July 2017, the trust reported a turnover rate of 8.4% for medical staff in Urgent and Emergency Care with a monthly average of 3.2% between August 2016 and July 2017, compared to the trust target of 9.7%.

The sickness rate for medical staff in the ED was above the trust’s target of 3.5%.

As at July 2017, the trust reported a sickness rate of 4.1% for medical staff in Urgent and Emergency Care with a monthly average of 2.5% between August 2016 and July 2017,
compared to the trust target of 3.5%
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The emergency department had a lower use of bank and locum staff compared with the rest of
the trust. There were clear processes in place for the induction of temporary medical staff. This
included a corporate and local induction for locums, which included statutory and mandatory
training checks and local orientation.

From August 2016 to July 2017, the trust told us that there were 1,213 unfilled shifts for medical
staff in urgent and emergency care core service. Of these shifts, 275 were covered by bank staff
and 768 covered by locum staff, 168 shifts were left unfilled. (Source: Routine Provider
Information Request (RPIR) P21 Medical Locums)

The clinical director for the department specialised in paediatric emergency medicine in line with
guidance (RCPCH, 2012). All medical staff were trained in advanced paediatric life support,
European paediatric life support or paediatric intermediate life support.

We observed effective medical handovers, which were conducted in a group for each area of the
ED. Medical staff, discussed the acuity levels of patients, safety alerts and briefings, updates on
protocols, issues with staffing and levels of demand.

**Records**

Patients’ individual care records were mostly managed and stored appropriately. However, some
of the records seen lacked detail and we were unable see if patients had been appropriately
escalated to the medical team by the nursing staff.

Records used in the ED were a mixture of electronic and paper-based. Staff used paper records
within the department to documents care and treatment for patients. Requests for tests and
diagnostics were made via the electronic system and results were reported on this system.

Records generally contained enough information about the patient’s care and treatment plan to
allow co-ordination and safe care; however, two out of the 15 records we reviewed had not been
completed appropriately to understand if a patient had received required tests and if a patient’s
condition had been escalated appropriately.

The ED scorecard from April to October 2017 showed that the department had met the trust’s
target of 90% for the monthly documentation audits. The department scored 100% in April, June,
July, August and October. The score for May was 97% and in September, the score was 95%.

In the majors streaming area staff stored patient records in pigeonholes at the nurses station. The
coordinating nurse on shift continually oversaw the area where records were stored, only staff
were permitted to access this area. Staff left records in the corresponding pigeonhole for the
cubicle patient was being cared for when the records were not in use.

The senior nurse co-ordinator was responsible for organising the hand over and transfer
documentation for patients moving from the ED to an inpatient ward or discharged.

The ED had developed continuation of care records that were paper-based to use to evidence that
all risk assessments and observations had been completed. The aim of the documentation bundle
was to aid and prompt staff to complete the assessments, as they were separate documents at the
time of our inspection. This documentation bundle was not rolled out at the time of inspection.

**Medicines**

Medicines were stored and handled in line with the hospital’s medicines management policy. For
example, fridge and room temperatures were regularly checked and temperatures recorded.

The storage of medicines in the majors area was not in a separate locked room. However all
medicines were locked in cupboards and could only be accessed by staff. The department was
waiting for a refurbishment to have a locked room for medicine storage in this area of the ED.
Controlled drugs (CDs) (a medicine that is controlled under the Misuse of Drugs legislation (2001)) were kept in locked cupboards. The nurse in charge held the keys to CD cupboards. We saw that all the CD records were accurate and up to date and nursing staff were aware of Nursing and Midwifery Council (NMC) standards for administration of CDs.

We reviewed 15 sets of patient records and found that allergies had been clearly documented in patient’s records. All prescribing charts showed when medicines (including oxygen therapy) had been requested and who had requested them, the charts showed when the medication had been given and by whom.

We observed nursing staff preparing and administering intravenous fluids in line with guidance.

Patient group directives (PGDs) allow some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a predefined group of patients without them having to see a doctor. Our observations of records and discussions with staff confirmed that there were effective processes in place to ensure that these were up to date and used by authorised personnel only.

**Incidents**

The emergency department (ED) had systems in place to monitor an appropriate range of safety and quality information.

All staff had access to the hospital’s electronic system for reporting incidents and staff that we spoke with described the process they followed.

The emergency department reported 802 incidents through the National Reporting and Learning System (NRLS) from November 2016 to October 2017. Of these incidents 700 related to no harm incidents, 70 related to low harm, 12 related to moderate harm, three related to severe harm, three related to deaths and 14 related to abuse.

The trust had reported six serious incidents (SI) relating specifically to the emergency department to National Reporting and Learning System (NRLS) and to the Strategic Executive Information System (STEIS) from July 2016 to June 2017.

All serious incidents were thoroughly investigated using root cause analysis methodology and opportunities for learning were identified. Changes were made to practice when necessary and this was disseminated to all necessary staff. There were no themes or trends to the serious incidents.

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

From September 2016 to August 2017, the trust reported no incidents classified as never events for Urgent and Emergency care. *Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)*

Data the trust provided showed the number of times duty of candour staff applied in the emergency department. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. The data showed that staff carried out duty of candour three times from July 2016 to June 2017.

The Risk & Patient Safety Team produced a trust wide incident newsletter sharing the learning from serious incidents, sent to all clinical staff twice a month and published on the trust staff net.
Senior staff shared incidents in directorate governance meetings, which had fixed agenda item for patient safety incidents. The medical directorate had governance folders on each ward for staff to read which included learning from incidents.

The ED held monthly morbidity and mortality meetings, which was inclusive to all members of the multidisciplinary team. The team discussed complex cases and deaths within the department for staff learning and to identify if changes to practice were required.

The trust held a ‘whole hospital learning from harm event’, however, the senior nurses within the ED were unsure when this event took place and if staff attended the event. The risk & patient safety team produced posters highlighting ‘never events’ and the identified learning. Updates on patient safety were provided at the monthly core brief and a regular patient safety update was introduced on the front page of the trust weekly Friday round up. Learning from serious incidents was shared with staff and other departments in a variety of quality and safety reports. Serious incidents were discussed at senior staff meetings.

The trust audited incident form investigation to ensure staff gained feedback after reporting an incident. Within the ED, anonymised incidents were discussed with staff at internal meetings.

**Safety thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from August 2016 to August 2017 within urgent and emergency care.

(Source: Safety thermometer - Safety Thermometer)

**Major incident awareness and training**

The ED had a major incident plan with clear guidance and action cards for individual roles in the event of specific incidents. There were clear diagrams strategically placed throughout the department directing staff of immediate actions required in the event of a major incident.

The department had clear processes in place to manage patients who may have been exposed to chemical, biological, radiological or nuclear (CBRN) hazards. This included a dedicated decontamination room that was located next to the resuscitation area and was accessible from the ambulance entrance to minimise the risk of cross contamination.

Major incident training took place on a yearly basis with simulated scenarios for staff.

**Is the service effective?**

**Evidence-based care and treatment**

The ED used evidence-based guidance to develop how care and treatment was delivered throughout the ED. All policies were up to date, reflected national guidance and staff said they were accessible via the trust’s intranet. Policies were inclusive of all patients and did not exclude patients groups or protected characteristics.

There was a clear programme of audits conducted in regards to compliance to organisational standards and protocols. Two clinical leads and senior nurse were responsible for managing the department’s annual audit calendar.
The department had patient pathways in place that reflected national guidance for example the stroke pathway and the fractured neck of femur pathway. The pathway documents had a yearly review to ensure they reflected national guidance and best practice documents.

There was a consultant lead for clinical audits and senior nursing staff had developed a system of auditing protocols and changes to practice to monitor and improve patient care.

The trust had the ‘Critical Care Outreach (Incorporating Adult National Early Warning System) Policy’, which set out staff responsibilities in the use of the NEWS. The policy had version control and a review date of December 2017.

The department used the ‘sepsis six’ and active cancer sepsis care bundle pathways, in line with Royal College of Emergency Medicine (RCEM) guidelines and the UK Sepsis Trust (2014) for adults and children. These pathways are to aid those delivering care with the rapid recognition and treatment of severe sepsis. There were proformas in place for staff to record their actions within defined guidelines.

The department was in the process of adapting national and local safety standards for invasive procedures. The senior staff within the department had reviewed the safety standards used across the hospital for the invasive procedures that the department undertook.

The ED had developed their fractured neck of femur pathway to include a fascia iliac block (this is an interventional radiological procedure that allows medical staff to give pain relief into a specific nerve) as standard.

The department submitted audit data to national audits for example the British Thoracic Society (BTS) asthma audit. The department also participated in the RCEM audits.

The department participated in internal audits to monitor the quality and performance of the services provided to patients for example time to treatment and fascia iliac block (FIB) audits.

The ED had processes in place to ensure that adults receiving intravenous fluids were cared for by staff who were competent to do so in line with national guidance (NICE QS66, statement two, 2014).

**Nutrition and hydration**

Patients’ dietary and hydration needs were being met appropriately.

Patients we spoke with told us that they had been offered food and drink whilst they were in department. We saw staff providing patients with hot drinks.

An escalation process was in place for patients that were in the department longer than four hours and they were routinely offered food and drinks. However, we saw staff offering patient food and drinks even though they had not been in the department for four hours.

The department had vending machines for snacks and drinks, which were accessible to patients and accompanying friends and family. The hospital had a coffee shop in the outpatients department adjacent to the ED.

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “Were you able to get suitable food or drinks when you were in the A&E Department?” This was the same as than other trusts.

(Source: CQC - A&E Survey (01/09/2016 - 30/09/2016)

**Pain relief**

The ED managed patients’ pain needs and generally met the Core Standards for Pain Management Services in the UK.

Patients’ pain relief was appropriately assessed and managed. All patients that we spoke with told us that they had been offered pain relief and felt that their pain was being managed well.
The ED used pain assessment scales appropriate to the age of the child or young person in line with the World Health organisation recommendation (2012) and the Royal College of Nursing (2012). These include the ‘Wong-Baker’ faces and the colour analogue scale.

The ED participated in the Royal College of Emergency Medicine (RCEM) standard for the Management of Pain in Children.

The nursing score card for the ED from April to October 2017, showed that the department had achieved the 90% target for pain and sedation management in July, August, September and October. However, the department had scored 80-83% in the months of April, May and June.

Pain scores had been recorded in all patient records that we reviewed and analgesia administered in a timely manner. Pain scores were recorded on initial assessment and the ED used a pain-scoring tool for adults that were based on the World Health Organisation's (WHO) ‘pain ladder’ on a scale from one to 10.

In the CQC Emergency Department Survey, the trust scored 5.2 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was the same as other trusts.

The trust scored 7.9 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q29. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q30. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. Were you able to get suitable food or drinks when you were in the A&amp;E Department?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC - A&E Survey (01/09/2016 - 30/09/2016)

**Patient outcomes**

The ED had a local audit programme which monitored care pathways and procedures such as fascia-iliac blocks, sepsis and the use of specific analgesia containing codeine.

The ED participated in the sepsis audits for the trust in sepsis management, which formed part of the local CQUIN for sepsis management.

The Royal College of Emergency Medicine (RCEM) invites emergency departments to take part in national clinical audits annually that evaluate care based against agreed standards. We saw that the ED participated in relevant audits annually, which allowed them to benchmark their performance against national performance.

The trust reported that latest national clinical audit reports from the RCEM show that performance was ‘disappointing’. The trust compared their performance against the national average and against the trust’s performance in the previous year’s audit. The audit lead reviewed and discussed the audit results at the directorate governance meetings.

The trust had action plans in place for all RCEM audits. An example of the action plans taken forward for the emergency department was in relation to treating patients with asthma. The trust developed a new asthma proforma for use in the department and provided training on asthma clinical guidelines for junior and middle grade doctors.
The trust performed about the same as other trusts, in the RCEM audit for moderate and acute severe asthma.

**RCEM Audit: Moderate and Acute Severe Asthma 2016/17**

In the 2016/17 Moderate and Acute Severe Asthma report, Southend Hospital failed to meet any of the seven fundamental standards (which were all set at 100%).

The trust’s results for one standard placed it in the upper UK quartile:

- Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Trust: 89.6%; UK median: 77%

The trust’s result for one standard placed it in the lower UK quartile:

- High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust: 11.8%; UK median: 25%.

The trust’s result for five standards placed it in the middle UK quartiles:

- O2 should be given on arrival to maintain sats 94-98%. Trust: 13.7%; UK median: 19%
- Vital signs should be measured and recorded on arrival at the ED. Trust: 27.5%; UK median: 26%
- If not already given before arrival to the ED, steroids should be given as soon as possible according to RCEM guidance for the patient’s age group.*
  a) Within 60 minutes of arrival (acute severe). Trust: 27.3%; UK median: 19%
  b) Within four hours (moderate). Trust: 33.3%; UK median: 28%
- Discharged patients should have oral prednisolone prescribed according to RCEM guidance for the patient’s age group.* Trust: 48.2%; UK median: 52%

*Adults 16 years and over: 0-50mg prednisolone for 5 days
Children 6-15 years: 30-40mg prednisolone for 3 days
Children 2-5 years: 20mg prednisolone for 3 days

The trust submitted 51 patient records to the audit.

The trust did not meet any of the four standards in the RCEM consultant sign-off audit 2015/6.

**RCEM Audit: Consultant sign-off 2016/17**

The 2016/17 Consultant Sign Off Audit monitors the proportion of patients of various groups who were reviewed by a consultant in emergency medicine prior to discharge from the ED. For each group, the RCEM standard is that 100% of all patients receive a review from senior medical staff on discharge.

Of all patients aged over 30 admitted for chronic chest pain in the 2016/17 audit, 7.8% were seen by a consultant and 56.9% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.

Of all children under one year of age admitted with a fever in audited in 2016/17, 0% were seen by a consultant and 40% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.

Of all patients making an unscheduled return to the ED with the same condition within 72 hours of discharge in the 2016/17 audit, 10% were seen by a consultant and 70% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.

Of all audited patients over 70 years of age who were admitted with abdominal pain, 2% were
seen by a consultant and 52.9% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.

The trust submitted 175 cases to the audit.

(Source: Royal College of Emergency Medicine)

The department performed worse than other trusts for the RCEM audit for vital signs in children in four of the six measures and about the same as other trusts for two of the measures.

RCEM Audit: Vital Signs in Children (2015/16)

In the 2015/16 RCEM audit for vital signs in children, Southend Hospital was in the upper quartile compared to other trusts for none of the six measures and was in the lower quartile for four of the six measures.

The measures that performed in the lower quartile were:

- Standard 1a: All children attending the emergency department with a medical illness should have a set of vital signs consisting of temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score.
- Standard 3: There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present).
- Standard 4: There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases.
- Standard 5: Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor).

(Source: Royal College of Emergency Medicine)

The trust performed better or the same as other trusts in the two measures in the RCEM audit, for VTE risk in lower limb immobilisation in plaster cast for the year 2015/16.

RCEM Audit: VTE Risk in Lower Limb Immobilisation in Plaster Cast 2015/16

In the 2015/16 RCEM Audit for Lower Limb Immobilisation in Plaster Cast, Southend Hospital performed:

- In the upper quartile for the measure ‘If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment’, with a score of 100% in one case.
- In the middle quartile for the measure ‘Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation’, with a score of 2% in 50 cases.

(Source: Royal College of Emergency Medicine)

The trust performed better than other trusts in four measures and worse than other trusts, in one measure, in the RCEM audit for procedural sedation in adults (2015/16).

RCEM Audit: Procedural Sedation in Adults (2015/16)
In the 2015/16 Procedural Sedation in Adults audit, Southend Hospital was in the upper quartile for four measures, the lower quartile for one measure and the middle quartiles for the remaining two measures.

The measures that performed in the upper quartile were:

- There should be documented evidence of the patient’s informed consent unless lack of mental capacity has been recorded. The trust result was 77.4% compared to the England median of 51.8% from 31 cases.

- Procedural sedation requires the presence of all of the below a) a doctor as sedationist, b) a second doctor, ENP or ANP as procedurist, c) a nurse. The trust result was 78.1% compared to the England median of 40.8% from 32 cases.

- Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area.

- Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below: a) Return to baseline level of consciousness b) Vital signs within normal limits for the patient c) Absence of respiratory compromise d) Absence of significant pain and discomfort e) Written advice on discharge for all patients. The trust result was 0% compared to the England median of 41% from seven cases.

The measure that performed in the lower quartile was:

- Monitoring during procedural sedation must be documented to have included all of the below a) non-invasive blood pressure b) Pulse oximetry, c) Capnography, d) ECG.

The measures that performed in the middle quartile were:

- Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including a) ASA grading b) Prediction of difficulty in airway management c) Pre-procedural fasting status. The trust result was 6.3% compared to the England median of 7.6% from 32 cases.

- Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. The trust result was 87.5% compared to the England median of 90% from 32 cases.

(Source: Royal College of Emergency Medicine)

The trust performed worse that the national standard of 5% of patients re-attending the department within seven days. However, the trust performed better the England average.

From September 2016 to August 2017, the trust’s unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average. In latest period, August 2017, the trust’s performance was 7.0% compared to an England average of 7.8%.

Unplanned re-attendance rate within 7 days - Southend University Hospital NHS Foundation Trust
Competent staff

There were systems and processes in place to ensure that staff had the necessary qualifications, skills, knowledge and competencies to do their jobs. There were systems in place to enable staff to take on new responsibilities and on a continual basis.

New staff in the nursing team were supervised by a more experienced member of the team at the start of their career for a period of no less than six weeks.

The trust had a policy for all new staff working in the trust called the ‘Onboarding (new starter) policy’. The policy had version control with a review date of October 2019. The policy set out that all staff were required to complete a trust induction within eight weeks of their start date and to complete a local induction within six months.

The ‘Onboarding (new starter) policy’ referred to temporary staff and stated that all temporary staff should complete a local induction for each new area within the trust.

The ED had a dedicated practice development nurse who was a member of the senior nursing team. The practice educator worked with junior staff to enhance their skills either as a group or individually. This member of staff also supported newly promoted band six staff nurses with the appraisal process and sickness reviews.

During a visit to the department at 9pm as part of our inspection, we found that the department did not have a registered children’s nurse on duty. We saw an agency nurse caring for an infant in the major’s area. The agency nurse was unsure if they had completed children’s competencies. We raised concerns with the trust, as we did not feel assured that adult nurses had the competencies to look after sick children. Adult nurses are able to care for children providing they have complete specific competencies in line with Royal College of Nursing guidance and have access to paediatric support if necessary.

Following our inspection, the trust supplied us with information that demonstrated how they would ensure that adult nurses had the correct skills to provide appropriate care for children. In addition, the department had a new agency nurse checklist in place. Agency nurses were not allocated to care for children without evidence they had completed the paediatric competencies.

The department had emergency department assistants who had been trained to complete procedures such as cannulation, phlebotomy and ECGs. The emergency department assistants had completed a formalised educational program in order to be competent in their role.
All non-training doctors had an appraisal and completed the revalidation process. Clinical supervision forms part of the process of appraisal and revalidation. All named clinical supervisors received additional training for this role. The trust had a process in place that all education and supervision was signed off by the trust’s education lead prior to an appraisal.

The ED had not met the trust’s target of 73% of nursing staff receiving an appraisal from April 2016 to March 2017. However, the HR department had taken a lead in the oversight of staff appraisals and sent monthly e-mails to each department to show which staff members had not received an annual appraisal.

The senior nursing team had a board to show the staff who required an appraisal and removed the names once the appraisal had taken place. The practice development nurse told us that removing staff from the ED for appraisals and education was challenging when the department was busy.

The table below shows that from April 2016 to March 2017, 76% of all staff within Urgent and Emergency Care at the trust had received an appraisal compared to a trust target of 73%. However, qualified nursing staff group did not meet the target, achieving 65% completion rate.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th># Appraisal Required</th>
<th># Appraisal Received</th>
<th>Completion Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>47</td>
<td>45</td>
<td>93.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>59</td>
<td>40</td>
<td>64.5%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>108</strong></td>
<td><strong>85</strong></td>
<td><strong>75.9%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Revalidation is the process introduced in April 2016 that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising. The practice development nurse assisted staff with the process of revalidation.

**Multidisciplinary working**

Effective multidisciplinary working was evident throughout the department. The clinical team in the ED, made of up of doctors, nurses, emergency nurse practitioners, emergency department assistants and an associate practitioner formed a specialist, cohesive multidisciplinary team and demonstrated consistent, well-developed collaborative working.

Staff we spoke with told us that the ED had good communication across all departments with the hospital especially medicine. The clinical director for the ED had also taken on the role as the clinical director for medicine in addition to the role in ED.

There were effective systems in place to ensure that all teams required in delivering care and treatment were involved in planning and assessing the needs of individual patients.

We observed collaborative working between ambulance crews and the staff from the ED to provide a seamless transfer into the department.

The ED worked closely with the frailty team to identify frailty patients and fast track assessments with the frailty team. This formed a part of the admission prevention strategy to enable patients to return home with the right resources in place if hospital admission was not required.

The mental health liaison team were based within the department 24 hours a day with a dedicated area for patient assessment. The mental health liaison team were integrated into the ED team and held honorary contracts with the trust. Staff told us that they discussed patients with the mental health liaison team and felt able to seek advice.
The trust worked collaboratively with other stakeholders for example another NHS trust responsible for the CAMHS provision, to improve mental health services. We reviewed the minutes from the mental health crisis care sub-group from May to July 2017, which demonstrated that the associate director of emergency medicine for the trust attended these meetings.

The department worked closely with the hospital’s integrated care team to co-ordinate care in the community and discharge planning for patients with complex medical conditions. This included working with physiotherapists, occupational therapists, and social workers.

The practice development nurse worked with the local ambulance trust to up skill their crew members in the skin closure and wound dressing to reduce ED attendances for minor injuries.

**Seven-day services**

The ED was open for adults and children, 24 hours a day seven days a week.

Our observations of patient records, discussions with staff and review of policies confirmed that the service met NHS England’s seven-day services priority standards:

- **Standard two** - (all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible and within 14 hours of arrival at the hospital).
- **Standard five** - (hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology).
- **Standard six** - (hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions).

The ED had access to diagnostics and imaging 24 hours a day, this included magnetic resonance imaging (MRI) and CT scanning.

The emergency department had access to the adult mental health liaison team, which were based in the department 24 hours a day seven days a week. However, mental health services for children were not based within the trust. The department had access to children's mental health services from 9am to 5pm every day, outside of these hours staff could contact the duty doctor.

The pharmacy department was open seven days a week. Opening hours were 9 am to 5:30pm Monday to Friday, 9am to 2:30pm on Saturdays, Sundays and bank holidays. The department had access to an on-call pharmacist outside of these hours.

**Health promotion**

The department actively identified patients who needed extra support including people in the last 12 months of their lives, people at risk of developing long-term conditions and carers.

Staff supported patients with asthma and gave additional training in the use and technique of inhaler medication. Staff gave clear advice to patients and carers about returning to the department in case of deterioration.

Staff gave life style advice to patients, for example smoking cessation, diet and exercise. Health promotion was tailored to each individual patient dependent on his or her needs and condition.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust was registered for assessment or medical treatment for persons detailed under the Mental Health Act 1983. The trust reported that any patient detained under a mental health section, was supported by a mental health professional until medically fit to transfer to mental health services. The mental health team assessed patients passing through the trust via ED within the mental health suite in ED.
The trust had a policy for consent that was in line with the Mental Capacity Act (MCA, 2005), this provided guidance to staff on the assessment of capacity involving care and treatment decisions. This included guidance on the use of Deprivation of Liberty Safeguards (DoLS) for those patients that do not have capacity to make the decision to remain in hospital to receive care.

The adult safeguarding team were responsible for oversight of DoLS and the mental capacity assessment process. The lead decision maker was responsible for the completion of the assessment; however, the adult safeguarding team were available to offer advice and support.

The trust had a policy for consent to examination or treatment, which outlined how staff should obtain and record a patient’s consent to care or treatment. The department had a written consent form for invasive procedures, which consultants completed. During times when the department did not have a consultant on site anaesthetists attended the department.

The trust conducted consent to examination and treatment audits every three months (quarterly). The audit covered treatment areas includes inpatient (including the ED), day case and outpatient procedures requiring consent. The audit aimed to improve the standard of obtaining patient consent.

Staff working with children in the ED were aware and understood their responsibilities in relation to Gillick competency and Frasier Guidelines.

Consent registers identified staff authorised to undertake consent and staff had access to an e-learning package.

Is the service caring?

Compassionate care

Staff were friendly, professional and helpful to patients. Staff used humour when it was appropriate and were respectful of all patient’s individual preferences, habits, culture, faith and background.

Staff were friendly, professional, compassionate and helpful to patients in all interactions that we observed.

Patients told us that the staff had been caring towards them and all spoke positively about the staff.

Staff spoke about their patients in a caring and compassionate manner and respected patients’ dignity at all times, even when the ED was very busy.

We observed staff treating children with patience and compassion to put them at ease.

Receptionists were warm and friendly when assisting all patients during the booking in process.

Patients and those accompanying them were treated with respect, including when receiving personal care. Patients and their relatives told us they had been impressed with the care and treatment provided by the staff in the ED.

One relative told us “the hospital is brilliant and they are caring and sympathetic.”

One child’s parent told us “they are marvellous” with regard to the staff in the children’s ED.

The trust’s Urgent and Emergency Care Friends and Family Test performance (% recommended) was generally about the same as the England average from August 2016 to July 2017. In the latest period, July 2017, the trust performance was 86.9% compared to England performance of 85.9%.

A&E Friends and Family Test Performance - Southend University Hospital NHS Foundation Trust
Emotional support

Staff told us that they would take the time to support patients and their loved ones if they were faced with distressing news even at busy times.

Staff were aware of the impact that a patient’s care, treatment or condition could have on their wellbeing and on those close to them both emotionally and socially.

Staff were fully aware of how to make referrals to adult and children’s mental health services when required.

Staff working with children and young people were aware of the support that parents needed when children attended the ED. The emergency department had chaplaincy services to support patients and relatives with their spiritual needs. A chaplain was available 24 hours a day.

Following a death in the department staff made themselves available to support bereaved relatives and answer any questions they had.

The ED staff had booklets they gave family members following a bereavement that contained information about local counselling services and support groups.

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 23 of the 24 questions relevant to caring. The one remaining question scored worse than other trusts in Q37. “Did a member of staff tell you about medication side effects to watch out for?”

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8. Were you told how long you would have to wait to be examined?</td>
<td>3.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q10. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. While you were in the A&amp;E Department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Q15. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. While you were in the A&amp;E Department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Overall, did you feel you were treated with respect and dignity while you were in the A&amp;E Department?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. If you were feeling distressed while you were in the A&amp;E Department, did a member of staff help to reassure you?</td>
<td>6.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q25. Before you left the A&amp;E Department, did you get the results of your tests?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q36. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q37. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>3.9</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did hospital staff take your family or home situation into account when you were leaving the A&amp;E Department?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the A&amp;E Department?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
| Q43. Overall... (please circle a number) | 8.2        | About the
<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC - A&E Survey (01/09/2016 - 30/09/2016)

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

Patients told us that they had felt involved in their care and treatment. We saw that patients were kept informed about the treatment plans at all times.

Patients and their relatives told us that staff had taken time to discuss the plan of care in a way that they understood.

Two parents told us that they had been kept informed of their child’s care and treatment. Another parent said “we feel safe and are not pressurised, it’s a pleasant experience”.

Staff had access to communication aids such as visual cards, to communicate with people who required extra support to discuss their care. Staff we spoke with knew how to access these aids and how to use these with patients.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The department planned services to meet the needs of the local population and worked with local commissioners to improve services.

The department had changed the way patients were triaged and streamed around the ED since our last inspection. The clinical director and leadership team had introduced a modified Luton and Dunstable triaged system to meet the needs of local patients. An example of the modification related to respiratory patients who would be streamed to the GP service, the clinical lead discussed the issues with this situation and why these patients needed to be treated within the ED.

People’s needs and choices were not always being met. The separate children’s ED was operational from 8am-9pm with children arriving after 7:30pm being treated in the adults ED. The clinical lead for the ED had submitted a business case for the children’s ED to be fully staffed and operational 24 hours a day seven days a week. Staff told us this was initially rejected by the trust’s board prior to our inspection. Following our inspection, the trust informed us that the business case was resubmitted and approved by the board in December 2017.

The premises were mostly appropriate for the services that the ED delivered. However, we found that the mental health assessment area did not meet the recommended standards in line with Royal College of Emergency medicine (RCEM) guidelines. We also had concerns about the security arrangements in the children’s ED waiting area.

Staff told us limited children’s and adolescent mental health services (CAMHS) was their main concern; this was also on the ED risk register. Meeting minutes showed that the department leads had attended external meetings, which discussed the provision of the CAMHS service. During our unannounced inspection, staff told us that an out of hours CAMHS service was due to commence in January 2018.

Senior nurses from the department were working with the local ambulance service to upskill ambulance crew in skin closure and wound dressing techniques. The initiative aimed to reduce the need for patients to attend the ED for minor injuries such as skin tears.

The ED had a waiting room with adequate seating for patients in the waiting room in the adults ED and the children’s ED. The reception area had wheelchair available for patients that were unable to stand while waiting for a receptionist to become free.
The department had good signage to direct patients to the appropriate area of the ED for example the radiology department (x-ray) was clearly sign posted.

The trust scored “about the same as” other trusts for all of the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Overall, how long did your visit to the A&amp;E Department last?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. Were you given enough privacy when being examined or treated?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC - A&E Survey (01/09/2016 - 30/09/2016)

Meeting people’s individual needs

Services had been planned to take into account the needs of different people, for example, on the grounds of age, disability, gender or religion.

The ED had clear systems and processes in place to meet the needs of patients with complex conditions such as those living with dementia or a learning disability.

The trust had a clinical nurse specialist to support adults with a learning disability that accessed inpatient or outpatient services. This staff member formed part of the adult safeguarding team. Administrative staff updated the flagging system on the electronic patient administration system ‘Medway’ which generated a notification that was sent to the clinical nurse specialist advising them of any adults with a learning disability that accessed services at the hospital. The adult safeguarding team supported patients in the absence of the clinical nurse specialist.

The trust had four whole time equivalent registered nurses that were dual trained as a registered adult nurse and a mental health nurse. Two of these nurses worked within the ED and assisted with upskilling staff in the ED in the care of patients with mental health needs.

The trust had a mental health team who worked on site (employed by mental health service and worked within the trust under honorary contracts). The mental health team participated in the care and management of patients with mental health needs.

The trust had a dementia clinical nurse specialist who supported patients living with dementia and staff caring for those patients. The clinical nurse specialist was notified via the flagging system on the patient administration system ‘Medway’.

Staff used the ‘This is me’ documentation following a discussion with patients, carers and other relevant parties, for example care homes. Staff had accessible communication resources used to supported discussions for patients living with dementia, had access to support from the trust’s dementia clinical nurse specialist

Access and flow

The department mostly provided timely access to initial assessments, test results, diagnosis or treatment to service users.

Service users could not always access care and treatment at a time that suited them. An example of this was the children’s ED staffed from 8am-9pm. The adult ED did not always have a registered sick children’s nurse on duty at night. The limited CAMHS provision meant that some young people remained in the department for longer than the four-hour standard. We found
evidence of this within incidents reported by ED staff and included in the department’s risk register.

The department implemented a modified version of the Luton and Dunstable triage system to the ED in October 2017. The triage system aimed to ensure service users were seen within the department at the right time and in the right area. The tool also helped staff to appropriately direct service users to the on-site GP service. The introduction of the triage system was one month before our inspection, although the department was auditing this, there were no results.

The department’s performance against the Department of Health’s standard for emergency departments that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E had improved.

From October 2016 to September 2017, performance against this metric showed a trend of improvement meeting the national standard of 95% in April 2017 and has since been similar to the England average up to September 2017.

**Four hour target performance – Southend University Hospital NHS Foundation Trust**

![Graph showing four hour target performance](image)

(Source: NHS England – A&E Waiting times)

The department had performed well compared to the England average for the percentage of patients waiting between four and 12 hours from the decision to admit until admission.

From October 2016 to September 2017 Southend University Hospital NHS Foundation Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average. Performance against this metric showed a trend of stability over the period with 0% of patients waiting between four and 12 hours from the decision to admit until being admitted from March 2017 to September 2017.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Southend University Hospital NHS Foundation Trust**

![Graph showing percentage of patients waiting](image)
Over the 12 months from October 2016 to September 2017, five patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in December 2016 and January 2017. No patients waited more than 12 hours from the decision to admit until being admitted from February 2017 to September 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between 4 and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-16</td>
<td>253</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
<td>37</td>
<td>1</td>
</tr>
<tr>
<td>Dec-16</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td>Jan-17</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td>Feb-17</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Mar-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>May-17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jun-17</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Aug-17</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

The department performed better than the England average for the percentage of patients who left the department before being seen for treatment.

From October 2016 to September 2017, the monthly median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was better than the England average.

From October 2016 to September 2017, performance against this metric showed a trend of decline, although continued to be better than the England average. In the latest period, August 2017 the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 2.0%, compared to the England average, which was 3.0% and has followed a similar trend to the England average for the reporting period.
Percentage of patient that left the trust without being seen - Southend University Hospital NHS Foundation Trust

(Source: NHS DIGITAL - A&E quality indicators)

From October 2016 to September 2017, the trust’s monthly median total time in A&E for all patients was consistently similar to the England average. Performance against this metric showed a trend of improvement. In August 2017, the trust’s monthly median total time in A&E for all patients was 150, which is similar to that of the England average, which was 144.

Median total time in A&E per patient - Southend University Hospital NHS Foundation Trust

(Source: NHS DIGITAL - A&E quality indicators)

**Learning from complaints and concerns**

There were effective processes in place so that people who used the service could make a complaint or raise concerns, however complaints were not always handled in a timely manner.
The ED had complaints leaflets in patient areas, which explained in large text how to make a complaint to the trust. The Patient Advice and Liaison Service (PALS) were able to supply service users with large print, audio tape and translated versions of the leaflet.

The trust published their complaints procedure and the contact information on the hospital website.

Patients we spoke with knew how to raise their concerns or make a complaint. Of the 14 patients and 21 relatives we spoke with, all of them were happy with service and did not want to complain about services they received.

The department did not effectively handle complaints in a timely way.

From August to July 2017, there were 108 complaints about Urgent and Emergency Care services. The trust took an average of 59 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 days or no fixed amount of days for complex cases.

The top three subjects of complaints were:

- All aspects of clinical treatment – 70
- Attitude of staff – 20
- Admissions, discharge and transfer arrangements - 5

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Data supplied by the trust showed that the emergency department received 215 compliments from service users from August 2016 to August 2017.

Senior staff shared learning from complaints within the monthly directorate performance reports, which were reviewed, scrutinised and discussed at the monthly performance meetings. The ED directorate's governance lead was responsible for ensuring completion of actions and sharing learning from complaints.

Staff shared learning from complaints during the directorate governance meetings, monthly Quality & Safety Meetings, Quality Assurance Committees and in the trust’s annual report for complaints.

Managers told us that they undertook reflective learning with staff to address concerns around attitude. Managers used anonymised complaints in ward meetings as a learning tool for staff.

The trust shared learning with complainants within the complaint response from the trust, if an investigation found actions arising from the complaint made. A review of complaint responses demonstrated that the department shared learning with patients following a complaint.

The department displayed a poster ‘you said, we did’ in the department’s main waiting area. Patients had reported that waiting times were too long and the waiting times were not clearly displayed. The trust had implemented a navigation service to redirect patients to the appropriate service, such as the GP service to reduce waiting times. The department had installed TV screens to display waiting times within the department.

Is the service well-led?

Leadership

Leaders had the skills, knowledge, experience and integrity that they needed to lead the department. The ED was led by the clinical director and the associate director.

The senior leadership team within the department understood the challenges to quality and sustainability they identified the actions needed to address them.
The clinical lead for the ED department was an experienced consultant who also held the clinical lead for the medical directorate. The clinical lead understood the challenges within the department and addressed them with mitigating actions. An example of this was the joint working with the frailty team and the admission avoidance teams with the aim to provide services closer to the home of the patients. The day assessment unit (DAU) provided an alternative to acute admission for individuals with complex co-morbidities and frailty. An experienced nurse held the position of associate director for emergency medicine. They understood the importance of quality measurement and sustainability.

The leadership team within the ED were visible and approachable. Staff told us that the leadership team were visible in the department and felt able to approach them with any concerns or for assistance.

The Trust had a succession planning initiative, which launched in 2016. This plan identified all critical roles across the directorates. The practice development nurse told us that the department had strategies in place for succession planning and supported staff in junior leadership posts.

The trust’s executive management team were visible within the department. Staff we spoke with told us that senior managers visited the department each morning. One of the senior nurses in the department told us about a recent visit from one of the non-executive directors.

**Vision and strategy**

The vision of the ED was aligned with the trust’s vision. In addition, the ED wanted to improve staffing to provide resilience and aid staff training. This included children’s ED being staffed 24 hour a day and increasing provision of out of hours CAMHS service.

The ED had realistic strategies to achieve their vision and had made progress with the provision of an out of hours CAMHS service, which was due to commence in January 2018.

The trust’s vision was to be a leading provider of seamless healthcare which supports every person that needs the trust’s services, whether in or out of hospital to achieve their best health possible. This information was published in the trust’s five-year strategy (2015-2019).

The trust had four strategic aims; excellent patient outcomes, excellent patient experience; engaged and valued staff and financial and operational sustainability.

The trust had five strategic actions, these included: to implement an effective recruitment and retention plan in order to have the right numbers of the right staff in place at the right time, to develop and retain a highly skilled, motivated and engaged workforce. To develop leadership capability and capacity. To develop a healthy organisation culture. To develop human resources capacity and capability.

**Culture**

The ED had a culture that promoted openness and honesty at all staffing levels. Action was taken to address staff behaviours and performance that was not consistent with the trust’s values, which included equality and diversity.

The department had processes in place to provide staff with development they needed and an appraisal process. However not all staff had protected time to complete training and appraisals and at busy times staff reported that this was challenging.

The department had a strong emphasis on the safety and well-being of staff. An example of this, staff had access to counselling services in the event of a distressing event.

All of the staff we spoke with felt valued by the leaders within the department. They reported that ED staff worked as a team and felt able to raise any concerns or make suggestions to improve patient care. All staff felt supported by their managers.

Staff reported that the trust’s senior leadership team were visible within the ED and would often visit the department especially at busy times to support staff.
Staff told us that they felt unsure of their future working within the ED. This was due to the potential merger with two other trusts in the local area. Staff also reported that they received limited communication about the merger from the trust’s executive team.

The trust expected staff to work to the organisational values and demonstrate the values in their roles. The trust values included; care with compassion, treating people as individuals, listening effectively and with empathy, striving to achieve the highest possible quality standards and going the extra mile.

The trust promoted partnership working between staff, patients and carers to ensure safe and effective care was provided in the best interest of the patients.

The ED had a staff member of the month award. Senior staff donated money for prizes for example vouchers awarded to the winning staff member each month. All staff could put forward their colleagues for the award.

The finding of the Health Education England inspection in November 2017 found that the relationship between medicine and the ED as medical trainees felt admissions were forced upon them. However, we did not see this during our inspection.

**Governance**

The department had effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services.

Staff at all levels were clear about the roles and understood what they were accountable for. Staff understood the process of escalating concerns to their line manager. The leadership team within the department had processes in place to report to the trust’s board.

In 2016, the Trust updated its quality governance arrangements to include risk identification, effective committees and to improve assurance with ward to board reporting.

The clinical governance meeting happened fortnightly with key staff, for example the matrons, and the associate director, amongst others and details of the meeting and minutes circulated to staff. Each meeting produced action points as required and we saw that these shared with the teams in flexible ways, by email and daily briefing meetings to ensure continual improvement to quality of the service.

The ED leadership team attended monthly performance meetings where all aspects of patient safety were discussed for example incidents and audit results. Information and concerned raised fed into the four trust wide committees.

The ED fed into the trust’s four committees. For example through the audit committee with the local, national audit results, the mortality surveillance group, and submitted learning from mortality reviews in the ED. The clinical lead for the ED or a representative attended these committee meetings.

The trust had four committees that reported to the Quality Assurance Committee (QAC). The QAC assured the board that the trust had an effective system of risk management and internal control across the clinical activities of the organisation. The QAC received assurance from each committee on the achievement of their objectives and reports to the trust.

The Quality and Safety Committee (QSC) held responsibility for co-ordinating and implementing the responsive actions taken by the trust in relation to quality and provided assurance to QAC that the quality agenda was embedded into practice. The QSC monitored the measurement of quality performance. The mortality surveillance group also reported into the QSC.

The Clinical Governance Committee (CGC): held responsibility for the oversight of the trust’s clinical governance arrangements and ensured the trust had robust systems in place for managing clinical risk.
The Corporate Governance Group (CGG) managed risk, agreed and implemented the trust’s corporate assurance framework. This group ensured the trust had systems of internal control is in accordance with statutory requirements.

The Corporate Management Team (CMT) had oversight of the day-to-day management of the trust and supported the board in setting and delivering the clinical and non-clinical strategy.

Management of risk, issues and performance

The ED had assurance systems in place to monitor their performance and escalate any issue identified.

The department had a systematic programme of clinical and internal audit to monitor quality, operational and financial processes and had systems in place to identify where action should be taken.

Safety and quality formed part of the trust board’s agenda and agreed quality measures, based on local and national priorities. The board reviewed the ‘Integrated Performance Board Report’ to highlight exceptions and actions.

The clinical lead and the associate clinical director of the department lead on the local audit programme within the department. The audit programme covered quality issues such as documentation and the cleanliness of the department. The department monitored times to treatment for all patients and compared their performance against other trusts and internally against the previous year.

The emergency department had 23 open risks on the risk register, with seven risks rated as high. All of the risks were appropriate and leaders had taken action to mitigate risks.

We saw that the non-staffing of the children’s ED at night was on the risk register and mitigation had been taken to try to separate children from adults in the main ED at night. The clinical director and associate director of nursing had also submitted a business plan to staff the children’s ED at night. The business plan agreed by the trust’s board will require the paediatric assessment unit (PAU) to move locations. The aim of the relocation of the PAU was to ensure efficient staffing and long-term sustainability of the 24 hour children’s ED.

Four of the senior staff working within the children’s ED cited the limited children’s and adolescent mental health services (CAMHS) as their main concern; this was also on the ED risk register. Meeting minutes showed that the department leads had attended external meetings, which discussed the provision of the CAMHS service. During our unannounced inspection, staff told us that an out of hours CAMHS service was due to commence in January 2018.

Information management

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way. All staff had access to policy and procedure documents electronically.

Staff used paper based records within the ED. However staff had access to an electronic patient record system which meant that the information needed, to deliver effective care and treatment was available to staff in a timely and accessible way for example clinical investigations.

The trust had mechanisms in place to review the quality of data used for external reports and internal and external benchmarking. The trust undertook quality assurance of data prior to any submissions to ensure consistent data integrity and completed regular accuracy audits, which helped to identify any weaknesses in localised processes.

The information governance committee produced data quality reports every three months (quarterly). The committee also produced an annual Data Quality report for the trust’s board.
Engagement

The trust has undertaken public engagement in the last year about the Essex success regime and proposed changes to the emergency department. The engagement process included public talks and meetings. The trust participated in engagement by means of social media, with stories and posts designed to create conversation.

The trust contributed in projects with community and religious groups to help assist their members gain a better understanding of services provided by the trust. The trust also participated in an event aimed at young people who wanted to be future doctors.

The trust distributed a newsletter called ‘The FuTure’ both online and in print to more than 14,000 members. A monthly staff letter called ‘The Look’ was also published online and across social media.

The trust held patient and carers meeting every three months (quarterly) and this group also provided feedback in the form of focus group for service improvement cross the trust.

Senior staff had a locked suggestions box in the main department for staff to anonymously make suggestions about ways services could be improved.

Senior staff left newsletters in the staff room to ensure all staff had updates about the department. The department had regular staff meetings to discuss local governance issues and changes to the department. However, staff at all levels within the ED did not feel informed and included within the consultation for the merger with two other NHS trusts.

Learning, continuous improvement and innovation

The clinical director strived for continuous improvement of the services provided by the department. The latest initiative introduced into the ED was the Luton and Dunstable triage tool. The clinical lead had adapted the tool to ensure the department met the needs of the local population. The tool was introduced in October 2017 and the tool was embedded within the department at the time of our inspection.

Senior nurses from the department were working with the local ambulance service to upskill ambulance crew in skin closure and wound dressing techniques. The initiative aimed to reduce the need for patients to attend the ED for minor injuries such as skin tears.
The trust provides medical services across a number of specialities and has 12 in-patient medical wards totalling 290 beds: These are:

- Two care of the elderly wards totalling 59 beds;
- One general medicine/diabetes and endocrine/gastroenterology ward with 35 beds;
- One general medicine/renal ward of 27 beds;
- One co-located cardiology ward and cardiac care unit with 29 beds - eight of which are Level 2 beds on the critical care unit (CCU);
- Two respiratory wards including acute respiratory care unit totalling 44 beds, including 12 Level 2 beds on the acute respiratory care unit;
- The acute stroke unit made up of two wards with a total of 40 beds including four Level 2 beds;
- Two oncology wards totalling 42 beds and one short stay medical ward of 14 beds (the short stay medical ward is utilised for extra capacity during ‘winter pressures’. An additional 10 beds can be opened during this time).

Medical services at Southend Hospital include short stay and day stay wards. The day assessment unit (DAU) provides direct access for primary care for multidisciplinary assessment and management of frail patients. Cardiac and medical day stay unit has capacity for 12 patients for medical day stay procedures including pleural effusion for lung cancer patients, stress echocardiography (ECG) and the implantation of cardiac loops.

The stroke team provide a transient ischaemic attack (TIA) referral service for primary care and in conjunction with interventional radiology and anaesthetic consultant colleagues provide a burgeoning thrombectomy (clot retrieval) service.

Elizabeth Loury ward undertakes chemotherapy for up to five patients each day and they have a radioactive iodine room for treating patients with thyroid cancer.

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 52,083 medical admissions from June 2016 to May 2017. Emergency admissions accounted for 22,810 (44%), 1,860 (4%) were elective, and the remaining 27,413 (53%) were day case.

Admissions for the top three medical specialties were:

- General Medicine: 26,592
- Clinical Oncology (Previously Radiotherapy): 9,748
- Clinical Haematology: 5,594

(Source: Hospital Episode statistics)

At the last inspection, we rated two key questions for the service as requires improvement so we re-visited all five key questions.

CQC carried out a focussed inspection of this service in February 2017. We looked at the safe, responsive and well-led domains. We rated the service as requires improvement for safe and responsive and good for well-led. The service was rated requires improvement overall.

During our inspection, we visited nine wards, the acute medical unit (AMU), the day assessment unit (DAU) and the discharge lounge. We spoke with 13 medical staff, 39 nursing staff, one
Is the service safe?

Mandatory Training
There were no effective processes in place to ensure that staff received mandatory training. Ward managers and matrons told us that mandatory training compliance was not meeting the trust’s target for compliance, mostly due to insufficient staffing and the difficulty in releasing staff from the ward. Managers told us that, to enable staff to access mandatory training more easily, some of it (around 50%) was available electronically via online learning.

Mandatory staff training covered many subjects including conflict resolution, cardio pulmonary resuscitation (CPR), equality and diversity, fire safety, infection control and information governance. Also, moving and handling, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Level 1.

The trust told us sepsis champions had been identified on each in-patient ward and a new e-learning package had been rolled out and was available online.

The trust set a target of 85% for completion of mandatory training modules, with the exception of information governance and safeguarding children level 1 where the target was 95% and Prevent (Levels 1-2) where the target was 69%.

Medical staff across the medical directorate did not meet the trust target for compliance with mandatory training in 20 out of 21 modules. The one module that did achieve the trust target was ‘Infection Prevention’ with 91% completion rate compared to 85% trust target.

A breakdown of compliance for mandatory courses from April 2016 to March 2017 for medical/dental staff in Medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>85%</td>
<td>54</td>
<td>137</td>
<td>39.4%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>85%</td>
<td>100</td>
<td>139</td>
<td>71.9%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>85%</td>
<td>10</td>
<td>139</td>
<td>11.5%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>80</td>
<td>139</td>
<td>57.6%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>85%</td>
<td>106</td>
<td>139</td>
<td>76.3%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>85%</td>
<td>91</td>
<td>137</td>
<td>66.4%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>88</td>
<td>137</td>
<td>64.2%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>43</td>
<td>80</td>
<td>53.8%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>96</td>
<td>139</td>
<td>69.1%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>81</td>
<td>137</td>
<td>59.1%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>85%</td>
<td>50</td>
<td>83</td>
<td>60.2%</td>
</tr>
<tr>
<td>CPR - Adults</td>
<td>85%</td>
<td>97</td>
<td>136</td>
<td>71.3%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85%</td>
<td>102</td>
<td>139</td>
<td>73.4%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>85%</td>
<td>126</td>
<td>139</td>
<td>90.6%</td>
</tr>
<tr>
<td>Local Induction</td>
<td>85%</td>
<td>64</td>
<td>84</td>
<td>76.2%</td>
</tr>
<tr>
<td>MCA DOLS Level 1</td>
<td>85%</td>
<td>92</td>
<td>137</td>
<td>67.2%</td>
</tr>
<tr>
<td>MCA DOLS Level 2</td>
<td>85%</td>
<td>44</td>
<td>80</td>
<td>55.0%</td>
</tr>
<tr>
<td>Prevent (Levels 1-2)</td>
<td>69%</td>
<td>48</td>
<td>139</td>
<td>34.5%</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>85%</td>
<td>30</td>
<td>79</td>
<td>38.0%</td>
</tr>
<tr>
<td>Oxygen Therapy</td>
<td>85%</td>
<td>82</td>
<td>137</td>
<td>59.0%</td>
</tr>
<tr>
<td>WHO Training</td>
<td>85%</td>
<td>4</td>
<td>12</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1494</strong></td>
<td><strong>2488</strong></td>
<td>60.0%</td>
<td></td>
</tr>
</tbody>
</table>

A breakdown of compliance for mandatory courses from April 2016 to March 2017 for qualified nursing staff in Medicine is shown below:
Nursing staff across the medical directorate did not meet the trust target for compliance with mandatory training in nine of the 23 mandatory training modules. Nursing staff met the trust target in 14 modules. Collection of blood products had the lowest completion rate of 25%, compared to the 85% trust target. (Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

There were systems and processes in place to ensure newly appointed staff, bank and agency staff completed local inductions. We spoke with one agency health care assistant (HCA) who told us they received an induction to the ward.

Safeguarding

The hospital had policies in place regarding safeguarding of adults and children, including guidance on identifying domestic violence and female genital mutilation. Staff could access these policies through the hospital intranet system. However, safeguarding training rates for medical and nursing staff did not meet the trust target.

The trust set a target of 85% for completion of safeguarding training, with the exception of Safeguarding Children (Level 1) which the trust set a target of 95% completion.

A breakdown of compliance for safeguarding courses between April 2016 and March 2017 for medical/dental staff in Medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>85%</td>
<td>225</td>
<td>269</td>
<td>83.6%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>85%</td>
<td>267</td>
<td>324</td>
<td>92.4%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>85%</td>
<td>284</td>
<td>324</td>
<td>87.7%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>85%</td>
<td>179</td>
<td>324</td>
<td>55.2%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>281</td>
<td>324</td>
<td>86.7%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>85%</td>
<td>304</td>
<td>324</td>
<td>93.8%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>85%</td>
<td>270</td>
<td>324</td>
<td>83.3%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>296</td>
<td>324</td>
<td>91.4%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>284</td>
<td>323</td>
<td>87.9%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>299</td>
<td>324</td>
<td>92.3%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>213</td>
<td>323</td>
<td>65.9%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>85%</td>
<td>252</td>
<td>267</td>
<td>94.4%</td>
</tr>
<tr>
<td>CPR - Adults</td>
<td>85%</td>
<td>266</td>
<td>324</td>
<td>82.1%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85%</td>
<td>273</td>
<td>324</td>
<td>84.3%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>85%</td>
<td>293</td>
<td>324</td>
<td>90.4%</td>
</tr>
<tr>
<td>Local Induction</td>
<td>85%</td>
<td>101</td>
<td>116</td>
<td>87.1%</td>
</tr>
<tr>
<td>MCA DOLS Level 1</td>
<td>85%</td>
<td>294</td>
<td>324</td>
<td>90.7%</td>
</tr>
<tr>
<td>MCA DOLS Level 2</td>
<td>85%</td>
<td>282</td>
<td>323</td>
<td>87.3%</td>
</tr>
<tr>
<td>Prevent (Levels 1-2)</td>
<td>69%</td>
<td>242</td>
<td>324</td>
<td>74.7%</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>85%</td>
<td>253</td>
<td>286</td>
<td>88.5%</td>
</tr>
<tr>
<td>Oxygen Therapy</td>
<td>85%</td>
<td>308</td>
<td>324</td>
<td>95.1%</td>
</tr>
<tr>
<td>Collection of Blood Products</td>
<td>85%</td>
<td>1</td>
<td>4</td>
<td>25.0%</td>
</tr>
<tr>
<td>WHO Training</td>
<td>85%</td>
<td>13</td>
<td>13</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>5480</strong></td>
<td><strong>6460</strong></td>
<td></td>
<td><strong>84.8%</strong></td>
</tr>
</tbody>
</table>
The service had an overall completion rate of 63% for medical staff and this did not meet the 85% or 95% target for any of the Safeguarding modules. Safeguarding Adults (Level 2) had the lowest completion rate of 54%.

A breakdown of compliance for safeguarding courses between April 2016 and March 2017 for qualified nursing & health visiting staff (Qualified nurses) in Medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>88</td>
<td>137</td>
<td>64.2%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>43</td>
<td>80</td>
<td>53.8%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>96</td>
<td>139</td>
<td>99.1%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>81</td>
<td>137</td>
<td>59.1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>308</td>
<td>493</td>
<td>62.6%</td>
</tr>
</tbody>
</table>

The trust had an overall completion rate of 84% and did not meet the 85% or 95% target for any Safeguarding modules. The training module that had the lowest completion rate was Safeguarding Children (Level 2) with 66% completion rate.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

All the nursing staff we spoke with understood their responsibilities in terms of safeguarding adults and children. All the nursing staff we spoke with told us how they would report a safeguarding concern and what they would report.

There was a designated safeguarding lead within the hospital. Staff we spoke with knew who the lead was and described how they would contact them.

Two nursing staff told us they had recently raised a safeguarding concern. Staff said the safeguarding team had been “Very supportive” and both staff said they had received feedback on the safeguarding outcome via email from the safeguarding team.

**Cleanliness, infection control and hygiene**

There were reliable systems in place to ensure that standards of hygiene and cleanliness were maintained and systems in place to prevent and protect people from health care associated infections.

All ward areas we visited were visibly clean. Staff completed hand hygiene before and after contact with patients. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.

Staff washed their hands in line with the World Health Organisation’s “Five Moments of Hand Hygiene” guidance between personal care activities with patients and utilised the hand sanitiser where appropriate.

Clinical staff arms were “bare below the elbows” in line with guidance from the Department of
Health (2008) and wore uniforms in line with trust policy. Staff wore appropriate personal protective equipment when treating patients.

Hand hygiene compliance audits carried out by the trust within the medicine division showed that within the four months June 2017 to September 2017 the stroke unit (Paglesham and Benfleet wards) consistently scored an average of between 80% and 90% compliance against a trust target of 90%. All the other medical wards who submitted data scored 100% compliance during the same period.

Nursing staff displayed ward cleaning audit scores in the ward entrance. In November 2017, acute medical unit (AMU), Paglesham and Benfleet (stroke unit) scored 98%, Rochford, Westcliff, and Windsor scored 97%, this was above the trust target of 95%.

We reviewed equipment such as blood pressure monitors, hoists, scales and walking aids. All the items were visibly clean and displayed green “I am clean” stickers with the date of cleaning to items to identify those that had been cleaned and were ready for use.

Nursing staff cared for patients who were at high risk of contracting an infection or who had an infectious illness in side rooms with doors closed to minimise the risk of infection. Medical staff identified two patients requiring increased infection prevention control. We observed nursing staff using personal protective equipment (PPE) in the form of disposable gloves and aprons when providing care to these patients. We observed one patient had a visitor who was also wearing an apron and gloves.

Medical staff had identified one patient on Benfleet ward who required isolation. Nursing staff cared for the patient in the side room but the room door was open. We spoke with the ward manager who told us that the patient kept opening the door because they did not like having it closed but assured us they would speak with the patient again regarding risk of infection.

**Environment and equipment**

During our inspection, we visited nine wards, the medical admissions unit (MAU), the day assessment unit (DAU) and the discharge lounge.

Information supplied by the trust stated equipment requiring planned and reactive maintenance was managed through the electronic asset management system. Each asset had a scheduled planned maintenance record to indicate to each technical team when maintenance was required.

We reviewed equipment such as blood pressure monitors, hoists, scales and walking aids. All the items had been calibrated and or serviced in the correct period. However, nursing staff on Benfleet ward stored equipment such as drip stands, walking frames and wheel chairs in an empty bed bay and in the corridor due to lack of storage space.

Resuscitation equipment was visibly clean and was stored in an accessible location on all the wards we visited. Staff carried out daily checks on resuscitation equipment. Staff completed daily records without omission for October and November 2017 on all the wards we visited and staff recorded when they removed or replaced equipment.

The service used pressure relieving boots and pressure relieving air mattresses to manage patients who were at risk of developing pressure ulcers. Staff had access to this equipment 24 hours a day, which is in line with the Royal College of Nursing guidance *(RCN, Management of pressure ulcers, 2005)* Nursing staff identified patients at risk of developing pressure sores using the Waterlow risk assessment scores.
Curtains providing privacy around patient beds appeared visibly clean throughout the wards. Curtains displayed the date of replacement and we found all curtains to be within replacement date and in good condition.

All wards utilised wipe clean white boards to display key information such as the nurse in charge, the number of staff planned and actual staff on duty. Signage was clear and enabled staff, patients and relatives to see the number of staff on duty, identify staff roles, and see who was in charge of the department.

Staff managed clinical waste in line with trust guidance. Waste bins were appropriately colour coded for the appropriate waste disposal method and we noted bins routinely emptied by domestic staff during our inspection. Nursing staff correctly labelled and secured sharps bins. Staff did not overfill any of the sharps bins.

The stroke rehabilitation ward met most of the needs of patients; however, the quiet room used for assessments and difficult conversations was not appropriate, as the walls needed repairing. Staff told us that the kitchenette on the ward did not have a cooker; they were not always able to fully assess how patients would cope when living alone in the community.

No ward areas we visited utilised the secure entry system and people were able to enter and leave wards without staff being aware. This represented a number of risks including if a patient was confused and wandered or if there was an infection control risk. Buzzer entry systems were in place but were not used. We raised our concerns with ward managers who told us wards were “open” during the day and closed at night or when there was a patient at risk of wandering. We were not assured the trust had considered the risk of unsecured access to wards. We raised our concerns with the executive team who arranged for an audit of all ward areas to assess the situation. After our inspection, the trust supplied us with an action plan that demonstrated that appropriate risk assessments had been taken and the trust planned to introduce an enhanced security system.

Assessing and responding to patient risk
Nursing and medical staff generally assessed patient risks appropriately including deteriorating health and wellbeing. However, there were examples where there was a lack of appropriate response to identified patient risks. Medical and nursing staff told us that they felt this was due to the lack of nursing staff across medical wards. For example, not always being able to provide one to one nursing for patients identified as requiring additional support with mobility.

Staff had 24-hour access to onsite level 2 and 3 critical care facility for patients who required additional care interventions such as ventilation.

All the medical records we reviewed confirmed that medical staff saw and assessed new admissions within 12 hours in line with National Institute for Health and Care Excellence (NICE) guidelines. Nursing staff wrote the surnames of new patient admissions and medical outliers on the ward white board in a different colour. This meant that everyone on the ward was responsible for ensuring the patient had received a timely medical review. Medical outliers are medical patients who are being nursed on surgical wards.

Medical patients had a medical review once every 24 hours and this was evidenced in all the patient medical records we reviewed. Doctors reviewed patients on the acute medical unit (AMU) twice per day. However, we were aware of a stroke outlier patient who had not received a medical review for two days. We raised this with the ward manager at the time who assured us they would arrange a medical review immediately.

The NHS services, seven days a week priority clinical standard two states that “all emergency admissions are seen by a consultant within 14 hours of arrival at the hospital”. All the medical
records we reviewed evidenced that the medicine directorate was meeting the standard.

Nursing staff carried out risk assessments to identify patients who were at risk of pressure sores, falls and malnutrition. We observed that patients identified as increased risk of pressure sores had pressure-relieving boots to protect their ankles and pressure relieving air mattresses.

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

Staff used hand held electronic devices to record patients’ NEWS scores. When scores indicated a deteriorating patient, the nurse was prompted to follow an escalation pathway. The electronic device automatically sent alerts to the “Nerve centre” where the senior nurses would receive an alert to the scores.

All the wards we visited had a named sepsis champion. Sepsis champions are staff members that undertake sepsis training and in turn provide sepsis training to other staff members in their department or ward. We observed nursing staff using the sepsis six screening tool. A NEWS score indicative of sepsis sent an automatic electronic alert to the “Nerve centre” and prompted the nurse to seek medical input for the patient concerned.

Nursing staff on Paglesham ward identified patients who required one to one nursing care. However, nursing staff told us that as there were not enough nursing staff available to do this and the service had implemented a “bay watch” scheme where one registered nurse (RN) or health care assistant (HCA) supervised the whole bay. There were periods throughout our inspection when neither care plan was in use or when the supervising staff member was behind the curtains helping delivering care to a patient.

We observed a patient who should have been receiving one to one nursing have a fall while visiting the bathroom alone. This was not in line with the patient’s care plan. The trust told us one of their key priorities for patient safety was ‘to reduce in-hospital falls…’ and they had identified that one of the key themes for patient safety incidents was ‘patient, falls, slips and trips’.

Patients requiring enhanced personal care did not always receive the appropriate level care. For example, out of the five records we reviewed on Paglesham and Benfleet ward, one patient had not received 15-minute observations in line with their care plan and one patient was not receiving hourly mouth care in line with their care plan. The lack of appropriate mouth care for patients had been discussed at team meetings. Team meeting minutes from Paglesham and Benfleet ward, 2 November 2017, evidenced nursing staff were aware that there were issues with mouth care. Minutes stated, “Standards are slipping and some patient’s mouth care is disgusting,” and evidenced that the ward manager reminded nursing staff that mouth care was essential. Meeting minutes stated new mouth care guidelines and policies were being updated.

The stroke unit had an emergency phone, which provided direct contact between the emergency department and the stroke ward. This meant that the stroke consultant could be immediately alerted to any patient presenting with signs of a stroke in the emergency department.

Staff could access the trust wide specialist mental health team (the RAID team) if they had concerns about a patient’s mental health 24 hours a day, seven days per week.

We reviewed eight do not attempt cardio pulmonary resuscitation (DNACPR). Medical staff had completed them appropriately, evidenced discussions with family and signed and dated them.

**Nurse staffing**
We were not assured that nursing staffing levels and skill mix kept patients safe at all times especially on Paglesham and Benfleet wards. This represented a continued breach of regulation 18: staffing of the Health and Social Care Act 2008 regulated activities regulations 2014. The concerns around staffing levels had been raised at our previous inspections and the trust had embarked on a recruitment drive. Although staffing levels had improved, there were still significant shortages and staffing levels were still not meeting the needs of patients.

All the ward areas we visited reported unfilled nursing shifts in the 12 months prior to our inspection. The stroke unit had the most unfilled shifts with a total of 1034, an average of 86 unfilled shifts per month, respiratory unit 651, average 54 per month followed by Blenheim ward with 219 shifts unfilled, an average of 18 per month. The gastroenterology ward and the cardiac ward reported the least number of unfilled shifts with nine and two in total respectively.

Senior nursing staff used the ‘Safer Nursing Care Tool’ to determine nurse staffing levels for the medical service. The Safer Nursing Care Tool is an evidence-based tool that allows nurses to assess patient acuity and dependency and to use this to inform the number of staff needed. The trust used a staffing risk assessment tool that was discussed three times a day at daily bed meetings. The risk assessment supported senior staff to make a decision where to deploy staff when shifts were unfilled; it included the regular assessment of acuity level of patients to determine where there was the greatest need.

The trust has reported their staffing numbers below for the period August 2016 to July 2017 for Medicine. The trust had 69.6 less WTE qualified nursing & health visiting staff in post than planned as at July 2017.

<table>
<thead>
<tr>
<th>WTE Planned Staff</th>
<th>Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>359.9</td>
<td>290.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Most of the wards we visited had vacancies for either registered nurses (RN) or health care assistants (HCA). We noted during our inspection that some wards were understaffed against the planned establishment; in these cases, the trust employed agency or bank staff. Staffing and recruitment was a recognised risk on the local risk register and the trust wide risk register.

From August 2016 to July 2017, the trust reported a vacancy rate of 23.2% in Medicine. This is higher than the trust's overall target vacancy rate of 7%. (Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From August 2016 to July 2017, the trust reported a turnover rate of 1.3% in Medicine. This is lower than the trust's overall target turnover rate of 9.7%. (Source: Routine Provider Information Request (RPIR) P18 Turnover)

From August 2016 to July 2017, the trust reported a sickness rate of 4% in Medicine. This is higher than the trust overall sickness target of 3.5%. (Source: Routine Provider Information Request (RPIR) P19 Sickness)

From August 2016 to July 2017, the trust reported a total of 17,427 unfilled shifts for qualified nursing staff within the medicine core service of which 4,972 were covered by bank staff and 6,079 covered by agency staff, 3,137 shifts were left unfilled. (Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)
Nursing staff recorded their “Actual” versus “Planned” staffing ratio on a chart in the ward entrance and identified the ward staffing level to be “As planned,” “Satisfactory but being monitored” or “Below level and escalated”.

During our inspection, we found Windsor ward planned staffing was to have four registered nurses (RN) caring for 30 patients; however, staff told us that there were times when three nurses cared for 30 patients on Windsor ward, Paglesham ward had three RN caring for 26 patients (1:9), Eleanor Hobbs ward had five RN caring for 35 patients (1:7). This was not consistently in line with Royal College of Nursing (RCN) guidelines 2009 which recommends one RN to eight patients (1:8).

In October 2017, the trust had opened seven escalation beds on Paglesham stroke rehabilitation ward. This meant existing nursing staff were nursing 26 stroke patients and an additional seven medical patients without any additional staffing.

Nursing staff used a red, amber, green (RAG) rating system for staffing levels, red - below planned, amber – satisfactory and green – as planned. On the second day of our inspection nursing staff rated staffing levels on Benfleet and Paglesham ward (stroke unit) as red. This was because the unit was three health care assistants (HCA) and two registered nurses (RN) below planned staffing levels. We asked the ward manager how they would deal with the staffing issue and the manager said staff would move between the two wards to keep patients safe.

Nursing staff completed a handover of information between each shift, which included discussion of patient care, staffing issues and any patient safety issues.

Ward managers reported it was difficult to get agency staff to cover shifts during the weekdays but they could cover night and weekend shifts more easily due to the increased financial reward for those shifts.

**Medical staffing**

Despite the number of medical staff in post being lower than the establishment, there was evidence that medical staffing was generally meeting the needs of patients. At the time of our inspection, there were 39 medical vacancies across all grades. This was a reduction from 89 vacancies at our last inspection. The trust used locum doctors to fill shifts. From August 2016 to July 2017, the trust reported a monthly average of 17% unfilled medical shifts.

The trust has reported their staffing numbers below for the period from August 2016 to July 2017 for Medicine. The trust had 50 less WTE medical/dental staff in post than planned as at July 2017.

<table>
<thead>
<tr>
<th>WTE Planned Staff</th>
<th>Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>161.1</td>
<td>111.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From August 2016 to July 2017, the trust reported a vacancy rate of 14% in Medicine. This is higher than the trust’s overall target vacancy rate of 7%. (Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From August 2016 to July 2017, the trust reported a turnover rate of 2.4% in Medicine. This is lower than the trust’s overall target turnover rate of 9.7%. (Source: Routine Provider Information Request (RPIR) P18 Turnover)

From August 2016 to July 2017, the trust reported a sickness rate of 2.6% in Medicine. This is
lower than the trust overall sickness target of 3.5%. (Source: Routine Provider Information Request (RPIR) P19 Sickness)

From August 2016 to July 2017, the trust reported 6,825 unfilled shifts for medical staff in medical care core service. Of these shifts, 716 shifts were filled by bank staff and 4,267 by locum staff, 1,042 shifts were unfilled. (Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

During June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

### Staffing skill mix for the 173 whole time equivalent staff working in Medicine at Southend University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>28%</td>
<td>22%</td>
</tr>
</tbody>
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(Source: NHS Digital - Workforce statistics (01/06/2017 - 30/06/2017)

During our inspection, we spoke with 13 medical staff including consultants and junior doctors (FY1 and FY2). A Foundation doctor (FY1 or FY2) is a grade of medical practitioner in the United Kingdom undertaking the Foundation Programme, which is a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist and general practice (GP) training.

Medical staff worked on a rota system, which provided medical cover to the wards 24 hours a day, 7 days per week. Trust rotas for FY1, FY2, registrar, and GP trainee were 8am until 4pm or 9am until 5pm, 5pm until 9.30pm and 9pm until 9.30am during the week. Weekend cover was 9am until 9.30pm and 9pm until 9.30am. Junior doctors contacted consultants by mobile phone for advice and support.

Between 10pm and 8am, the trust operated an on call system out of hour’s team via the hospital switchboard. Nursing staff told us it was easy to obtain medical input overnight.

All the wards we visited had a resident consultant and a number of junior doctors based on the ward. Estuary short stay ward and the acute medical unit (AMU) had consultants rostered separately to cover each area. Estuary ward and the AMU each had three junior doctors. The acute medical unit (AMU) had two consultants between 8am and 4pm, one consultant from 10am until 6pm, and one consultant between 2pm and 10pm. Junior doctors from these wards were seconded into the medical outliers’ team. Consultants told us medical staffing was adequate to support this.
A medical handover took place every morning, seven days per week, which included discussion of clinical incidents, patient care plans, scans, and investigations requiring urgent review. The handover meeting also included a review of medical staffing gaps and agreed redistribution of doctors.

There were daily white board rounds on speciality medical wards, which included multidisciplinary discussion of each patient’s medical care and plans for discharge.

**Records**

Staff had access to all the information needed to deliver safe care and treatment in a timely and accessible way. This included test and imaging results, care and risk assessments, care plans and case notes.

The trust used paper based medical and nursing records and staff kept records in lockable trolleys within staff areas on each ward. However, staff did not lock records trolleys. We raised this with a ward manager who told us they were not locked because staff kept losing the keys but a recent request for key pads had been submitted to the trust.

The trust flagged patients living with dementia and or learning disability on the electronic patient administration system.

Nursing staff carried out monthly record audits on the completion of risk assessments for falls, nutrition, pressure ulcers and pain management. The trust set a compliance target of 85%. In September 2017, all medicine wards except Estuary exceeded the target. In October 2017, Windsor ward and Princess Anne ward did not meet the target and in November 2017, all medicine wards except for Princess Anne ward met the target.

Nursing staff had completed risk assessments for falls, pressure ulcers and nutrition in all ten of the records we checked. Nursing and medical staff had signed and dated records.

During our inspection, we reviewed ten paper based patient medical care records and five nursing care records for a selection of the wards we visited. All the records we reviewed were legible, clear and staff had signed and dated each entry.

Nursing staff stored patients’ daily care charts in a folder at the bottom of the patient’s bed. These included information such as records of observations, food and drink records and ‘Comfort’ checks (enquiring about the patients comfort, did they want to be moved, go to the toilet or want a drink).

All staff we observed closed computer screens and medical records when moving away from them in order to protect patient confidentiality.

**Medicines**

Nursing staff locked medicine trolleys when not in use and secured them to the wall or stored them in the locked clean utility room in all the wards we visited.

Nursing staff wore disposable red tabards to identify they were carrying out a drug round. This meant other staff knew not to interrupt them whilst carrying out a drug round.

Staff stored medicines securely. Controlled drugs (CDs) were stored behind two locked doors and staff could only access and administer CDs in pairs. This was true on all wards we visited.

We reviewed controlled drug (CD) records in all the wards we visited. One nurse from the outgoing shift and one nurse from the new shift checked and recorded the stock level of CDs at each shift change. We reviewed one CD at random in each ward and found the stock level had been recorded accurately and there were no omissions in records for November 2017.
Nursing staff monitored medicine fridge temperatures on a daily basis. There were no omissions for all of the fridges we reviewed for the three months September, October and November 2017. Nursing staff used an electronic prescribing and medicines administration system. Patients who required medicine had a red cross displayed on their electronic records. Once nursing staff had given the medication and updated the record a green tick was displayed.

Nursing staff recorded the patient’s allergy status on the electronic medicine management system. Nursing staff also recorded patient allergies on the patient care record.

Patients who were admitted to medical wards and were dependent on alcohol were offered medicines to assist their withdrawal. Medical staff had started one patient on the acute medical unit (AMU) on an alcohol withdrawal scheme and this was detailed in the patient’s care plan. This was in line with National Institute of Health and Care Excellence (NICE) guideline 100.

Incidents

All the nursing staff we spoke with knew their responsibility to report incidents internally and externally. Nursing staff described how to report incidents via the trust electronic incident reporting database and were able to describe what they would report.

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

From September 2016 to August 2017, the trust reported no incidents classified as never events for Medicine. Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)

In accordance with the Serious Incident Framework 2015, the trust reported 34 serious incidents (SIs) in Medicine that met the reporting criteria set by NHS England from September 2016 to August 2017.

Of these, the most common type of incident reported was:
Slips/trips/falls meeting SI criteria with 16 (47% of total incidents).
Pressure ulcer meeting SI criteria with six (18% of total incidents).
VTE meeting SI criteria with six (18% of total incidents).
All other categories with three (9% of total incidents).
Medication incident meeting SI criteria with two (6% of total incidents).
Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with
one (3% of total incidents).

(Source: Strategic Executive Information System (STEIS))

There was evidence that learning from incidents was used to improve patient care and safety. For example, the stroke ward introduced magnetic boards above the patient’s bed to indicate when the patient needed a specific diet. This was in response to a trend of incidents relating to diet and fluids.

We reviewed ward meeting minutes dated October 2017 and November 2017 for the stroke unit, Windsor ward (October 2017) and Eleanor Hobbs ward (August 2017) and noted nursing staff discussed incidents and shared learning from them.

Staff knew their responsibilities in relation to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

We reviewed a duty of candour letter sent by a consultant to a relative the day after a patient fall. The letter was clear and detailed with minimal medical jargon. The letter apologised, detailed actions the hospital was taking to investigate the incident and described the next steps with regard to keeping the relative informed and who they could contact for more information.

Consultants held monthly multidisciplinary team (MDT) morbidity and mortality meetings to review all inpatient deaths both expected and unexpected. We reviewed the minutes of the mortality surveillance group meetings dated 26 July and 4 October 2017. Minutes evidenced MDT input and clear areas for sharing learning and development.

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 27 new pressure ulcers, 18 falls with harm and 35 new catheter urinary tract infections from August 2016 to August 2017 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Southend University Hospital NHS Foundation Trust

Source: Safety thermometer - Safety Thermometer

Nursing staff collected information for the NHS safety thermometer, although this was not displayed on the wards we visited, and completed monthly nursing dashboards.

We reviewed the medicine wide nursing dashboard for September 2017, October 2017 and November 2017. Nursing staff recorded number of avoidable and unavoidable PUs and number of falls. We reviewed the senior sisters meeting minutes dated 24 April 2017, 27 July 2017 and 30 October 2017 which showed dashboards were discussed and actioned.

Is the service effective?
Evidence-based care and treatment

Nursing and medical staff delivered medical services in line with evidence-based practice and followed recognised and approved national guidance across the medical directorate. Nursing staff we spoke with had a good knowledge of guidelines, best practice and where to find guidance on the intranet system.

Nursing staff on the stroke unit described the pathways for both newly admitted stroke patients and patients who had a transient ischaemic attack (TIA) which met best practice National Institute of Health and Care Excellence (NICE) guidance.
The medical directorate had care pathways based on the NICE guidance for stroke patients, heart failure, diabetes, and respiratory conditions. The hospital contributed to national audits such as the renal registry. This meant that performance could be compared against other hospitals and when needed improvements made.

Nursing staff used the sepsis six screening tool, which is best practice for the early identification of sepsis.

**Nutrition and hydration**

Patients chose meals from a set menu supported by staff to make choices where required. Patients could ask for vegetarian, vegan, Kosher, Halal and soft options to promote their wellbeing and respect individual beliefs and cultures.

Nursing staff completed the Malnutrition Universal Screening Tool (MUST) to assess and record patients’ nutrition and hydration needs. Nursing staff had completed the MUST in all the care records we observed.

Nursing staff completed fluid balance and food charts appropriately in all the care records we reviewed. This ensured that staff were aware and had taken appropriate actions when there were any concerns about patients’ dietary and fluid intake. Patients had access to a jug of fresh water by their bedside.

The trust used a “Red tray” system to identify patients who needed additional support to eat their meals.

Patients we spoke with said staff gave them choices of food and snacks. Patients generally told us that the food was good quality and there was enough choice.

The hospital promoted “Protected mealtimes.” During lunch and evening meal times all non-urgent activity on the ward stopped so that nurses and ward assistants were able to help with the meal service and provide extra assistance for those patients that needed it.

The food and fluid intake record for one patient living with diabetes showed they had not eaten breakfast or dinner for two days. The patient’s named nurse explained they had requested a hardboiled egg; however, the catering staff were unable to provide hard-boiled eggs. The patient had been receiving overnight tube feeds to meet their nutritional needs.

On Paglesham and Benfleet wards, nursing staff displayed magnetic symbols depicting a plate and a knife and fork above the bed of any patient who needed help with feeding, liquid diets and thickened fluid. Nursing staff told us the hospital was planning to roll this out across all medical wards.

The hospital had ‘Feeding buddies’ to assist patients who struggled to feed themselves. The feeding buddies were volunteers trained to assist with patient eating and drinking on the stroke wards and elderly care wards. However, we did not see any feeding buddies during our inspection.

A nutritional specialist attended the multidisciplinary meeting to provide advice and support. In addition catering staff would visit the ward weekly to discuss the ongoing dietary needs of their patients.

**Pain relief**

We were satisfied that nursing staff assessed and managed patient pain levels appropriately. The trust had an acute pain team, who provided specialist advice on pain management. The team
included a consultant anaesthetist and specialist nurses

Nursing staff asked patients if they were in any pain hourly. All the care rounding records we reviewed showed that patients had been asked whether they were in any pain at regular intervals throughout the day.

We observed nursing staff asking patients about their pain level. All the patients we spoke with said that staff managed their pain well and that “Nurses are always asking me if I am in any pain.”

Nursing staff used pictorial prompt cards and the Abbey Pain Assessment tool to enable patients with communication difficulties to express their pain.

**Patient outcomes**
The trust regularly reviewed the effectiveness of care through the collection and monitoring of patient outcomes and participation in local and national audit.

**Trust level**
From June 2016 to May 2017, patients at the trust had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Patients in clinical oncology (previously radiotherapy) had a lower than expected risk of readmission for elective admissions

Patients in general medicine had a higher than expected risk of readmission for elective admissions

Patients in clinical haematology had a lower than expected risk of readmission for elective admissions

Patients in general medicine had a higher than expected risk of readmission for non-elective admissions

Patients in geriatric medicine had a higher than expected risk of readmission for non-elective admissions

Patients in rheumatology had a higher than expected risk of readmission for non-elective admissions

**Elective Admissions – Trust Level**

**Non-Elective Admissions – Trust Level**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (June 2016 – May 2017))

Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in the latest audit, April 2017 to July 2017. This is an improvement on the previous quarter where a grade B was achieved.

Performance for Patient Centred discharge processes improved from a grade C in the previous quarter to a grade A. Performance for Team Centred at the Stroke unit also improved from a Grade D in the previous quarter to a grade C.

Southend Hospital
In-hospital Care Scores

Results for Southend University Hospital NHS Foundation Trust in the 2015 Heart Failure Audit were worse than the England and Wales average for two of the four of the standards relating to in-hospital care.

Discharge Scores

Results for Southend University Hospital NHS Foundation Trust results were worse than the England and Wales average for three of the seven standards relating to discharge.
The trust’s performance was 87.2% for average for Referral to HF liaison service (LSVD only) which was better than the England and Wales of 70.8%. SOURCE: NICOR - Heart Failure Audit (April 2014 – March 2015)

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric, which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 80 in-patients with diabetes at the trust, 81.4% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile four. (Source: NHS Digital)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2014 to March 2015, 75.3% of nSTEMI patients were admitted to a cardiac unit or ward at Southend Hospital and 96.8% were seen by a cardiologist or member of the team compared to an England average of 55% and 95.1% respectively.

The proportion of nSTEMI patients who were referred for or had angiography at the trust was 97% compared to an England average of 79%.
The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 40%, which was worse than the audit minimum standard of 90%. The 2015 figure was 0%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 16.6%, this is not significantly different than the national level. The 2015 figure was 16.0%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 62.9%, this is not significantly different to the national level. The 2015 figure was 58.0%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 57.1%, this is not significantly different than the national level. The 2015 figure was 52.0%.

The one year relative survival rate for the trust in 2016 is 34.4%. *(Source: National Lung Cancer Audit)*

The trust registered for the 2015 National Audit of Inpatient Falls but did not submit data. *(Source: Royal College of Physicians)*

The trust was identified as a Dr Foster mortality outlier for acute bronchitis. Consultants we spoke with described how this had been because of a coding issue and they had implemented changes to address this. For example, identifying end of life patients sooner and starting palliative care pathways, making sure patients are being nursed on the correct ward and ensuring do not attempt cardio pulmonary resuscitation (DNACPR) documents are filled in correctly where appropriate.

Nursing staff discussed audit outcomes and actions at team meetings, 16 August 2017, 31 October 2017 and 2 November 2017.

**Competent staff**

Staff had the appropriate skills, knowledge and experience to deliver effective care and treatment.

The trust employed specialist nurses to provide support to nurses caring for patients who were living with specific conditions, including dementia and learning disability.

From April 2016 to March 2017, 69% of staff within Medicine at the trust had received an appraisal compared to a trust target of 73%.

A split by staff group can be seen in the graph below, however, the data supplied by the trust did not highlight the rate for medical staffing group specifically:  

<table>
<thead>
<tr>
<th>Southend Hospital</th>
<th>401</th>
<th>401</th>
<th>203 (203)</th>
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<tr>
<td></td>
<td>96.8%</td>
<td>75.3%</td>
<td>97% (No data)</td>
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<table>
<thead>
<tr>
<th>England: overall</th>
<th>45500</th>
<th>45500</th>
<th>38099 (38099)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>95.1%</td>
<td>55%</td>
<td>79% (No data)</td>
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The trust was not meeting the target for medical directorate staff appraisal. However, all the nursing staff we spoke with confirmed they had received an annual appraisal or had one scheduled. Staff told us that as part of their appraisal, they discussed their development and any training needed for their revalidation.

We reviewed team meeting minutes (August 2017 and October 2017) showing ward managers reminded staff to complete training, encouraged them to nominate themselves as link nurses and sign up for additional training, for example diabetes care. Link nurses act as a link between their own clinical area and the specialist team. For example, an infection prevention control link nurse role is to increase awareness of infection control issues in their ward and motivate staff to improve practice.

On Paglesham ward, we spoke with the health care assistant (HCA) supervisor. This was a new post and the role involved supporting HCAs working towards developing new competencies. The HCA supervisor and the ward manager told us the role was having a positive impact on the HCAs.

Throughout the wards we visited, posters displayed the times for junior doctors’ protected learning hours. One junior doctor told us they had a “Good learning experience” and had been involved with daily ward rounds, attended three one-hour teaching sessions per week and were able to take study leave. Junior doctors could also attend the Journal Club on Fridays.

A ward manager explained that an incident investigation identified that an HCA required more training to increase their skills. The HCA repeated some training modules and shadowed another staff member until they were deemed competent.

We spoke with one trainee nurse who told us they had two mentors and had been very well supported by nursing staff and medical staff. The trainee nurse worked on all shifts but was always supervised by a named nurse and was never left alone.

**Multidisciplinary working**

Medical staff delivered care in a coordinated way with the involvement of different teams and specialities. There was effective multidisciplinary working across the service.

The service held weekly multidisciplinary team (MDT) meetings to discuss, in detail, the needs of patients. All members of the MDT were involved with assessing, planning and implementing patient care. Nurses, consultants, occupational therapists (OT) physiotherapists, social workers, and the discharge facilitator attended the meetings.

Staff recorded details of the MDT meeting electronically and copies given to the patient and sent to their GP. There was evidence of discussion at MDT meetings in all patient medical records we
reviewed.

A nutritional specialist attended the monthly MDT meeting to provide advice and support to medical and nursing staff. In addition catering staff would visit the ward weekly to discuss the ongoing dietary needs of their patients.

We saw the daily inpatient board rounds and routine ‘Red to Green’ patient management meeting during the daily meeting. However, nursing staff on Eleanor Hobbs ward told us the board round was too early and medical staff had not had chance to complete their rounds before the meeting meaning they did not have all the necessary information required.

Wards had access to a range of allied health professionals and nursing staff described good collaborative working practices between the teams. All staff described teams working well together and sharing best practice to improve patient outcomes.

The discharge facilitator liaised with all staff groups and external care providers to ensure a smooth discharge for patients and the early discharge support team liaised with wards daily to help get medically fit patients discharged earlier.

**Seven-day services**

The trust was meeting the NHS services, seven days a week forum’s seven day services for time to first consultant review and ongoing patient medical review.

The medicine directorate had access to physiotherapy and occupational therapy services seven days a week.

Speech and language therapy (SALT) was available Sunday to Friday from 8.30am until 4pm.

Medical staff told us the lack of SALT services over the weekend meant that any suspected stroke patients admitted on a Friday evening remained nil by mouth until Monday when the SALT team could assess their swallow reflex. We observed in two patient records that patients had been nil by mouth from Saturday until Tuesday when they were reviewed by the speech and language therapy (SALT) team.

Physiotherapists provided physiotherapy services seven days per week from 8am until 4 pm Monday to Friday and Saturday and Sunday mornings.

Occupational therapy (OT) services were available Monday to Friday 8am until 4pm. The OTs provided on call cover at weekends in order to meet new admission patients within 12 hours of admission.

Magnetic resonance imaging (MRI) scanning was available for stroke patients seven days per week with an on call service overnight.

The trust thrombolysis service was consultant led and available 24 hours seven days per week.

**Health promotion**

The trust used a “#EndPJparalysis” initiative. Staff displayed posters throughout wards encouraging patients to “Get up get dressed.” Getting up and getting dressed is believed to result in a quicker recovery, maintaining normal routine and returning home quicker.

Occupational therapists had access to kitchenettes to support patients in regaining their independence in making hot drinks and snacks before discharge.
The trust utilises the services of a Specialist Advisor working for the local stop smoking service to give support and information to patients who smoke and to also provide nicotine replacement where appropriate.

The trust’s catering company utilised a steam cooking system to provide meals for patients. Meals are steamed so they are cooked fresh and maximise the nutritional value. The aim of this process is to promote healthy, wholesome food.

**Consent, Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS)**

From April 2016 to March 2017, 91% of qualified nursing staff and 67% of medical/dental staff within Medicine completed MCA DoLs Level 1. 87% of qualified nursing staff and 55% of medical/dental staff had completed MCA DoLs Level 2 compared to the trust target of 85% for Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training. *(Source: Trust Routine Provider Information Return)*

The Trust’s policy for Consent to Examination or Treatment and the policy for the Mental Capacity Act (MCA) 2005 set out the approach on how staff should assess whether patients had the capacity to consent.

Nursing staff we spoke with about mental capacity understood the relevant consent and decision-making requirements, in line with legislation and guidance.

We reviewed five MCA and DoLS records. Medical staff had completed them appropriately, evidenced discussions with family and signed and dated them.

We observed nursing staff seeking patient consent verbally or implied before carrying out care.

**Is the service caring?**

**Compassionate care**

During our inspection, we spoke with 18 patients and 17 relatives or carers.

We observed staff being polite and courteous to patients and respond compassionately to patients’ needs throughout our inspection.

We observed a health care assistant (HCA) comforting a patient who was distressed, holding their hand and speaking reassuringly to them until they calmed down.

Nursing and medical staff preserved patient privacy and dignity by closing curtains before carrying out care and asking permission before entering patient rooms and curtained bed spaces.

Nursing staff closed bay and side room doors while having “white board” meetings in order to protect patient confidentiality.

Nursing staff drew curtains around patient beds and offered blankets to put over patient legs when they were sitting out in their chairs to promote privacy and dignity.

The Friends and Family Test response rate for Medicine at the trust was 22%, which was similar to the England average of 25% from September 2016 to August 2017.

**Friends and family Test – Response rate between September 2016 and August 2017 by site**
Four out of five patients we spoke with on Eleanor Hobbs ward described the care they had received as “Exemplary”, “First class” and “Couldn’t ask for better.”

Five out of six patients on Windsor ward gave positive feedback about their care and used words like “Terrific” and “Excellent”

Three out of four patients we spoke with on Paglesham ward told us their care had been good and that the nurses were kind and helpful.

However, friends and family test (FFT) response rates were low across medical wards in November. Rochford and Westcliffe wards had only one response, Windsor ward had eight
responses, acute medical unit (AMU) had ten responses and Eleanor Hobbs ward had 23 responses.

Two relatives of patients told us that their loved ones had not received personal care in a timely manner, which had been distressing for the patient and family members. Both relatives had made formal complaints to the trust.

**Emotional support**
The trust wide chaplaincy department provided for pastoral, spiritual and religious needs and supported staff, patients, relatives, friends and visitors of all faiths and none.

The trust wide specialist mental health team (the RAID team) provided mental health assessment and treatment to patients throughout the trust, 24 hours a day, seven days per week.

The hospital offered a trust wide bereavement service in a dedicated bereavement suite.

Two relatives told us that nursing staff had offered to arrange spiritual support for them and their family member.

In the department of medicine for the elderly (DME) patients could be referred to the community mental health team. There was a nurse-led follow up memory clinic once a week and a telephone helpline for patients and carers where people could gain information or discuss problems.

The trust employed specialist nurses to provide practical and emotional support to patients with specific conditions, including patients living with dementia and patients with a learning disability.

**Understanding and involvement of patients and those close to them**
All the patients we spoke with said they had felt involved in their care planning and decision-making.

All the wards we visited had open visiting hours and nursing staff told us about the availability of fold up guest beds used in side rooms for family to stay overnight with their relative.

A wide range of information was available to patients and their families on large notice boards and leaflet racks on the wards and visitor waiting areas. The notice boards were clearly visible and accessible for patients and families.

Nursing staff on Windsor ward offered daily half hour information sessions for relatives and carers. Sessions included information on dementia, nutrition and swallowing as well as topics suggested by relatives and carers.

However, two relatives told us during the inspection they had found it difficult to speak to a medic about the care of their family member in a timely way.

**Is the service responsive?**

**Service planning and delivery to meet the needs of the local people**
The trust had systems and process in place to manage admissions, discharges, and peaks of patient admissions for example the use of the early supported discharge team, the discharge facilitator and the use of escalation beds.
The day assessment unit (DAU) provided an alternative to acute admission for individuals with complex co-morbidities and frailty. This meant patients had access to early intervention from other services such as occupational therapy (OT) and physiotherapy.

The stroke team had a seven-day transient ischaemic attack (TIA) clinic that general practitioners could access electronically. The GP could use the electronic system to assess and identify patient risk and priority of appointment.

The ambulatory care unit, where patients referred from their GP were triaged, was open from 9am until 8pm Monday to Friday and 9am until 8.30pm at weekends. Nursing staff cared for patients with falls, dementia, confusion and social and psychological problems among other conditions before they were admitted or discharged to suitable places of care.

**Trust Level**

From July 2016 to June 2017, the average length of stay for medical elective patients at the trust was 3.9 days, which is similar to the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 4.8 days, which is lower than the England average of 6.6 days.

Average length of stay for elective specialties:

Average length of stay for elective patients in Clinical Oncology (Previously Radiotherapy) is higher than the England average.

Average length of stay for elective patients in General Medicine is higher than the England average.

Average length of stay for elective patients in Medical Oncology is similar to the England average.

Average length of stay for non-elective specialties:

Average length of stay for non-elective patients in General Medicine is lower than the England average.

Average length of stay for non-elective patients in Stroke Medicine is similar to the England average.

Average length of stay for non-elective patients in Geriatric Medicine is lower than the England average.

**Elective Average Length of Stay – Trust Level**

**Non-Elective Average Length of Stay – Trust Level**
Meeting people's individual needs
The hospital had specialist nurses in place to support the care of patients with complex needs. These included a specialist falls nurse, a learning disability nurse and a dementia lead nurse.

The trust told us any patient identified as living with a learning disability or dementia would be assessed by the relevant nurse specialists. There were relevant care plans, pathways and policies that staff utilised to enhance care for patients with complex needs.

Staff identified patients living with dementia using a 'Forget-me-not' symbol on the patient information board. However, this was not displayed above their bed. This meant that staff could not easily identify patients who may have complex needs due to dementia. We asked the ward manager why they did not use the forget me not symbol above the patients bed; they explained it was because they did not have a forget me not magnetic symbol now but they were on order.

The hospital had “This is me’ booklets which family members could complete to give staff information on the needs and preferences of patients living with dementia.

Nursing staff gave patients living with dementia a newsletter called “The Daily Sparkle” which encouraged patient engagement, orientation and reminiscence. This was a daily newsletter, which included the day’s date and features titled “On this day” and “Do you remember.”

Nursing staff encouraged relatives to bring in items that were familiar to their family member. Some patients had fleece blankets and small teddy bears on their beds. Nursing staff told us this often comforted and calmed the patient.

We observed staff supporting a patient living with dementia to colour in pictures and on Benfleet ward, staff used knitted pieces of fabric called ‘twiddlemuff’ comforters for patients living with dementia to provide sensory stimulation and reduce distress.

Nursing staff on Windsor ward fundraised to develop a reminiscence room. This was a comfortable room where patients could play old-fashioned games, read books and generally spend time relaxing away from the bedside.

We spoke with one volunteer who attended the ward in a befriending capacity two mornings per week to read and chat with patients.

The home from hospital team helped patients with complex needs to settle back into their homes after discharge from hospital. This team supported patients by taking equipment to the patient’s home, ensuring that heating and hot water was turned on and helping patients to make a meal when they returned home.

There was an interpretation service available for patients and their families who did not have English as their first language. Staff told us that although they had used this service the hospital had a multi-cultural staff and they were usually able to get a member of staff to translate.
We spoke with the learning disability nurse who told us that any patient with a learning disability (LD) was ‘flagged’ on the hospital computer system. This meant that the specialist nurse was aware of any patient with a learning disability admitted to the hospital and could provide appropriate care and support within 24 hours. The learning disability nurse had made a game of bingo in preparation for the admission of a patient with a learning disability who enjoyed playing the game while they were in hospital.

Nursing staff gave patients living with a learning disability a booklet called a hospital passport to be completed by their carers. This included important information for example, how the patient communicated, their preferred name, and what they liked to eat.

**Access and flow**

Patients were usually admitted to the medical wards from the emergency department (ED), the short stay medical unit (estuary ward) or via the acute medical unit (AMU). The AMU also admitted patients via their own GP making a direct referral to the unit.

Estuary short stay medical unit took patients from the emergency department or the AMU for a maximum of 72 hours for assessment.

Medical wards used the “Red to green” system as recommended by NHS England to help the flow of patients through to discharge by providing a visual management system to assist in the identification of wasted time in a patient’s journey. A red day is a day where a patient is not receiving care that can only be provided an acute setting. For example, patients who are medically fit to be discharged into a community care setting or home with a defined support package. A green day is when the care and treatment delivered can only be delivered an acute setting and adds value to the patient’s recovery. Nursing staff felt the system was working well.

Staff discussed patients’ discharge dates at daily ward rounds and multi-disciplinary team (MDT) meetings in the presence of social services, the discharge facilitator, and occupational therapists. This was to ensure those patients who were medically fit could be prioritised to leave the hospital.

Nursing staff told us that the main reasons for delayed transfer of care (DTOC) was difficulties in arranging care packages and placements in care settings outside the hospital. We reviewed the medical records of one patient who had been medically fit for two weeks but was unable to be found a placement in a care setting. One relative told us that their family member had been waiting for a care placement for over a week.

The trust had introduced a discharge facilitator who liaised with external organisations such as care homes and agencies to speed up and coordinate the discharge process. Ward managers told us that since the development of the discharge facilitator post, complaints about patient discharge had significantly reduced. Nursing staff told us the discharge facilitator role was working well and we saw this was recorded in the minutes of a ward team meeting.

Medical outliers are medical patients who are being nursed on surgical wards. During our previous inspection in February 2017, we raised our concerns regarding the management of medical outliers. During this inspection, we saw some improvement had now been made, however, processes were still being embedded and there were still some areas for further improvement.

The trust monitored medical outlier numbers on a weekly and monthly basis. From June 2017 to October 2017 the trust recorded the lowest number of medical outliers in August (184) and the highest in June (698). Since our previous inspection, the service had introduced a ‘buddy ward’ system in February 2017 where resident consultants reviewed outlier patients and their ‘buddy wards’ did the same. However, there were still large numbers of medical outliers and we saw some examples where the processes in place needed further development.
For example, the medical directorate had a large number of medical outliers on day one (70 outliers) and day two (67 outliers) of our recent inspection. Our review of patient records confirmed that a stroke patient being nursed on a surgical ward had not received a medical review for two days, despite being seen by physiotherapy and other specialities. We raised this with the ward manager who assured us they would contact the medical outlier team immediately. We raised our concern with the executive team who confirmed that although patients were reviewed by the resident speciality there was no formalised process for consultant-to-consultant medical handover. After our inspection, the trust sent us an action plan evidencing plans to develop a formalised process and present it at the next consultant meeting. The executive team informed us of a proposal drafted to implement a dedicated consultant led outlier team. On our return announced visit (4 December 2017), we found that this process had been implemented and the service had plans to audit and review the process on a regular basis.

Six wards used the ‘buddy ward’ system where resident consultants reviewed outlier patients on that ward. Medical staff told us they thought the outlier team was a good idea and said it had a positive effect on patient care. Nursing staff told us they liked the medical outlier team, as they knew who to contact and the team provided continuity of care as the patient was reviewed by the same consultant team each time.

These processes had yet to be embedded and medical staff gave examples of patients who had not been cared for appropriately due to being an outlier. One patient did not receive a timely medical review and therefore missed their medicine. One patient had elevated early warning scores and was reviewed by a junior doctor who did not consult with the medical consultant and the patient received the wrong care.

We were not assured the trust used escalation areas appropriately. The trust had recently opened seven escalation beds on Paglesham ward and ten escalation beds on Estuary ward. Medical staff told us that on day one of opening the escalation ward was fully staffed but from day two onward nursing staff from the ward staffed the unit. This meant on Paglesham ward, the nurse to patient ratio was increased to one registered nurse (RN) to nine patients this was not in line with the Royal College of nursing (RCN) guidelines of one RN to eight patients.

The Department of Health required all providers of NHS-funded care to confirm by 1 April 2011 that they were compliant with mixed sex accommodation except where it was in the patient’s best interests or reflected their choice. A breach of ‘mixed sex accommodation’ refers not only to sleeping arrangements but also bathrooms and toilets and the need for patients to pass through areas for the opposite sex to reach their own facilities.

On day two of our inspection, we observed nursing staff caring for two female patients in a male patient bay on Benfleet (the acute stroke unit). This was because both patients needed increased monitoring and there were no beds available in the female bay. We spoke to the ward manager about this who assured us that the both the female and male patients had signed consent forms agreeing to be cared for in mixed sex accommodation. Both female patients had care plans in place, which confirmed they would be moved into female accommodation as soon as possible pending the outcome of diagnostic tests.

The stroke unit provided rapid access treatment for transient ischaemic attack (TIA) patients. If a patient presented at their GP with symptoms of TIA the GP could send an electronic request to the stroke unit. Patients identified by the electronic triage system as being at high risk came to the emergency department (ED) immediately and met by a stroke consultant. Patients identified as low risk were started on a course of treatment at the GP service and advised to make an appointment to attend the stroke clinic. This system reduced the risk of patients suffering a stroke.

Nursing staff arranged for patients awaiting discharge to be cared for in the discharge lounge. The discharge lounge had nine comfortable chairs for patients and could access beds for those
patients who were unable to sit in a chair.

The stroke unit had an early supported discharge (ESD) team that was made up of a consultant, nurse, occupational therapist, physiotherapist, speech and language therapist and had access to a psychologist. The ESD team enabled those patients with slight to moderate difficulties following their stroke to be discharged earlier and receive their therapy at home.

The day assessment unit (DAU) was open from 9am until 8pm Monday to Friday and provided frailty assessment for the elderly via referrals from their own GP. Occupational therapists (OT) physiotherapists and social workers along with nursing and medical staff carried out rapid assessments of patients and arranged discharge to respite care or an overnight stay on Princess Anne ward or Windsor ward. Nursing staff told us the DAU prevented medical admissions of patients who only needed medicine reviews for multi-morbidities.

On the second day of our inspection, the executive team declared the hospital was on black alert. This is the highest level of alert, which usually means the trust has met their bed capacity and that patients arriving at the ED may have to go to another hospital.

From September 2016 to August 2017, 92% of individuals did not move wards during their admission, and 8% moved once or more. (Source: Trust Routine Provider Information Return)

The trust’s referral to treatment time (RTT) for admitted pathways for Medicine over the 12 months from August 2016 to July 2017 have been consistently better than the England average. The latest performance for July 2017 showed 97% of patients were treated within 18 weeks versus the England average of 90%.

(Source: NHS England)

All four specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Medicine</td>
<td>100%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>100%</td>
<td>92.1%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>100%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>99.6%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Learning from complaints and concerns

From August 2016 to July 2017, there were 160 complaints about medical care. The trust took an average of 87 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 days or no fixed amount of days.
for complex cases.
The top three subjects of complaints were:

- All aspects of clinical treatment – 95
- Admissions, discharge and transfer arrangements – 33
- Communication/ Information to patients (written and oral) – 11

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The hospital had a trust wide complaints policy. We observed leaflets called “Making a complaint about the NHS” available in all the wards we visited.

Minutes of the medicine governance committee meeting dated 5 September 2017, 4 October 2017 and 1 November 2017 evidenced the committee had oversight of the complaints and the themes received by the medicine directorate.

Nursing staff discussed complaints at team meetings and there was evidence of changes in process because of complaints. For example, reminding nursing staff to be quieter during the night shift. Minutes of ward staff meetings (August 2017) evidenced there was learning and sharing from complaints.

All the nursing staff we spoke with said they would try to resolve complaints at the bedside but would escalate to senior nurses if they were unable to resolve it.

All the patients we asked told us they knew how to raise a concern or complaint.

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**Is the service well-led?**

**Leadership**

The clinical director with support from the associate director and the head nurse led the medical directorate. The assistant director of operations had oversight of the directorate and the director of operations position was vacant at the time of our inspection.

Nursing staff reported to the senior ward sister who reported to the matron. The matron reported to the head nurse who reported to the clinical director and director of nursing. This meant there was ward to board communication.

The executive team told us that they felt consultants were disengaged with the Mid and South Essex Sustainability and Transformation Plan (STP). Consultants told us they were fully engaged with the plan as long as patient safety was not compromised.

The trust told us all senior nurses trust wide, band 7 and above, are in the process of completing the mandatory leading better care programme as part of the succession planning process.

In the 12 months prior to our inspection, we received two whistleblowing enquiries describing alleged bullying by the executive team towards staff members.

Two matrons and one ward manager told us nursing staff were not familiar with the executive team and the executive team was a “bit invisible” and that nurses on the ward “would not recognise them”

All the nursing staff we spoke with were positive about their relationship with their immediate team and line manager.

**Vision and strategy**

The trust had a trust wide statement of vision and values but did not have a medicine specific vision. The hospital was working towards the establishment of the Mid and South Essex Sustainability and Transformation Plan (STP).
The trust wide vision was: We will deliver care with compassion which is responsive to patients' needs. Working together, we will work in partnership with our patients, colleagues and stakeholders. Professional and accountable, we will do the right things for the right reasons.

Three staff we spoke with about the trust wide values told us they knew the values and felt that the staff lived by them.

Medical wards had a medical specific philosophy developed by ward staff as part of a staff engagement workshop. Staff displayed the philosophy in each ward and included pride, team focussed, welcoming, professional, respect, communication, caring, trustworthy.

The trust had a vision to develop the stroke unit into a hyper-acute stroke unit (HASU). However, this was dependent on the trusts ability to recruit and maintain the correct staffing levels. At the time of our inspection nurse, staffing levels were below the required standard but the unit was recruiting to attract experienced nurses.

**Culture**

Consultants spoke positively about their relationships with the clinical director, the associate director and the head nurse as well as line managers and junior doctors. Consultants spoke proudly about nursing staff saying, “They are excellent, really hard working, and caring.”

Nursing staff told us the culture on medical wards was very positive and that doctors and consultants were helpful and supportive towards nursing staff.

We observed a culture of multidisciplinary staff working on the wards we visited. Therapy staff felt included by nursing and medical staff in decisions related to patient care and treatment. All staff worked together to meet the needs of patients on the wards.

Consultants told us there was poor communication between the executive team, operations leads and consultants. Consultants said there was unacceptable pressure from the executive team to implement changes, which they believed; posed significant risks to patient care and that when they raised these concerns with the executive team they were accused of being disengaged.

Consultants explained that the “winter pressures plan” had been implemented by the executive team without discussion with consultants and that the opening of extra beds with no additional nursing staff meant patient safety was “not good” and their concerns had been disregarded.

Four nurses told us they felt under pressure due to staff shortages and that “unreasonable pressure” was applied to them from the executive team especially during black alerts.

**Governance**

There was a clear governance structure in place for the service with quality governance arrangements, which included risk identification, effective committees and ward to board reporting.

Four committees, quality and safety, clinical governance, corporate governance and corporate management team reported to the quality assurance committee (QAC) who in turn reported to the board.

Consultants told us that the governance had improved since our last inspection. The medicine division now had a specific member of human resource staff who attended weekly consultant meetings and managed the recruitment of consultants and nursing staff. This meant recruitment was quicker and smoother and medical vacancies had reduced from 89 to 39 since our last inspection.

All the nursing staff we spoke with could describe the senior management structure at the hospital and knew their specific roles and responsibilities.

Ward managers told us about the monthly senior sisters’ meetings with the purpose of discussing ward issues and governance. We reviewed the meeting minutes dated 24 April 2017, 27 July 2017
and 30 October 2017 that showed infection prevention and control (IPC), staffing, incidents and clinical governance were standing agenda items.

Ward managers held monthly team meetings however, one ward manager told us that sometimes it was not always possible due to clinical demands. Meeting minutes dated August 2017 showed that managers shared incidents, complaints, and compliments with staff.

Matrons conducted monthly ‘dashboards’, which were nursing assessment audits, and fed back to managers in the senior sisters’ meetings. Ward managers conducted ward level spot check audits and fed back all audit results in team meetings.

Management of risk, issues and performance

Executives at the trust recognised staffing, both nursing and medical, was a risk. This was the same risk relayed to us by ward staff. The trust was addressing this with a continual recruitment drive.

Other risks identified on the trust wide risk register included care of outliers. Each risk identified had mitigating steps, a risk “owner” and a review dated assigned.

Minutes of the medicine governance committee meeting dated 5 September 2017, 4 October 2017 and 1 November 2017 evidenced the committee had oversight of the medicine related risks. Risks were discussed, actioned and reviewed.

The medicine wards participated in a number of audits to measure the quality of provision of patient care, these included local audits for hand hygiene, record keeping, medication, and care planning. These audits formed part of ward monthly dashboard reports completed by the matrons.

The service regularly reviewed the effectiveness of care and treatment through local and national audits. The ward managers displayed quality performance data on their wards, allowing patients, visitors and staff to view their performance regularly.

Ward meeting minutes (August 2017) showed the discussions with teams about incidents, quality of care, ward dashboard performance and patient feedback.

The trust had a major incident plan (known as MAJAX) and business continuity plan in place in case of disruption to service from terrorism or transport incidents.

Information management

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via paper patient records and the staff intranet.

The trust held policies and procedures in electronic format on the hospital wide intranet. All nursing and medical staff could access them.

The information governance committee produced data quality reports every three months and produced an annual data quality report for the trust board.

A trust magazine was published three times a year to update staff and service users on the latest hospital updates and events.

Engagement

The trust held ‘Safe at Southend’ meetings. These meetings were held at 8.30am daily in the hospital canteen Monday to Friday and staff of all grades were welcome to attend and raise any concerns.
The medical directorate held a staff engagement programme called “Wonder ward.” Staff were encouraged to write down a colleague’s name on a paper star and identify their strength. The aim of the exercise was to boost staff morale and engagement. Staff displayed the stars in the wards and staff spoke positively about the exercise.

The trust carried out an annual trust wide staff survey.

The trust told us every directorate had an action plan regarding the lower scoring elements on the staff survey. The associate directors undertake the role of engagement champions running result workshops in their area. The trust has employed an external consultant to lead on the staff well-being initiatives within the trust.

Staff we spoke with told us they attended regular team meetings with their managers and received information in a number of ways including face-to-face, email, and newsletters.

We spoke with two staff members who had been nominated for a trust wide Care with Compassion hospital award. Both staff told us they had felt proud to be recognised by colleagues and nominated for the award.

The friends and family test (FFT) response rates were generally low across all medical wards however; ward managers encouraged staff to promote this and this was evidenced in ward meeting minutes. Nursing staff displayed FFT results on display boards on entry to the wards we visited.

Learning, continuous improvement and innovation

Nursing staff told us the implementation of new technology such as the electronic handheld devices used to record patients’ national early warning scores (NEWS) and the electronic medicines management system had positively impacted on patient care.

At the time of our inspection, nursing staff on Windsor ward were fundraising to create an end of life care room for patients at the end of life and those close to them to use. Nursing staff planned that the room would have a coffee machine, a reclining chair for relatives to stay overnight and a television.

The stroke unit was aiming to develop a 24-hour Regional Essex thrombectomy service. The trust was planning to change Balmoral surgical ward to a medical ward at the end of December 2017 to address the number of medical outliers. Existing surgical nurses on the ward would remain to nurse the medical patients.

**Facts and data about this service**

Southend University Hospital NHS foundation trust provides surgery services to a local population of over 300,000 people in Southend and surrounding areas. Southend Hospital is the trust’s main site for providing surgery services.

The trust had 33,581 surgical admissions between June 2016 and May 2017. Emergency admissions accounted for 9,590 (29%), 18,973 (57%) were day case, and the remaining 5,018 (15%) were elective.

(Source: Hospital Episode Statistics)

The surgery service is made up of a number of specialities, including trauma and orthopaedics, ophthalmology, ear nose and throat (ENT), breast, urology, vascular, colorectal, oral, and maxillofacial surgery. The surgery service includes approximately 180 inpatient beds, 20 day surgery beds and 33 recovery beds. The surgery service also includes an emergency surgical...
ambulatory care (ESAC) service and a trauma ambulatory care service.

There are 18 operating theatres at the trust including a dedicated endovascular theatre. At our previous inspection in February 2017, the laparoscopic theatre was in the process of being renovated as part of a rolling programme of maintenance and improvement. This theatre was now operational and a new brachytherapy (treatment of cancer) suite was in place. A new elective admissions lounge opened on 1 October 2017.

During this inspection we visited nine clinical areas including the surgical pre-assessment unit, elective admissions unit, Chalkwell surgical assessment unit (SAU), Southbourne (urology) ward, Shopland (orthopaedic) ward, Balmoral (vascular) ward, theatres, J Alfred Lee ward (theatre recovery), and the discharge lounge.

We spoke to 38 members of staff including consultants, junior doctors, nursing staff, allied health professionals, and support staff. We spoke to 14 patients, four relatives or carers and reviewed 18 patient care records. We also observed theatre safety briefings and reviewed information including meeting minutes, audit data, action plans and training records.

**Is the service safe?**

**Mandatory Training**

Mandatory training was delivered to staff through a combination of electronic learning and face-to-face training sessions. Topics included equality and diversity, fire safety, infection prevention, information governance, health and safety, manual handling, safeguarding adults and children, and resuscitation, among others.

Compliance with mandatory training was monitored for each staff group and ward. The trust set a target of 85% for completion of mandatory training modules, with the exception of information governance and safeguarding children level 1 where the target was 95% and Prevent training (levels 1 and 2) where the target was 69%.

Two nursing staff told us it could be difficult to access training due to staffing pressures and clinical workload. A member of staff on Balmoral ward gave us an example of a recent training session on moving and handling, which was cancelled at short notice.

Records showed that compliance with mandatory training in the surgery service was variable but was generally higher for nursing staff than for medical staff.

A breakdown of compliance with mandatory training from April 2016 to March 2017 for qualified nursing staff in surgery is shown below:
Out of 22 mandatory training modules for qualified nursing staff, 16 modules achieved the trust target. The six modules that did not achieve the trust target were: blood transfusion with 83% completion rate, conflict resolution with 76% completion rate, health and safety (slips, trips and falls) with 50% completion rate, safeguarding children (level 2) with 71% completion rate and local induction with 76% completion rate.

A breakdown of compliance with mandatory training from April 2016 to March 2017 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>85%</td>
<td>168</td>
<td>203</td>
<td>82.7%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>85%</td>
<td>241</td>
<td>316</td>
<td>76.3%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>85%</td>
<td>278</td>
<td>317</td>
<td>87.7%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>85%</td>
<td>158</td>
<td>317</td>
<td>49.8%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>205</td>
<td>317</td>
<td>69.9%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>85%</td>
<td>287</td>
<td>317</td>
<td>90.5%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>85%</td>
<td>273</td>
<td>316</td>
<td>86.4%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>201</td>
<td>316</td>
<td>92.1%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>279</td>
<td>311</td>
<td>89.7%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>302</td>
<td>317</td>
<td>95.3%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>217</td>
<td>306</td>
<td>70.9%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>85%</td>
<td>296</td>
<td>312</td>
<td>94.9%</td>
</tr>
<tr>
<td>CPR - Adults</td>
<td>85%</td>
<td>277</td>
<td>316</td>
<td>87.7%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85%</td>
<td>274</td>
<td>317</td>
<td>86.4%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>85%</td>
<td>277</td>
<td>317</td>
<td>87.4%</td>
</tr>
<tr>
<td>Local Induction</td>
<td>85%</td>
<td>62</td>
<td>82</td>
<td>76.6%</td>
</tr>
<tr>
<td>MCA DOLS Level 1</td>
<td>85%</td>
<td>201</td>
<td>316</td>
<td>92.1%</td>
</tr>
<tr>
<td>MCA DOLS Level 2</td>
<td>85%</td>
<td>279</td>
<td>311</td>
<td>89.7%</td>
</tr>
<tr>
<td>Prevent (Levels 1-2)</td>
<td>60%</td>
<td>228</td>
<td>317</td>
<td>71.0%</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>85%</td>
<td>140</td>
<td>163</td>
<td>85.9%</td>
</tr>
<tr>
<td>Oxygen Therapy</td>
<td>85%</td>
<td>229</td>
<td>239</td>
<td>95.8%</td>
</tr>
<tr>
<td>WHO Training</td>
<td>85%</td>
<td>72</td>
<td>73</td>
<td>98.6%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>5204</strong></td>
<td><strong>6116</strong></td>
<td><strong>85.1%</strong></td>
<td></td>
</tr>
</tbody>
</table>
Of the 21 mandatory training modules for medical/dental staff, 18 modules did not achieve the trust target. The three modules that did achieve the trust target were fire safety with 86% completion rate, infection prevention with 88% completion rate and local induction with 94% completion rate, compared to the trust target of 85%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Records of department level training dated November 2017 showed continued variation in compliance with mandatory training. Chalkwell surgical assessment unit (SAU) ward achieved 97% overall compliance, the day stay ward achieved 91% and the oral surgery department achieved 95% compliance. However, overall compliance in the breast surgery department was 60%, in the colorectal department 72% and for orthopaedic medical staff, 70%.

Safeguarding
Staff completed safeguarding training as part of their mandatory training. The trust set a target of 85% for completion of safeguarding training modules, apart from safeguarding children level 1 where the target was 95%.

A breakdown of compliance with safeguarding training from April 2016 to March 2017 for medical and dental staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>104</td>
<td>136</td>
<td>76.5%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>92</td>
<td>83</td>
<td>62.7%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>85%</td>
<td>97</td>
<td>136</td>
<td>71.3%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>97</td>
<td>136</td>
<td>71.3%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>360</td>
<td>491</td>
<td>73.3%</td>
</tr>
</tbody>
</table>

The service had an overall completion rate of 73% and did not meet the 85% target for any of the safeguarding modules.
A breakdown of compliance with safeguarding training from April 2016 to March 2017 for qualified nursing and health visiting staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>291</td>
<td>316</td>
<td>92.1%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>279</td>
<td>311</td>
<td>89.7%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>302</td>
<td>317</td>
<td>95.3%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>217</td>
<td>306</td>
<td>70.9%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>1089</td>
<td>1250</td>
<td>87.1%</td>
</tr>
</tbody>
</table>

The trust had an overall completion rate of 87% and met the 85% target for three of the four safeguarding modules. The training module that did not meet the target was safeguarding children (level 2) with 71% completion rate.

(Source: Trust Provider Information Request P18)

Records of department level training dated November 2017 showed continued variation in compliance with safeguarding training. For example, Chalkwell (SAU) ward and the post operative ward met compliance targets for all safeguarding modules. However, the colorectal service and Shopland ward did not meet the target for any of the safeguarding modules.

Staff understood their responsibilities in terms of safeguarding adults and children. We asked nine staff about safeguarding and all of them understood what would constitute a safeguarding concern and how to report this.

There were policies in place regarding safeguarding of adults and children, including guidance on identifying domestic violence and female genital mutilation (FGM). Staff could access these policies through the hospital intranet system.

There was a designated safeguarding lead in the hospital. Staff were able to identify who the lead was and how they would contact them. We saw contact details for the safeguarding lead displayed in theatres and on all surgical wards we visited.

Cleanliness, infection control and hygiene
There were systems in place to ensure that standards of hygiene and cleanliness were maintained and to prevent and protect people from health care associated infections.

Staff adhered to the trust infection prevention and control policy in relation to ‘arms bare below the elbows’ guidance. Personal protective equipment, such as gloves and aprons, was available on all surgery wards we visited.

Gel dispensers were available on entry to all wards we visited. We saw information on infection control displayed on Southbourne ward.

Nursing staff cared for patients who were at high risk of contracting an infection or who had an infectious illness in side rooms with doors closed to minimise the risk of infection.

Ward staff stored and segregated clinical and non-clinical waste appropriately. We saw two sharps bins on Southbourne ward, both of which were signed, dated and had not been overfilled.

All wards and theatre areas we visited were visibly clean. We saw staff completing hand hygiene before and after contact with patients. This was in line with National Institute for Health and Care
Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.

We checked the cleanliness of 14 pieces of equipment across clinical areas and found all equipment was visibly clean and marked with green ‘I am clean’ stickers on wards. This meant the equipment had been cleaned and was available for use.

We saw records in theatres dated November 2017 showing daily cleaning of surfaces and equipment was completed appropriately.

Local cleaning audits showed positive results. Results of monthly cleaning audits from June 2017 to October 2017 on Southbourne ward showed compliance ranged from 97% to 98.9%, on Chalkwell (SAU) compliance ranged from 96.7% to 99.4% and on Balmoral ward compliance ranged from 98.6% to 100% in this period.

We saw an action plan from an external review of infection prevention and control in the trust, this took place in August 2017. One recommendation related to surgery services, specifically to uniform policy in theatres. We saw an action was in place to address this, with a named person responsible, timescale and confirmation the action was completed.

Records provided by the trust showed compliance with infection prevention training of 87.4% for nursing staff and 88.2% for medical staff in the surgery service. This was above the trust target of 85%.

There were systems in place for sterilising reusable flexible laryngoscopes, which were used in cases where patients were difficult to intubate. Laryngoscopes were available for use and disposable laryngoscopes were available if required.

Two patients we spoke with on Chalkwell (SAU) gave us positive feedback about the cleanliness of the ward.

A nurse on Balmoral ward told us how staff had managed a recent outbreak of Acinetobacter (a type of bacteria), which affected four patients on the ward. Staff had identified the reason for the spread of the infection and had taken action to prevent further patients being affected and to prevent recurrence of this type of incident. For example, staff had put in place a new process for admitting patients transferred from other trusts and had taken action regarding cleaning of equipment and the use of disposable hoist slings.

Patients listed for elective surgery were screened for MRSA. Information displayed on surgery wards showed there were five cases of methicillin-resistant staphylococcus aureus (MRSA) within 48 hours of admission from April 2017 to October 2017, across the trust. One of these cases occurred on a surgery ward.

There were 17 cases of Clostridium difficile in the trust from April 2017 to October 2017 across the trust. Four of these cases occurred on surgery wards. We saw that goals had been set by the service in terms of managing infection rates.

Environment and equipment

Resuscitation equipment was visibly clean and was stored in an accessible location in all the clinical areas we visited.

There were processes in place to ensure emergency equipment was checked daily and ready for use. Records showed ward staff completed daily safety checks of resuscitation equipment. On Southbourne ward, records dated 01 September 2017 to 21 November 2017 confirmed staff had completed all required checks. On Shopland ward, EAU and the surgery pre-assessment
unit records dated 22 October to 22 November confirmed staff had completed required checks.

In theatre, records dated from July 2017 showed staff had completed all daily safety checks of resuscitation equipment.

We looked at eight pieces of electrical equipment on surgery wards and found all pieces of equipment had been electrical safety tested. Each piece of equipment was within the stated date for its next review. We saw records of electrical safety testing for equipment in theatre and found all equipment reviewed was within the stated date for its next review.

We checked four consumable items on Chalkwell (SAU) and four consumable items on Balmoral ward and found all were within date to ensure sterility.

Staff had a system in place for checking equipment and stock levels in theatres. We saw signed and completed records of these checks and the theatre manager told us two staff were assigned to complete these checks every evening.

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

Staff escalated deteriorating patients appropriately. Staff recorded early warning scores on electronic handheld devices, which linked to an internal computer system (the nerve centre). This system gave senior staff an overview of all patients and provided continuity between nurses and shifts.

The nerve centre system required all recorded observations to be authorised by a trained member of staff. This was a safety mechanism to ensure that early warning scores were recorded accurately. Any early warning scores indicating the patient was at risk and required clinical review triggered an automatic notification to the critical care outreach team. Staff in the critical care outreach and out of hours teams checked these notifications daily to make sure deteriorating patients were reviewed in a timely way.

Records confirmed staff recorded early warning scores and escalated concerns in a timely way. Results of an audit of NEWS for inpatient wards from June to October 2017 showed 100% compliance with recording of NEWS.

The critical care outreach team supported staff with management of deteriorating patients. A nurse on Chalkwell (SAU) told us staff from the outreach team did a ‘walk around’ of wards every evening to support ward staff with identifying and managing deteriorating patients.

There were sepsis link nurses on surgical wards who provided a point of contact for staff for advice on sepsis management. Staff in the hospital out of hours team told us they were planning to order lanyards to identify these link nurses more clearly.

Staff received training on sepsis. Completion of this training was variable but had improved since our last inspection. Records dated 13 November 2017 showed compliance with sepsis training ranged from 58% to 100% across surgery wards. Training compliance on Balmoral ward had improved from 10% at our last inspection to 100% in November 2017. Senior staff told us about initiatives they had developed, including competitions and targeted support, to improve training on wards with the lowest compliance.

A sepsis trolley was available on Chalkwell (SAU). This contained equipment to assist staff in
providing rapid treatment to patients identified as having sepsis. Staff on duty completed daily safety checks of the sepsis trolley. We viewed records dated 9 September 2017 to 21 November 2017, which confirmed staff had completed all required checks. This was an improvement since our last inspection.

Patient records contained documentation of screening and treatment for sepsis using evidence based tools. This meant that patients with sepsis were treated according to an agreed protocol based on national guidance. There were designated sepsis champions on surgery wards to support staff in managing patients with sepsis.

Senior leaders held a daily ‘safe at Southend’ meeting, which was an open forum where staff could raise any concerns about patient safety.

Staff completed the World Health Organisation and five steps to safer surgery checklist in all theatres. This is a safety checklist used to reduce the number of complications and deaths from surgery. We observed staff completing these safety checks appropriately, including confirmation of the patient's identity and site of surgery.

Staff completed training on the World Health Organisation and five steps to safer surgery checklist. Information provided by the trust showed 95% compliance with this training for theatre staff and 89% compliance trust-wide.

Senior staff in theatres audited compliance with the World Health Organisation and five steps to safer surgery checklist. Senior staff carried out observational audits of 10-15 cases per month. All aspects of the five steps were audited including team briefing, sign in, time out, sign out and debrief. Results dated January to October 2017 showed 100% compliance with the ‘sign in’, ‘time out’ and ‘sign out’ steps of the checklist.

Information on the ‘brief’ and ‘debrief’ steps of the World Health Organisation and five steps to safer surgery checklist was collected through an electronic system. Snapshot audits were completed and showed the following results:

![WHO Brief & Debrief Audits 2017]

*Source (Post-inspection data provided by trust)*

The theatre manager and theatre matron completed weekly theatre safety briefs with staff to encourage improved compliance and to discuss actions resulting from any issues noted during
Patients receiving day surgery received a leaflet with contact details for medical advice after discharge. Patients could access advice 24 hours a day if required in an emergency.

Staff in theatres had access to a difficult intubation trolley, which included appropriate equipment, including flexible fibre optic laryngoscopes, for carrying out a difficult intubation. The trolley was stocked in line with guidance from the Difficult Airway Society.

The theatre governance lead and theatre manager assessed practice in relation to National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs).

Staff had arrangements to respond to cases of major haemorrhage in theatre. A cell-saver machine was available and blood bank and haematology services were available on site with staff available 24 hours a day, seven days a week.

All patients requiring emergency surgery were assessed on admission by a clinical team, including an anaesthetist consultant, the ‘consultant of the week’ and the relevant speciality team. This meant patients requiring emergency surgery receiving timely review by a consultant and that emergency theatre lists were determined by clinical need.

Medical outliers were risk assessed by clinical staff before being placed on surgical wards. We observed discussions between site managers and nursing staff about plans for safe care of patients. Staff told us the ward buddy system was helpful in ensuring timely review of outliers by medical consultants.

Staff had access to a specialist mental health team (the RAID) team, 24 hours a day, seven days per week. Staff we spoke to knew how to refer to this team if they had concerns about the mental health of any patient.

**Nurse staffing**

The trust reported their staffing numbers below for the period from August 2016 to July 2017.

The trust had 28.1 less whole time equivalent (WTE) qualified nursing and health visiting staff in post than planned in July 2017.

<table>
<thead>
<tr>
<th>WTE Planned Staff</th>
<th>WTE Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>178.7</td>
<td>150.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Staff in the surgery service used an acuity-based tool to calculate staffing needs. Nursing staff on Southbourne and Chalkwell wards told us they reported staffing levels to matrons on a daily basis and escalated any concerns so that matrons could assess risk and allocate staff appropriately depending on patient numbers and acuity levels. There was a daily 'safe at Southend' meeting, where staff could raise any safety concerns about staffing to senior leaders.

All wards we visited had planned versus actual staffing numbers displayed. On Chalkwell ward (SAU), the elective admissions unit and Balmoral ward, the actual number of staff was in line with the planned number.
On Southbourne ward, the actual number of nursing staff did not meet the planned number on 21 November 2017. There were three qualified nursing staff caring for 30 patients. This was not in line with Royal College of Nursing recommendations that one nurse should care for no more than eight patients. Staff told us staffing was a frequent concern. Data provided by the trust showed there were 7.6 WTE nurse vacancies on Southbourne ward. The overall shift fill rate for the ward from August 2017 to October 2017 ranged from 89.8% to 94%.

From August 2016 to July 2017, the trust reported a vacancy rate of 9% in surgery for qualified nursing and health visiting staff. This is higher than the trust’s overall target vacancy rate of 7%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From August 2016 to July 2017, the trust told us that there were a total of 6,336 unfilled shifts for qualified nursing staff within the surgery core service, of which 2,223 shifts were covered by bank staff and 1,213 covered by agency staff and 1,411 shifts were left unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Ward staff on Southbourne ward had escalated concerns about staffing through the incident reporting system and senior staff had taken action to address concerns and to mitigate risks in relation to nurse staffing. Actions included using agency staff and intermittently closing six beds at weekends to keep staffing levels safe and free up staff for weekday cover. On the day of our inspection an additional health care assistant had been allocated to support nurses on Southbourne ward.

Senior staff also had long term plans to manage vacancies on Southbourne ward, including a rolling job advert for nursing vacancies, an advertised post for a health care assistant with development plans to complete a work based nursing qualification and the recent recruitment of two surgical care practitioners.

Agency staff completed an induction and had access to systems and information to complete their role. For example, on Shopland ward, agency staff told us they had access to I.T systems and received training to complete their role.

Nursing staff completed a handover of information between each shift, which included discussion of patient care, staffing issues and patient safety issues.

From August 2016 to July 2017, the trust reported a turnover rate of 1% in surgery for qualified nursing and health visiting staff. This is lower than the trust’s overall target turnover rate of 9.7%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From August 2016 to July 2017, the trust reported a sickness rate of 4.3% in surgery. This is higher than the trust overall sickness target of 3.5%. The highest three average monthly sickness rates for surgery wards were:

- Colorectal services: 20.6%
- Day stay ward: 7.8%
- Central ophthalmic unit – Dept.: 6.7%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Medical staffing
Medical staff worked on a rota system, which provided medical cover to the surgery wards 24 hours a day, 7 days per week. A rota coordinator managed medical staffing rotas and senior staff told us the rota included a red, amber, green rating for each staff group. This highlighted to senior staff any areas where medical staffing was below planned levels.

Surgical consultants were available in person or on-call at all times. This meant patients had access to consultant-led care 24 hours a day, seven days per week.

Medical staff completed daily ward rounds, which included discussion of each patient’s care and plans for discharge.

From August 2016 to July 2017, the trust reported a vacancy rate of 16.6% in surgery for medical and dental staff. This is higher than the trust’s overall target vacancy rate of 7%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The trust reported the staffing numbers below for August 2016 to July 2017. The trust had 24.2 less WTE medical and dental staff in post than planned in July 2017.

<table>
<thead>
<tr>
<th>WTE Planned Staff</th>
<th>Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>112.5</td>
<td>88.3</td>
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(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Staff we spoke to identified medical staffing as a challenge. For example, senior staff told us medical staffing in urology was heavily reliant on locum staff and three ward staff expressed concerns around staffing of Balmoral ward during the winter months, when this ward was due to open six escalation beds. Senior staff were aware of concerns and had recorded medical and nursing staffing on the risk register for surgery. Senior staff told us about actions they were taking to manage staffing, including a clear process for staff to escalate concerns on a daily basis, advertising for permanent staff and using agency staff.

From August 2016 to July 2017, the trust reported a turnover rate of 0.5% in surgery for medical and dental staff. This is lower than the trust’s overall target turnover rate of 9.7%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From August 2016 to July 2017, the trust reported a sickness rate of 1.6% in Surgical care for medical and dental staff. This is lower than the trust overall sickness target of 3.5%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

The trust told us that from August 2016 to July 2017 there were a total of 4,194 unfilled shifts for medical staff within the surgery core service, of which 555 shifts were covered by bank staff and 2,816 covered by locum staff and 814 shifts were left unfilled.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

During June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the whole time equivalent staff working at Southend University
Records

There was a paper-based system in use for patient medical records. Patient medical records were stored securely in lockable trolleys in staff areas on each ward we visited.

We reviewed 18 patient care records. All the records we reviewed were legible, signed and dated. Records contained pre-operative assessments and risk assessments, including falls risk assessment, pressure risk assessment and nutritional assessments. Out of 18 records reviewed, 17 contained completed assessments.

Records contained referrals to specialist teams including the falls team, critical care outreach team and mental health team. Records contained information on patients’ individual needs including mental health, dementia and physical needs. Staff referred to patient-specific records, such as the ‘This is me’ booklet, to guide patients’ care.

Staff on Balmoral ward used a printed ‘nursing checklist’, which gave staff a clear, quick reference summary of daily nursing assessments including nutrition, mobility, pressure area care and psychological needs among others. Staff told us they were working with colleagues in governance to roll this out to other areas of the hospital.

Staff sent discharge summaries, including relevant information about the patient’s care, to each patient’s GP to ensure continuity of care.

Medicines

Staff used an electronic system for managing medicines. This meant there was a clear system for prescribing, ordering, administration and recording of medicines.

Staff stored medicines securely. We checked access to medicines rooms on all wards we visited and found these rooms were secured with keypad access. A senior nurse held the keys for the controlled drugs (CD) cupboard and CDs were stored behind two locked doors. This was in line with NICE guideline 46 “Controlled drugs: safe use and management” (2016).

Staff on wards and in theatres checked the stock of controlled drugs (CDs) twice a day to ensure all stock was monitored and accounted for. We checked five CDs and found the stock matched the recorded balance.

Staff stored medicines requiring refrigeration appropriately. We checked records dated 1
October to 21 November on Chalkwell (SAU) ward, Southbourne ward and the surgical pre-assessment unit and found daily temperature checks were complete and abnormal readings were appropriately escalated. On Balmoral ward, we found five days where staff had not completed checks. Senior staff had identified these gaps through a medicines audit and had put an action plan in place to address this. We saw the audit results displayed on the ward information board and a reminder to staff to complete checks.

All wards we visited had a pharmacist to support with the safe prescribing of medicines. This was an improvement since our last inspection.

All surgery wards completed monthly medicines audits and took action to improve medicines management. On Chalkwell (SAU), the most recent audit score was 82% and the ward manager told us about actions they had put in place to increase compliance. On Balmoral ward, the ward manager gave us examples of actions taken to improve compliance, including staff training, a change to the storage location of IV fluids and the sharing of audit results with staff.

We checked the expiry dates of 14 medicines on surgery wards and found thirteen were within their expiry dates. One medicine on Southbourne ward did not have a visible expiry date. We raised this with the deputy ward manager who advised they would send this back to pharmacy immediately.

Staff gave us examples of how they used results from safety monitoring to improve patient care. A nurse on Southbourne ward told us how ward staff had implemented a stamp for use in patient notes to remind doctors to prescribe patients’ regular medications.

Allergies were clearly recorded in all 18 patient care records we reviewed.

Incidents

The trust used an electronic system for reporting incidents. Staff understood how to report incidents using this system. We asked 11 staff about incident reporting and all staff were aware of their responsibilities regarding incident reporting. Two nurses on Southbourne ward and Chalkwell (SAU) told us there was a positive ‘no blame’ culture about reporting incidents on the ward and described recent incidents they had reported.

There were clear processes in place for investigating incidents. Staff on Southbourne ward and Chalkwell ward told us about recent incidents, which were under investigation and could identify initial areas of learning from the incidents. Staff confirmed that debriefing sessions had taken place following incidents to ensure shared learning.

Senior staff shared learning from incidents with ward staff. A senior member of staff on Chalkwell (SAU) told us learning was shared with staff at team meetings and via email. Meeting minutes dated 10 August 2017 and 19 October 2017 confirmed incidents were discussed at team meetings.

We saw information on how to report an incident displayed on Southbourne ward. This included information on the electronic incident reporting system and the option to report an incident directly by phone. Information relating to incidents was displayed in the theatre area for staff.

We asked 14 staff about duty of candour and all understood their responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.
Morbidity and mortality meetings took place every month. We saw records of recent mortality reviews for the MSK directorate, which were well attended and included analysis of the causes of mortality and recommendations and learning points from each case.

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

From September 2016 to August 2017, the trust reported three incidents classified as never events related to surgery services. Both related to surgical/invasive procedure incidents meeting serious incident (SI) criteria.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 50 serious incidents in surgery, which met the reporting criteria set by NHS England from September 2016 to August 2017.

Of these, the most common type of incident reported was:

- Treatment delay meeting SI criteria with 22 (44% of total incidents)
- Slips/trips/falls meeting SI criteria with nine (18% of total incidents)
- Surgical/invasive procedure incident meeting SI criteria with eight (16% of total incidents)
- Pressure ulcer meeting SI criteria with six (12% of total incidents)
- All other categories with three (6% of total incidents)
- HCAI/Infection control incident meeting SI criteria with two (4% of total incidents)
Senior staff completed detailed investigations into never events and serious incidents. We reviewed investigations and action plans for two never events relating to incorrect implants used in surgery. Investigations included analysis of the root cause of the incident, lessons learned, arrangements for sharing learning and evidence of compliance with duty of candour requirements.

Staff could explain actions taken following never events. Staff in theatre had taken actions including implementing a sheet to record implants before retrieving them from stores and introducing a ‘stop moment’ where verbal confirmation of implant details were read aloud by two separate members of staff. Senior staff had implemented scenario-based training for staff and a training video to help embed new processes.

We saw posters about learning from never events displayed in staff areas and staff recorded never events and actions taken in response to them on the department risk register.

**Safety Thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the safety thermometer showed the trust reported 19 new pressure ulcers, eight falls with harm and 11 new catheter urinary tract infections (CUTIs) from August 2016 to August 2017 for Surgery.

The graphs below show there was a variable trend in terms of the number of falls reported over this period and a variable trend in the number of CUTIs reported, with an increasing trend in the number reported from June to August 2017.
Information from the National Hip Fracture Database (2016) showed the proportion of patients not developing pressure ulcers was 83.6%, which falls in the bottom 25% of trusts. The 2015 figure was 92.7%.

A senior member of staff on Chalkwell ward told us that matrons telephoned the ward on a daily basis to monitor safety outcomes and request updates on staffing levels and any incidents in the last 24 hours, including falls and pressure ulcers. This meant that senior staff had oversight of any safety concerns and could ensure timely action was taken in response to concerns.

Safety performance was discussed and actioned at monthly team meetings and governance meetings. Minutes from the surgical directorate governance meeting dated 6 September 2017 confirmed staff discussed patient safety, incidents, themes and learning from harm.

We saw information on safety performance displayed on Chalkwell (SAU) ward. Results dated November 2016 to October 2017 showed 100% compliance for falls assessment audits, nutritional assessment audits and pressure ulcer prevention audits in this period.

Is the service effective?

Evidence-based care and treatment

Staff had access to policies, which were based on national guidelines. We reviewed the “Policy for management of antimicrobials” dated January 2017, which referenced national guidelines from the Department of Health and the National Institute for Health and Care Excellence (NICE).

Staff used evidence-based guidelines to guide patient care. A nurse on Southbourne ward told us how they used guidance on gentamicin (an antibiotic) from NICE in their practice and a nurse on Balmoral ward told us about NICE guidance on diabetes, which they used.
Staff in the surgery service used an evidence-based tool to screen patients for sepsis and start appropriate treatment. Patient records showed staff completed this tool and we saw information on evidence-based sepsis care displayed on Southbourne ward and Balmoral ward. Ward staff from all disciplines we spoke to were knowledgeable about sepsis and its management.

The trust had policies relating to the management of patients with sepsis and staff knew how to access these. We reviewed the policy “Antibiotic guidelines for immediate management of sepsis” dated 24 April 2017 and found it was version controlled, ratified and in date for review.

Staff had access to evidence-based guidance on antibiotic prescribing through the hospital intranet. The lead for the hospital out of hours team told us how they provided individual prescriber-level information to clinical leads, to allow individual feedback on antibiotic prescribing.

Staff in theatres were auditing compliance with NICE guideline CG65 “Hypothermia: prevention and management in adults having surgery” (2016). Staff had identified areas of non-compliance and had an action plan in place to improve compliance with the guideline.

Staff in theatres delivered care in line with guidance from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). For example, staff minimised the number of non-essential surgeries taking place between midnight and 8am. At the time of our inspection, 4% of non-elective surgeries took place between these hours.

The urology service employed a nurse to support patients with participation in the enhanced recovery programme. The enhanced recovery programme is an evidence-based approach, which helps people recover more quickly after surgery. Staff on Southbourne ward told us how the nurse reviewed patients before surgery and gave advice on how to take part in the programme. We saw information for patients on the enhanced recovery programme displayed on Southbourne ward.

Staff completed local audits to evaluate the effectiveness of care. This included audits relating to trust policies, such as hand hygiene and audits of clinical practice, for example, a post-operative care plan audit and an audit of 30-day mortality rate in patients with a fractured neck of femur. Information from audits was fed back to senior leaders.

Nutrition and hydration
Staff gave patients information on nutrition and fasting times before surgery. For example, we saw a patient leaflet relating to the urology enhanced recovery programme, which advised patients on drinking fluids until two hours before surgery and taking supplement drinks before surgery to provide energy and aid recovery after surgery.

Staff in the discharge lounge provided patients with refreshments before they were discharged home. We saw a healthcare assistant offering patients tea and coffee.

Dieticians were available to support all patients in the surgery service with nutritional needs. We asked five staff about nutritional support for patients and all five knew how to refer patients for support.

Pain relief
Staff we spoke to understood how to assess patients’ pain and understood protocols around prescribing of pain relief. We observed a member of nursing staff on Southbourne ward monitoring a patient’s pain and administering pain relief.
Results of a pain and sedation management audit displayed on Chalkwell (SAU) showed 100% compliance from November 2016 to October 2017.

We spoke with two patients on Chalkwell (SAU) and both told us staff offered pain relief in a timely way.

The trust had an acute pain team, who provided specialist advice on pain management. The team included a consultant anaesthetist and specialist nurses. Staff knew how to contact the team if required.

**Patient outcomes**
The trust was performing slightly better than the England average for elective admissions in the majority of specialties with the exception of general surgery where results were slightly worse than the England average.

For non-elective admissions the trust was performing slightly worse that the England average, with the exception of urology.

From June 2016 to May 2017:

All patients at Southend Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

General Surgery patients at Southend Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

Urology patients at Southend Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

Trauma & Orthopaedics patients at Southend Hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

All patients at Southend Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

General Surgery patients at Southend Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Trauma & Orthopaedics patients at Southend Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

Urology patients at Southend Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

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**Elective Admissions – Southend Hospital**

![Elective Admissions Graph](image)
Non-Elective Admissions – Southend Hospital

Hip Fracture Audit

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 7.6%, which was within the expected range. The 2015 figure was 4.8%.

The proportion of patients having surgery on the day of or day after admission was 64.9%, which was worse than the national standard of 85%. The 2015 figure was 67.2%.

The perioperative medical assessment rate was 72.6%, which failed to meet the national standard of 100%. The 2015 figure was 88.9%.

The length of stay was 14.2 days, which falls in the top 25% of trusts. The 2015 figure was 12.5 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 75% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 69.4%.

The risk-adjusted 90-day post-operative mortality rate was 5.3%, which was within expected range. The 2015 figure was 5.8%.

The risk-adjusted 2-year post-operative mortality rate was 22.1%, which was within expected range. The 2015 figure was 31.4%.

The risk-adjusted 30-day unplanned readmission rate was 10.6%, which was within expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 55.4% which within expected range. The 2015 figure was 50.5%.

(Source: National Bowel Cancer Audit)

We saw an executive summary report dated January 2017 in relation to the National Bowel Cancer Audit, which included areas of good practice and a recommended action around accuracy of ASA grade measurement (a system for assessing the fitness of patients before surgery) to ensure the accuracy of data on mortality.

National Vascular Registry

In the 2016 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 1.3% for Abdominal Aortic Aneurysms, indicating that the
trust was within expected range. The 2015 figure was 1.6%.

Within Carotid Endarterectomy, the median time from symptom to surgery was eight days, which was better than the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was within expected range at 0.8%. The 2015 figure was 0.7%.

(Source: National Vascular Registry)

**Oesophago-Gastric Cancer National Audit**

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 22.9%. This placed the trust within the bottom 25% of all trusts for this measure.

The trust was not eligible for the 90-day post-operative mortality rate.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 33.8%, which was lower than the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

**National Emergency Laparotomy Audit**

In the 2016 National Emergency Laparotomy Audit (NELA), the Southend University Hospital NHS Trust achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 156 cases.

The trust achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 119 cases.

The trust achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 87 cases.

The trust achieved green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 57 cases.

The risk-adjusted 30-day mortality for the trust was higher than expected, based on 282 cases.

(Source: National Emergency Laparotomy Audit)

Senior staff had reviewed national audit results and told us they had taken action, including introduction of a new acute abdomen pathway, to improve outcomes.

**Patient Reported Outcome Measures**

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed
In 2015/16:

- Performance on groin hernias was about the same as the England average
- Varicose veins performance was about the same as the England average
- Hip replacements performance was about the same as the England average.
- Knee replacements performance was about the same as the England average

(Source: NHS Digital)

Staff monitored the effectiveness of sepsis management as part of a commissioning for quality and innovation (CQUIN) audit, which included eight wards across the trust. Results showed compliance with sepsis screening had improved from 48% in June 2017 to 64% in September 2017. This was above the CQUIN target of 60% compliance by September 2017. The percentage of IV antibiotics given within one hour was 73% in September 2017. We did not see a target for the percentage of antibiotics given within one hour.

Only one of the wards audited as part of the sepsis CQUIN was a surgery ward. We discussed this with the lead for the out of hours team at the time of inspection and they advised they would consider collecting data for a wider sample of surgery wards.

Two senior theatre staff told us about a national group of hospitals they were part of, which was working collaboratively to set standards and benchmark practice against each other.

Competent staff

A senior member of staff in the outreach and out of hours team told us staff were supported to undertake further training. Staff described opportunities for training including a prescribing course and a degree level qualification in advanced practice.

Training on sepsis was available to staff through an e-learning module. The lead for the hospital out of hours team told us how they incentivised staff to complete this training by having a competition between wards to achieve the best compliance.

The theatre practice development team led the development of “Post-operative emergency treatment scenarios,” which were carried out in a fully equipped simulation training room.

Staff in theatres had half a day each month of protected time, which was dedicated to training. All
theatre staff had individual training plans to support their development.

Senior staff told us staff working in theatre recovery attended external training on high dependency care, to support their understanding of managing high dependency patients.

Staff on Shopland ward told us they had access to training and were supported by the ward manager to attend training.

From August 2016 to July 2017, 73% of staff within Surgery at the trust had received an appraisal, which met the trust target of 73%. Support to doctors and nursing staff did not meet the target with 72% completion rate and other qualified scientific, therapeutic and technical staff (other qualified ST&T) did not meet the target with 44% completion rate.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th># Appraisal Required</th>
<th># Appraisal Received</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>7</td>
<td>6</td>
<td>85.7%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>249</td>
<td>169</td>
<td>71.6%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>196</td>
<td>154</td>
<td>74.0%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>9</td>
<td>8</td>
<td>80.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>6</td>
<td>4</td>
<td>44.4%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>11</td>
<td>8</td>
<td>80.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>478</strong></td>
<td><strong>349</strong></td>
<td><strong>72.7%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Updated records provided by the trust after our inspection showed staff compliance with appraisal was 75.1% for staff in the theatres directorate, 71.4% for staff in the musculoskeletal (MSK) directorate and 85.7% for staff in the surgical directorate. This gave an overall compliance rate of 77.5% for staff in the surgery service, which was above the trust target of 73%.

**Multidisciplinary working**

Staff described positive working relationships between multidisciplinary teams. A nurse on Southbourne ward described medical staff as “very helpful” and a doctor on Balmoral ward told us consultant staff were “very welcoming” and said they had been well looked after by the ward team.

Ward staff had daily handover and communication meetings. We observed a handover meeting on Shopland ward, where staff shared information between the multidisciplinary team and identified risks and management plans for patients.

Staff across the three directorates providing surgery services worked together to deliver safe care. Action plans developed following never events showed evidence of staff sharing learning across directorates.

Nursing, medical and therapy staff worked together to increase patients’ independence and recovery after surgery. Staff in the pre-assessment clinic assessed patients’ fitness for surgery and supported patients to make arrangements for discharge before surgery took place. Patients were encouraged to bring a relative or friend to their pre-assessment appointment to support with this.

Staff had introduced a ‘buddy system’ between wards. This meant staff in the surgery service had a clear point of contact within the medical service, to support with the care of medical outliers. Two ward staff told us this system was helpful in accessing medical support for these patients.
Ward staff described positive working relationships with specialist nurses, including the critical care outreach team and specialist learning disability nurse.

The out of hours team explained how they worked with ward staff to triage overnight tasks for junior doctors and allocate these to appropriate staff. Senior staff told us this had reduced the number of requests junior doctors received, which meant that junior doctors could focus more time on treating patients.

Nursing staff in the discharge lounge communicated with ward staff to ensure safe discharge of patients. Staff used a check sheet to record information including patients’ mobility, nutritional needs and care required on discharge.

Nursing staff in the discharge lounge communicated with healthcare professionals in the community about patients’ needs. A nurse in the discharge lounge told us how they confirmed referrals to district nursing teams and communicated with care providers to ensure care was in place when patients returned home.

**Seven-day services**
Patients had access to consultant led care, 24 hours a day, seven days per week. There was access to all key diagnostic services, seven days a week to support clinical decision-making.

Theatres were staffed with at least one full emergency team, 24 hours a day, seven days per week. One full team was on-call at all times. Urgent imaging services were available seven days per week with imaging and reporting prioritised according to clinical need. Radiography staff were available to support in theatres.

The hospital out of hours team was available seven nights per week and the critical care outreach team was available 24 hours a day, seven days per week.

Surgery wards each had a named pharmacist, who was available five days per week (Monday to Friday) to provide support with management of medicines. An on-call pharmacist was available during evenings and weekends. Therapy services were available seven days per week.

**Health Promotion**
Staff assessed patients before elective surgery and provided guidance and support to help patients improve fitness and make lifestyle changes, which would improve recovery after surgery.

Staff supported patients to be mobile and independent after their surgery. Physiotherapy and occupational therapy staff were available to support patients across the surgery service. An enhanced recovery programme, which encouraged early post-operative mobility, was in place in the urology service and the early rehabilitation and nursing team (ERAN) supported patients with rehabilitation after orthopaedic surgery.

A nurse on Southbourne ward told us patients were encouraged to get dressed and become mobile as soon as possible after surgery, to promote their recovery. A nurse on Chalkwell (SAU) ward told us the ambulatory care service was helpful in encouraging patients to receive treatment, while remaining mobile and minimising changes to their usual routine.

We saw information for patients on Southbourne ward, which included guidance on sitting out of bed in the early post-operative period and encouragement to walk with the support of the physiotherapist on the first day after surgery.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**
The trust policy for consent to examination or treatment and the policy for the Mental Capacity Act (MCA) 2005 set out a clear approach for how staff should assess patients’ capacity to consent.

From April 2016 to March 2017, 92% of qualified nursing staff and 76% of medical/dental staff within Surgery completed MCA DoLs Level 1 training. In this period, 90% of qualified nursing staff and 60% of medical/dental staff had completed MCA DoLs Level 2 compared to the trust target of 85% for Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with had a good understanding of the Mental Capacity Act (2005) and Deprivation of Liberty safeguards and could tell us their responsibilities relating to these. Records contained documentation of staff assessing patients’ capacity to consent to treatment.

Patients’ consent was gained before surgery as part of the pre-assessment process. Patients we spoke to in the surgical pre-assessment unit told us they felt well informed about their care.

A nurse on Balmoral ward told us they had cared for patients on the ward who had been sectioned under the Mental Health Act. They told us they would contact the matron and the RAID team (specialist mental health team) for advice to ensure appropriate care of these patients.

Is the service caring?

Compassionate care

The Friends and Family Test response rate for surgery at Southend University Hospital NHS Foundation Trust was 32%, from September 2016 to August 2017, which was better than the England average. A breakdown of response rate by site and ward can be viewed below.

Friends and family test response rate between September 2016 and August 2017 at Southend University Hospital NHS Foundation Trust, by site

Friends and family test response rate between July 2016 and June 2017 at Southend University Hospital NHS Foundation Trust, by ward
Ward staff received regular updates on friends and family test results and we saw displays of recent results. Results dated 01 October 2017 to 9 November 2017 displayed in the discharge lounge showed 89.5% of patients would recommend care, on Chalkwell ward 88.9% of patients would recommend care and on Balmoral ward 100% of patients would recommend care. Results dated 06 November 2017 to 12 November 2017 on Southbourne ward showed 100% of patients would recommend care.

We saw positive comments from patients displayed on Chalkwell (SAU) ward and Balmoral ward. Comments included “The staff were extremely helpful and caring all the way through” and “The individual care shown to each patient I also found a wonder to watch.”

We spoke with 14 patients and 13 gave positive feedback about their care. One patient said “Everyone’s been great” and another said they had been treated with “Excellent care, courtesy and dignity.” One patient we spoke with on Southbourne ward was not satisfied with the care they received. This patient raised concerns relating to staff communication and elements of care, including emotional support and prescription of medicines. We raised this with senior staff at the time of inspection and they provided evidence that the patient’s concerns in relation to the clinical aspects of their care had been addressed. Senior staff told us they would follow up with the patient regarding their concerns about staff communication.

A urology surgeon was nominated for the trust’s 2017 patient choice award by a patient who said the surgeon gave “the best care” and was “encouraging, respectful [and] caring.”

Emotional support
There was a specialist mental health team (the RAID team), who provided mental health assessment and treatment to patients throughout the trust, 24 hours a day, seven days per week. A nurse on Southbourne ward told us they referred patients undergoing life-changing surgery to this team for support.

A nurse on Balmoral ward told us they worked closely with the RAID team to provide pre-operative and post-operative mental health support to patients undergoing amputation of a limb due to diabetes.
We saw staff on Shopland ward providing emotional support and encouragement to patients following their surgery.

The trust employed specialist nurses to provide practical and emotional support to patients with specific conditions, including patients living with dementia and patients with a learning disability.

On Chalkwell (SAU) ward, we saw information displayed about a carers’ hub, which was a forum offering practical, financial and emotional support for carers.

A nurse told us how they had talked to a patient who was anxious and distressed and offered them choices about their care. We reviewed the patient’s notes and saw they had been offered a referral to the mental health team.

Understanding and involvement of patients and those close to them
Patients we spoke to were positive about involvement in their care. One patient on Chalkwell (SAU) ward said, “I’ve been kept updated by doctors”.

Patients on the surgical pre-assessment unit told us they felt “informed” and “well cared for.”

The specialist learning disability nurse provided communication aids to assist staff in caring for patients with a learning disability. We saw information about coming into hospital for patients with a learning disability displayed on Balmoral ward.

Is the service responsive?

Service delivery to meet the needs of the local people

The service had systems to aid the delivery of care to patients in need of additional support. For example, specialist nurses were available to support patients with a learning disability and patients living with dementia.

The service had systems to manage patient admission and discharge in a timely way, including ambulatory care areas on Chalkwell ward and Balmoral ward and escalation beds, which could be used when the number of patient admissions increased.

Senior staff had a plan to develop the number of high dependency beds available for surgery patients, which they told us would prevent delays and improve safety. Recruitment for staff to work in these areas was ongoing at the time of our inspection.

On Balmoral ward, staff displayed information to show actions they had taken in response to patient feedback. For example, in response to feedback about noise levels at night staff had bought soft closing bins to reduce noise and in response to feedback about a lack of space for belongings staff had ordered new bedside lockers and provided baskets at patients’ bedsides.

Average length of stay

Trust Level

From July 2016 to June 2017:
- The average length of stay for all elective patients at the trust was 2.9 days, which is lower compared to the England average of 3.3 days.
- The average length of stay for Trauma & Orthopaedics elective patients at the trust was 2.7 days, which is lower compared to the England average of 3.4 days.
- The average length of stay for Urology elective patients at the trust was 2.2 days, which is as expected compared to the England average of 2.0 days.
- The average length of stay for General Surgery elective patients at the trust was 5.0 days, which is higher compared to the England average of 3.3 days.
- The average length of stay for all non-elective patients at the trust was 3.8 days, which is lower compared to the England average of 5.1 days.
- The average length of stay for General Surgery non-elective patients at the trust was 3.0 days, which is lower compared to the England average of 4.0 days.
- The average length of stay for Trauma & Orthopaedics non-elective patients at the trust was 6.8 days, which is lower compared to the England average of 8.9 days.
- The average length of stay for Urology non-elective patients at the trust was 4.0 days, which is higher compared to the England average of 3.0 days.

**Elective Average Length of Stay – Trust Level**

**Non-Elective Average Length of Stay – Trust Level**

**Southend Hospital**
From July 2016 to June 2017:
- The average length of stay for all elective patients at Southend Hospital was 3.0 days, which is as expected compared to the England average of 3.3 days.
- The average length of stay for Trauma & Orthopaedics elective patients at Southend
Hospital was 2.7 days, which is lower compared to the England average of 3.4 days.

- The average length of stay for Urology elective patients at Southend Hospital was 2.2 days, which is as expected compared to the England average of 2.0 days.
- The average length of stay for General Surgery elective patients at Southend Hospital was 5.1 days, which is higher compared to the England average of 3.3 days.
- The average length of stay for all non-elective patients at Southend Hospital was 3.8 days, which is lower compared to the England average of 5.1 days.
- The average length of stay for General Surgery non-elective patients at Southend Hospital was 3.0 days, which is lower compared to the England average of 4.0 days.
- The average length of stay for Trauma & Orthopaedics non-elective patients at Southend Hospital was 6.8 days, which is lower compared to the England average of 8.9 days.
- The average length of stay for Urology non-elective patients at Southend Hospital was 4.0 days, which is higher compared to the England average of 3.0 days.

**Elective Average Length of Stay – Southend Hospital**

**Non-Elective Average Length of Stay – Southend Hospital**

**Meeting people’s individual needs**

Single sex accommodation was available across surgery wards.

The trust employed specialist nurses, including a learning disability specialist nurse and a dementia specialist nurse, to support patients with their individual needs. The learning disability specialist nurse was automatically notified through an electronic system when a patient with a learning disability was admitted to the hospital.

Surgery wards displayed information for patients and relatives relevant to their individual needs.
On Balmoral ward, we saw a poster about support available to patients with a learning disability, including contact details for the specialist nurse and on the day assessment unit; we saw a display on dementia research.

Staff provided tailored activities for patients living with dementia. We saw information on Chalkwell (SAU) ward about sensory comforters for patients living with dementia and a magazine called “The Daily Sparkle” which aimed to encourage engagement, orientation and reminiscence.

Staff identified patients living with dementia through patient care records and provided individualised care. A nurse on Balmoral ward told us how they supported patients by using sensory comforters and providing extra support with food choices. A nurse on Chalkwell (SAU) told us how they supported the communication needs of patients with learning disabilities and dementia by adapting their communication style and working closely with carers. Both staff told us they used the ‘This is me’ booklet to guide patients’ care.

Staff provided patients with information leaflets about their care. On Southbourne ward, we saw information leaflets for patients and relatives including “The last days of life”, “Operation for bladder tumours” and “Urology enhanced recovery”.

Staff knew how to access interpreters for patients whose first language was not English.

The chaplaincy team was available 24 hours a day, seven days per week to support the spiritual needs of patients.

Staff had access to training on dementia. Records provided by the trust showed 37.7% of staff in the theatres directorate, 22.7% of staff in the surgery directorate and 16.2% of staff in the MSK directorate had completed this training.

One patient we spoke to on Southbourne ward told us staff were “busy” and said it could take “about 10 minutes” for staff to respond to the call bell.

Access and flow

Referral to treatment (percentage within 18 weeks) – admitted performance

From August 2016 to July 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery steadily declined in performance and was below the England average for the 12 month period.

In July 2017, 47% of this group of patients were treated within 18 weeks versus the England average of 70%.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Surgery broken down by specialty is below. Of these, one specialty was above the England average and two specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>75.0%</td>
<td>74.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>59.9%</td>
<td>77.5%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>60.6%</td>
<td>72.9%</td>
</tr>
</tbody>
</table>

RTT performance was included on the surgery risk register. Senior staff had identified potential causes for the trust’s RTT performance. These included staffing deficits, lack of capacity, delayed referrals and patient pathway inefficiencies among others.

We saw that actions were in place to improve RTT performance including additional clinics, additional theatre lists at weekends for general surgery, ear, nose and throat (ENT) surgery and urology, outsourcing of some services and daily monitoring of the RTT position with feedback at weekly performance meetings.

Leaders worked closely with surgical consultants to manage waiting lists. A urology consultant told us how they had developed a process for reviewing any patients waiting 25 weeks or more for surgery so that reasons for delay could be identified and addressed. Consultants told us how they proactively reviewed the waiting list for gall bladder surgery to identify cases suitable for day surgery.

Senior staff took actions to improve the safety and efficiency of theatre lists. Senior staff told us they had extended theatre schedules for gall bladder surgery to include afternoon slots, which meant more patients could receive this type of surgery. All patients requiring emergency surgery were assessed on admission by a clinical team, which meant emergency theatre lists were prioritised based on clinical need.

Consultants told us they proactively identified cases where a registrar could lead the patient’s care during periods of consultants’ annual leave.

Consultant orthopaedic surgeons had identified delays in accessing orthopaedic surgery and had opened up extra trauma theatre lists to address this. Trauma theatre lists took place seven days per week and there was a dedicated trauma anaesthetics team.

There was good overview and management of theatre utilisation by the theatre manager and matron. Staff had extended weekend theatre lists to help manage waiting lists.

However, data provided by the trust showed that from October 2016 to September 2017, the average number of theatre cases per session remained consistently below the optimum number of cases per session. The actual number of hours surgery was also consistently below the planned number of hours surgery in this period. This meant that theatres were not used to their full capacity.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice. In the latest period of Q1 2017/18, this trust cancelled 136 surgeries. Of the 136 cancellations, 24% were not treated within 28 days.
Over the two years, the percentage of cancelled operations at the trust showed an upward trend and was generally higher than the England average.

Over the two years, the percentage of cancelled operations at the trust showed a trend of decline, and was generally similar to the England average. Cancelled operations as a percentage of elective admissions include only short notice cancellations.  
(Source: NHS England)

We requested updated information on cancellations of elective operations after our inspection. The trust provided records dated April to October 2017, which showed the percentage of short notice cancellations of operations remained variable but showed a trend of improvement since
June 2017. In June 2017, 3.3% (76) patients had short notice cancellation of their operations and 22 patients were not treated within 28 days. This had improved to 0.6% (15 patients) in October 2017, with one patient not treated within 28 days.

Clinical staff reviewed all cancellations of elective operations required due to bed capacity pressures. This meant the clinical needs of the patient were risk assessed before any decision to cancel an operation was made.

There was a system in place for monitoring and reviewing theatre lists and a theatre flow coordinator was responsible for managing any issues relating to staffing, stock and timings of theatre lists on a daily basis. Staff told us this allowed them to manage theatre time efficiently.

Senior staff in theatres could identify the reasons for cancellations of surgery and told us these included patients becoming clinically unfit for theatre, patients not attending for surgery and patients no longer requiring surgery. There was a clear escalation plan in case of cancellation on the day of surgery.

There was a high number of medical outliers on surgery wards, which was a factor impacting on cancellation of elective surgeries. Medical outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space. The trust monitored medical outlier numbers on a weekly and monthly basis. From June 2017 to October 2017 the number of medical outliers on surgical wards varied from 184 (in August) to 698 (in June).

A designated consultant led the daily review of medical outliers on surgery wards. Senior staff had also introduced a ‘buddy ward’ system between medicine and surgery wards to support timely review of patients. Two ward staff told us this system was helpful in accessing medical support for these patients.

Staff on surgery wards used an electronic system on handheld devices, to monitor progress with each patient’s care. This gave staff an overview of outstanding investigations and a ‘red, amber, green’ rating of progress towards discharge.

Chalkwell (SAU) ward included a consultant-led ambulatory care service, known as ESAC (emergency service ambulatory care). This service enabled patients to see a surgical consultant and receive treatment within an ambulatory area, which helped prevent unnecessary admissions to the hospital. The service accepted referrals from GPs, accident and emergency (A and E) and community nurses.

There was an ambulatory care area on Balmoral ward, where district nurses, GPs, podiatrists and A and E could refer patients for specialist assessment of wounds. A nurse on Balmoral ward told us this prevented admissions and enabled patients to receive rapid treatment and discharge from hospital.

The early rehabilitation and nursing team (ERAN) provided an early supported discharge service for patients undergoing orthopaedic surgery. This service had expanded to include patients with a fractured neck of femur, in addition to patients undergoing elective orthopaedic surgery.

**Learning from complaints and concerns**

From August 2016 to July 2017, there were 102 complaints about surgical care. The trust took an average of 75 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 days or no fixed amount of days for complex cases.
The top three subjects of complaints were:

- All aspects of clinical treatment – 57
- Admissions, discharge and transfer arrangements – 14
- Communication/Information to patients (written and oral) – 14

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

There was a trust wide complaints policy and all wards we visited displayed information on how to make a complaint, including contact details for the patient advice and liaison service (PALS). Patients we spoke with knew how to make a complaint.

Nursing staff told us they tried to resolve any complaints locally and would escalate any complaints they could not resolve to senior nurses.

Learning from complaints was shared with ward staff at team meetings. We saw team meeting minutes dated 23 September 2017, 6 October 2017 and 22 November 2017, which confirmed meetings included discussion of complaints.

A patient on Southbourne ward told us about a complaint they had in relation to their care. We raised this with a senior member of staff who told us they would discuss this with the patient. When we returned to the ward the next day, the patient had been discharged (in line with their wishes). We saw documentation showing the patient’s clinical concerns had been acted upon but we could not see any documentation of staff talking to the patient about their concerns or the complaints process. We raised this with the ward manager, who advised they would telephone the patient to follow up on their concerns and identify any areas of learning.

Is the service well-led?

Leadership

The surgery service was delivered across three clinical directorates (musculoskeletal, surgery and theatres, critical care and anaesthetics). Each directorate was led by an assistant director and a clinical lead. Matrons provided day-to-day operational leadership of surgery wards.

Staff told us senior nurses were visible and approachable. Nursing staff on Southbourne ward and Chalkwell ward told us the head of nursing and matrons were visible on the wards and generally provided a positive response to any concerns raised.

A nurse on Chalkwell ward (SAU) told us the head of nursing for surgery was focused on patient safety and was ‘hands on’ in their approach. They gave us an example of how the head of nursing had gone to a ward to personally review a patient when staff raised concerns that it would not be appropriate for the patient to transfer wards.

Senior leaders took steps to engage with staff at ward level and provided a forum for staff to raise concerns through daily ‘safe at Southend’ meetings.

Staff in theatres gave us positive feedback about support from senior managers.

Staff gave positive feedback about local leadership at ward level. Ward managers were supportive of staff and communicated information to staff through team meetings and daily handover meetings. We saw that ward managers were visible and approachable on the wards we visited.
Vision and strategy
There was a trust-wide statement of vision and values. The trust wide vision was “We will deliver care with compassion which is responsive to patients' needs. Working together, we will work in partnership with our patients, colleagues and stakeholders. Professional and accountable, we will do the right things for the right reasons.”

The surgery service did not have a separate formally documented vision and strategy. Staff we spoke to understood plans for their individual service areas and how these linked to the wider trust vision.

Senior staff had a plan to develop the number of high dependency beds available for surgery patients, which they told us would prevent delays and improve safety. Recruitment for staff to work in these areas was ongoing at the time of our inspection.

Culture
Senior staff in the surgery service described a ‘culture shift’ in the service and told us teamwork between different specialities had improved. All the ward staff we spoke with were positive about the working relationship with their immediate team and line manager.

Staff on Shopland ward told us they received support from their manager to achieve a work life balance.

We saw effective communication and team working between different staff groups in theatres and on surgery wards.

Staff reported positive working relationships with speciality teams, including the critical care outreach team and hospital out of hours team.

Governance
There was a clear governance structure in place for the surgery service. Governance arrangements included monitoring of safety and quality outcomes, with reporting from ward to board. Information was communicated from wards to governance committees, which escalated information to the quality assurance committee. The quality assurance committee reported to the trust board.

Senior staff had systems to ensure communication between the three directorates delivering surgery services. Assistant directors for the three directorates met on a daily basis, clinical leads for the three directorates met each week and representatives from all three directorates attended bed meetings and daily ‘safe at Southend’ meetings.

Governance meetings took place monthly in each directorate. Meeting minutes dated 6 September, 11 October and 1 November for the surgical directorate showed oversight and discussion of topics relating to quality and safety. Topics included infection control, incidents, complaints, updates to policy, patient feedback and risks to the service.

There were clear systems in place for communicating information between senior staff and ward staff. Staff shared information through noticeboards, email, daily handover meetings and monthly team meetings.

Senior nursing staff attended monthly sisters’ meetings. We saw meeting minutes dated 10 August 2017 and 19 October 2017, which showed meetings included discussion of incidents, complaints and evidence-based practice, amongst other topics.
Ward staff attended monthly team meetings. We reviewed meeting minutes dated 23 September 2017 and 22 November 2017 for Balmoral ward and 6 October 2017 for Chalkwell ward, which confirmed meetings included discussion of incidents, complaints, infection control and staffing. On Chalkwell ward, a member of staff told us attendance could be difficult due to staffing. Important messages were also communicated between staff through email and noticeboards.

There were clear processes for communication between staff in theatres. Theatre staff had weekly rota meetings, monthly governance meetings and there was a governance support group, which met every two months. There was a named lead member of staff for governance, scheduling and education.

Ward managers understood and implemented processes for escalating staffing concerns. This meant that senior staff had oversight of staffing issues and could allocate available nursing staff to areas of greatest need. Ward managers escalated concerns through daily contact with matrons and through monthly sisters’ meetings, which fed into governance meetings.

Management of risk, issues and performance

The risk register for the surgery service identified risks including referral to treatment (RTT) backlogs, ophthalmology waiting lists, bed pressures and staffing. Each risk had a ‘RAG’ rating for the level of risk and there were identified controls to manage the risk, including clear owners and timelines for review. The items on the risk register were in line with the concerns identified by staff in the surgery service.

Staff in the hospital out of hours team told us how staff had responded to an identified risk around mortality for patients diagnosed with sepsis. Staff responded to this risk by completing a review of all case notes where the cause of death was recorded as sepsis to identify possible areas for improvement in care. Staff had identified several cases where there were errors in coding and were working with the coding team to rectify this. Senior staff also had plans to increase the number of high dependency beds available to ensure availability of appropriate treatment for patients diagnosed with sepsis.

The trust had a major incident plan (known as MAJAX) and business continuity plan in place in case of disruption to service. We asked seven staff about major incident plans and all knew how to access information on these plans.

Senior staff had plans to manage increase in demand for services over the winter period. Plans included converting Balmoral ward into an escalation ward for medical outlier patients and increasing the number of high dependency beds available. Staff we spoke to were aware of these plans.

Surgery wards conducted a number of audits to measure the quality of patient care. Audits included cleanliness and infection control, hand hygiene, record keeping and medicines. Information from audits was fed back to senior leaders through performance dashboards.

Managing Information

Policies and procedures were available to staff in electronic format through the trust intranet. All staff we spoke to knew how to access policies and procedures.

A trust magazine was published three times a year to provide staff and service users with updates on the hospital news and events.

Engagement
There were regular team meetings at all levels to ensure effective communication across the service. Daily ‘safe at Southend’ meetings took place, where staff could raise any safety concerns with senior leaders. Managers held regular team meetings on wards and in theatres. Meeting minutes showed discussion of incidents, complaints and staffing.

Senior leaders engaged clinical staff in managing access and flow within the service. For example, consultants gave us examples of actions they were taking to improve waiting lists for orthopaedic surgery and gall bladder surgery.

Senior leaders recognised staff that had made an outstanding contribution to patient care. For example, we saw the ward manager on Balmoral ward had received an ‘employee of the month’ certificate in May 2017 and staff in theatres told us about two nominations they had received for the ‘Hospital Heroes’ award.

The service engaged with patients and their loved ones through the NHS Friends and Family test. The Friends and Family Test response rate for surgery at Southend University Hospital NHS Foundation Trust was 32% from September 2016 to August 2017, which was better than the England average.

Staff collaborated with other trusts to improve quality of care. Staff in the hospital out of hours team told us about a teaching event about sepsis for GPs, which the hospital was running in November 2017. The out of hours team were part of an academic health science partnership of 13 hospital trusts, which aimed to share good practice in sepsis management between hospitals and collaborate to improve patient safety.

In the majority of areas staff we spoke to felt engagement with leaders was good. However, staff in the surgical pre-assessment unit expressed that service development suggestions were not always listened to or acted upon by leaders.

**Learning, continuous improvement and innovation**

Senior staff had shared a training video on sepsis with community providers to improve sepsis management across the healthcare system.

The lead for the hospital out of hours team told us they were working on a patient group direction, which would allow some specialist nurses to give patients with suspected sepsis the first dose of antibiotics, without waiting for a medical review. The aim of this was to improve the pathway for timely administration of antibiotics for patients with suspected sepsis.

The lead for the hospital out of hours team showed us an app, where the hospital could upload guidelines on antimicrobial prescribing and provide easy access to guidance linking medical conditions with indicated medicines. This was not accessible to all staff at the time of our inspection but the out of hours lead told us roll out to medical staff would take place as part of planned upgrades to technology.

The trust recently opened a new brachy therapy (treatment of cancer) suite and a newly renovated laparoscopic theatre. A new elective admissions lounge opened in October 2017.

**Services for children and young people**

**Facts and data about this service**

Services for children and young people are provided on the main site and at the Lighthouse Child
Development Centre by approximately 100 staff.

Neptune ward cares for children and young people, up to the age of 16, requiring routine or emergency medical care and treatment. The ward provides high dependency beds for children requiring more specialist care. Capacity is currently reduced to 21 beds whilst recruiting to nursing vacancies. The ward also houses the paediatric assessment unit. The unit assesses, investigates, observes and treats children and young people, reducing inpatient admission.

The neonatal unit provides 16 Level 2 beds for sick and premature infants. The unit contains a special care nursery for infants who no longer require intensive care.

Outpatient appointments for children and young people, with the exception of three clinics, are held in a dedicated paediatric outpatient department. The department provides clinics for an array of specialities including asthma, allergy, diabetes, general surgery, rheumatology, seizure and dietetic.

The Lighthouse Child Development Centre specialises in outpatient care for children and young people with significant delay in multiple areas of development. The centre functions as a multi-agency facility, for children and young people requiring support from more than one secondary agency, service or discipline.

The trust had 2,199 spells between July 2016 and June 2017. Emergency spells accounted for 76% (1664 spells), 17% (372 spells) were day case spells, and the remaining 7% (163 spells) were elective. From August 2016 to July 2017, there were 99,775 paediatric emergency department attendances and 107,911 paediatric outpatient attendances.

Is the service safe?

Mandatory training

Staff generally received effective training in safety systems, processes and practices.

The trust had an up-to-date policy for mandatory training. Current mandatory training compliance rates were displayed on staff information boards across the service.

The trust set a target of 85% for completion of mandatory training modules, with the exception of information governance and safeguarding children (level 1) where the target was 95% and Prevent (levels 1-2) where the target was 69%.

A breakdown of compliance for mandatory courses from April 2016 to March 2017 for medical staff in children and young people’s care is shown below:
The paediatric medical staff were not meeting mandatory training trust targets. Of the 18 mandatory training modules for medical staff, 12 modules did not achieve the trust target of 85%. The six modules that met the trust target were: Equality and Diversity with 85% completion rate, Manual Handling – Object with 89% completion rate, Safeguarding Children (Level 2) with 85% completion rate, CPR – Adults with 92% completion rate, Fire Safety with 92% completion rate and Infection Prevention with 100% completion rate.

A breakdown of compliance for mandatory courses from April 2016 to March 2017 for qualified nursing staff in children and young people’s care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Transfusion</td>
<td>85%</td>
<td>53</td>
<td>61</td>
<td>95.1%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>85%</td>
<td>77</td>
<td>81</td>
<td>95.1%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>85%</td>
<td>73</td>
<td>81</td>
<td>96.3%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>85%</td>
<td>52</td>
<td>81</td>
<td>64.2%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>78</td>
<td>81</td>
<td>93.8%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>85%</td>
<td>80</td>
<td>81</td>
<td>98.8%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>85%</td>
<td>73</td>
<td>78</td>
<td>93.6%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>61</td>
<td>81</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>61</td>
<td>81</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>80</td>
<td>81</td>
<td>98.8%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>85%</td>
<td>79</td>
<td>81</td>
<td>97.5%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>85%</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>CPR - Adults</td>
<td>85%</td>
<td>74</td>
<td>78</td>
<td>94.0%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85%</td>
<td>72</td>
<td>81</td>
<td>88.9%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>85%</td>
<td>75</td>
<td>81</td>
<td>93.8%</td>
</tr>
<tr>
<td>Local Induction</td>
<td>85%</td>
<td>25</td>
<td>28</td>
<td>100.0%</td>
</tr>
<tr>
<td>MCA DOLS Level 1</td>
<td>85%</td>
<td>81</td>
<td>81</td>
<td>100.0%</td>
</tr>
<tr>
<td>MCA DOLS Level 2</td>
<td>85%</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Prevent (Levels 1-2)</td>
<td>69%</td>
<td>76</td>
<td>81</td>
<td>93.8%</td>
</tr>
<tr>
<td>Collection of Blood Products</td>
<td>85%</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>1245</td>
<td>1322</td>
<td>94.2%</td>
</tr>
</tbody>
</table>
Paediatric nursing staff performed well against mandatory training trust targets. Neptune ward nursing staff achieved the trust target for all mandatory training modules. The paediatric assessment unit nursing staff achieved 100% for all 19 mandatory training modules.

As of November 2017, the neonatal nursing staff were compliant with all of their mandatory training modules, with one exception. Seven staff were required to complete Prevent Level 3 training and senior staff confirmed training dates had been booked.

All staff had competencies on the electronic learning system and we saw a paper copy of an equipment competency teaching session, signed by all staff.

Staff told us that they were encouraged to undertake any additional training relevant to their role, including degree modules. Staff told us they felt well supported with their educational development.

**Safeguarding**

The service had effective processes in place to keep children and young people safe and protected from harm across this service.

Since the last inspection, the trust had combined the adult and child safeguarding committees into one, to ensure a streamlined approach and joint working. The safeguarding leads reported quarterly to the clinical governance committee.

The hospital had an up-to-date child protection policy. The policy included staff guidance on recognising child sexual exploitation, female genital mutilation and cyber bullying. Staff could access these policies through the hospital intranet system.

Staff told us they completed safeguarding training as part of their mandatory training. We saw how easily they accessed the policies on the staff intranet. There was a dedicated intranet page for safeguarding with emergency contact details.

The content of the safeguarding training was peer reviewed monthly to ensure that staff received the correct level of training. The findings were escalated through the directorate board meeting.

The trust provided additional face-to-face adult safeguarding training sessions, in addition to electronic learning, in order to improve access to support. The child safeguarding team introduced a quiz to evidence current staff knowledge, following training.

The intercollegiate document ‘Safeguarding children – roles and competencies for healthcare staff’ 2014 published by the Royal College of Paediatrics and Child Health (RCPCH), provides guidance on the level of safeguarding training required for different staff groups. The document states that all clinical staff working with children and young people should be trained in safeguarding for children levels one, two and three.

A breakdown of compliance for safeguarding courses from August 2016 to July 2017 for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>95%</td>
<td>20</td>
<td>26</td>
<td>76.9%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>24</td>
<td>26</td>
<td>92.3%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>22</td>
<td>26</td>
<td>84.6%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>85%</td>
<td>20</td>
<td>26</td>
<td>76.9%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>86</td>
<td>104</td>
<td>82.7%</td>
</tr>
</tbody>
</table>

The trust had an overall completion rate of 83% for safeguarding modules. The two modules that failed to meet the 85% target were safeguarding adults (Level 1) and safeguarding children (Level 3) both with a completion rate of 77%.
A breakdown of compliance for safeguarding courses from August 2016 to July 2017 for Qualified nursing & health visiting staff (Qualified nurses) in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>81</td>
<td>81</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>81</td>
<td>81</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>80</td>
<td>81</td>
<td>98.8%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>85%</td>
<td>79</td>
<td>81</td>
<td>97.5%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>328</td>
<td>331</td>
<td>99.1%</td>
</tr>
</tbody>
</table>

The table shows nursing staff were meeting trust targets in all five modules.

The safeguarding team worked across all directorates and externally with other agencies. The safeguarding team's contact details were displayed throughout the service and on the safeguarding intranet page. This meant that staff could escalate concerns in a timely manner.

From August 2016 to July 2017, there were 546 safeguarding referrals made for children, the majority of which were made by staff from the emergency department and maternity services.

There was a flagging system used to identify children at risk. Currently, the electronic reporting system holds alerts for children under child protection, children in need and children in care. From December 2017, the service will take part in the child protection information sharing (CP-IS) project. The project improves communication between healthcare and social care. Once a child’s NHS number is submitted into the system, the healthcare staff will be alerted that the child is on a child protection plan. The health care staff can also access the child’s social care team details. The social care team are also automatically notified when the child attends a health care setting. Staff described their responsibilities in relation to safeguarding children. Staff told us when they would report a safeguarding concern and how they would report it.

Children attending an outpatient appointment were seen in the children’s outpatient area, not in the main outpatient department. A member of staff told us that they worked in the children’s outpatient clinic when required and told us that they were trained to safeguarding Level 3. The trust confirmed that 100% of staff who work solely in paediatric outpatients had completed Level 3 safeguarding training.

**Cleanliness, infection control and hygiene**

During our last inspection, we raised concerns that staff did not follow good practice in relation to infection prevention and control (IPC). Since our last inspection, the service has updated the infection control policy. IPC champions have been identified in each area to promote and challenge practice within the service.

From August to November 2017, the infection control team carried out spot check hand hygiene audits. Results showed 100% compliance from paediatric staff.

The 2016-17 IPC report showed that 92% of staff within the service had received updated IPC training, to improve staff knowledge.

Staff followed the trust’s ‘bare below the elbow’ policy when providing care. Hand sanitiser points were widely available to encourage good hand hygiene practice, with noticeable signage for visitors and staff to decontaminate their hands.

Personal protective equipment (PPE), such as gloves and aprons, was accessible for staff in all clinical areas to ensure their safety and reduce the risk of cross-infection when providing care. We saw staff using PPE appropriately.
The last inspection reported that the patient and public toilets were not regularly cleaned in the paediatric assessment unit. During this inspection, we visited all wards and clinical areas where children were cared for and found them to be visibly clean. We saw daily cleaning checks were completed for all areas. The cleaning response team were able to attend to any cleaning concerns raised by staff and delivered ad hoc cleaning when needed.

Within this service we saw ward areas that had not been updated for a while. For example, there were areas of bare plaster showing through the paint in the special care room. When this was raised with senior staff, they contacted the facilities department who repainted those spot areas immediately.

All equipment not in use was seen to have “I am clean” labels, which were signed and dated by the staff member who cleaned the equipment.

Staff described how a recent NHS England peer review found that waste and linen bags were full at the end of a shift. Senior staff told us that they now walk around their area before taking handover so they can address any infection prevention and control concerns. During the inspection, we saw linen and waste bags were removed prior to the end of a shift. All sharps bins we checked were signed, dated and positioned out of reach of patients.

Information displayed on the staff board showed that there were no hospital acquired infection cases within children and young people services.

We saw staff complete enhanced monitoring of areas that were not frequently used to reduce the risk of waterborne infections, for example legionella. Areas that were not used frequently were subject to enhanced monitoring to ensure the risk of waterborne infections was mitigated. Staff completed daily water tap checks.

Disposable curtains were changed by an external contractor on a monthly basis. If curtains required replacing prior to the regular disposal, the cleaning response team replaced them. All curtains seen were dated and clean.

Domestic supervisors completed weekly ward manager logs to highlight any issues and obtain feedback on ward cleanliness. Ward managers documented when issues were completed.

Environment and equipment

The neonatal unit and children’s ward both had a secure entrance, accessed by card or through a buzzer system controlled by staff. Staff recognised that security was their highest risk and it was at the top of their risk register. The service recently replaced the entrance doors on the ward and confirmed they were upgrading the buzzer on the children’s ward to a video system, allowing staff to see who was at the entrance.

Neptune Ward looked after children and young people requiring high dependency care, in a dedicated six-bedded bay.

Children’s outpatient clinics were held in a dedicated area within the main outpatients department. There was a play area, well supplied with toys and games for a variety of ages.

We checked the resuscitation trollies on the ward, neonatal unit and children’s outpatients department and found the contents matched the equipment checklist. The daily checks had been completed in all areas for the previous three months. Other areas where children and young people were seen, for example on the day surgery unit, had an identified paediatric resuscitation bag.

There was a fridge for expressed breast milk (EBM) on the neonatal unit. The expressed breast milk was correctly identified with the baby’s full name, hospital number and date when the mother expressed to ensure that EBM was given to the correct infant. All expressed milk was checked daily and before use. Daily checks of the fridge temperature had been documented and signed
off for the previous six months.

Fire extinguishers were fixed securely to the wall so they did not present a trip hazard and were all in date.

Medical equipment was managed by the Medical Equipment Management Services Team. Equipment requiring planned and reactive maintenance was managed through the electronic asset management system. We observed the team to respond immediately when the transport incubator battery failed its morning check.

We saw the neonatal unit shower room for parents that had discoloured grouting and a raised step, potentially difficult for newly delivered mothers to use. This was raised with the senior staff and work commenced to rectify this during our inspection.

We checked 18 pieces of equipment within the neonatal unit, six pieces of equipment within the Lighthouse Child Development Centre and ten within the children’s ward. Each piece of equipment was clean and within date for review, with the exception of three new expressing breast pumps which had no service label attached. This was raised with the lead nurse who reported this immediately. The breast pumps were reviewed the following day and were found to be correctly labelled.

Staff completed daily safety checks of all equipment. This audit was checked by the lead nurse or matron and signed off by the head of paediatrics. Equipment reviews from May 2017 to November 2017 showed that all daily checks were fully completed and signed by senior staff.

The results of the CQC national children’s survey 2016 are displayed in the table below. The results show that the trust performed similar to other trusts for all three questions relating to the ward environment.

<table>
<thead>
<tr>
<th>Question</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child’s physical or mental needs?</td>
<td>Parents/carers</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>How clean do you think the hospital room or ward was that your child was in?</td>
<td>Parents/carers</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>Parents/carers</td>
<td>9.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Assessing and responding to patient risk

The service had a paediatric consultant and registrar on call to respond to any concerns over patient risk or deterioration. On the neonatal unit, there was a senior house officer available 24 hours a day, seven days a week, to respond to risk.

There was always a doctor with advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on every shift.

Staff used the Paediatric Early Warning Score (PEWS) to assess patient deterioration. The PEWS is a tool, used by staff, to quickly determine the degree of patient illness, based upon cardinal vital
signs and patient observation. We looked at twelve PEWS charts; all were fully completed and signed by staff with the correct actions taken.

The neonatal unit used the Neonatal Early Warning Score to assess deterioration. All records we reviewed had fully completed observation assessment tools.

In the event of a neonate or child deteriorating, escalation charts were available for staff with details of who to contact. We observed staff escalate concerns immediately when both a neonate and a child’s condition deteriorated.

The trust monitored all early warning scores centrally via the ‘Nerve Centre’. All children scoring three on the PEWS assessment were screened for sepsis. The ‘Nerve Centre’ kept a central record of early warning scores and the outcome of sepsis screening.

We saw evidence of staff using a sepsis care bundle for the management of patients with sepsis. Following staff feedback, the service has amended the sepsis assessment form so that it was easier to use.

We attended a doctors and nurses safety briefing to ensure staff awareness of high dependency patients, deteriorating patients and patients that require safeguarding. Staff described how the handover process had changed following an incident. The departing nurse in charge allocated the on-coming nursing staff to patients based on acuity.

Each month there was a paediatric-only surgery list. Following their surgery, all children were treated in a recovery bay and then moved to the day surgery unit, opposite theatre. All day surgery unit staff were trained in APLS and two paediatric nurses were allocated to the unit on the paediatric only day, to ensure that the guidance from the Royal College of Anaesthetists (RCoA) was followed. This guidance states that immediately after anaesthesia, a child should be managed in a recovery ward or post-anaesthesia care unit on a one to one basis, by designated staff with up-to-date paediatric competencies, particularly resuscitation.

The service had proposed plans to move the paediatric assessment unit nearer to the paediatric emergency department. This would ensure the emergency department had trained paediatric staff out of hours.

**Nurse staffing**

Staffing levels were displayed on the governance information board in ward areas. During the inspection, we saw that each day staffing was displayed with equal numbers of staff for planned and actual staffing levels.

Nursing staffing levels were reviewed on a monthly basis and documented in the safer staffing monthly report, submitted to the trust board. The report contained the nurse backfill rate percentage by clinical area. The head of paediatrics confirmed the nursing establishment was reviewed twice a year and had improved across the service.

At the time of our inspection, the service had the following establishment of neonatal nursing staff: five whole time equivalent (WTE) band seven, 11 WTE band six, 14 WTE band five and 7.6 WTE band four.

For July 2017, the service had 37 paediatric nurses WTE, giving a total of 55.2 WTE nursing and support staff employed on Neptune ward.

Senior staff reported that they felt able to manage their areas and had the appropriate staffing levels to manage the level of care required.

The trust submitted data showing current vacancies for Neptune Ward were 8.4 WTE nurses and 4.4 WTE health care workers. Senior staff described various ways in which they attracted and retained paediatric staff. For example, the service offered a 5% retention payment twice yearly and a one-off nurse referral payment.

Senior staff described how they encouraged their own staff to develop by supporting them with
additional training. In addition, they recruited newly qualified staff with an interest in undertaking qualifications in speciality training.

From August 2016 to July 2017, the trust told us that there were a total of 2,457 unfilled shifts for qualified nursing staff within the Children and Young People’s core service, of which 618 shifts were covered by bank staff and 1,247 covered by agency staff and 512 shifts were left unfilled.

We reviewed staff rotas for October to November 2017. Rotas were planned two months in advance to ensure that there were sufficient staff on each shift. Senior staff added agency and bank staff to the rota, once the rotas for substantive staff had been completed. Substantive staff confirmed they completed additional bank shifts to maintain the correct staff to patient ratio.

From August 2016 to July 2017, the trust reported a sickness rate of 3.2% in children’s services. This is lower than the trust overall sickness target of 3.5%.

The trust reported a turnover rate of 1.6% in children’s services. Again, this is lower than the trust’s overall target turnover rate of 9.7%. This data was not broken down by individual areas and staff groups, in order to fully analyse staff turnover.

**Medical staffing**

From August 2016 to July 2017, the trust reported a vacancy rate of 19.5% in children’s services; this is higher than the trust’s overall target vacancy rate of 7%.

Within the same period, the proportion of consultant staff reported to be working at the trust was lower than the England average (32% compared to 42%) and the proportion of junior (foundation years one and two) staff was higher (16% compared to seven per cent).

At the time of inspection, there were 13 consultants working in children’s services. The service had recently introduced a twilight shift.

There were no vacancies reported for junior staff at the time of the inspection.

Paediatric support was available 24 hours a day from on call paediatricians, the paediatric matron and the head of paediatrics.

From August 2016 to July 2017, the trust reported a medical staff sickness rate of 2.2% in children’s services. This is lower than the trust overall sickness target of 3.5%.

Within the same time period, the trust reported that there were a total of 1,808 unfilled shifts for medical staff within the Children and Young People’s core service, of which 397 shifts were covered by bank staff and 1,093 covered by locum staff and 318 shifts were left unfilled.

The table below shows the staffing skill mix for the 35 whole time equivalent staff working in children and young people’s services.
During June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Records**

We reviewed 20 sets of patient records across the service. All were legible and in chronological order. Following the last inspection, all staff had been given name stamps to ensure records were signed appropriately.

Records were stored near the nursing station in a locked trolley. Staff told us they had no concerns accessing records or test results.

We saw observation and daily charts kept by the patient’s bedside which were completed and included the neonatal PEWS records.

Medical staff completed the ‘first hour of care’ documentation on the neonatal unit. We reviewed six documents and saw that staff had completed all sections except for the maternity delivery room temperature. This was brought to the attention of the lead nurse who raised this with medical staff.

The service completed a monthly record keeping audit to ensure compliance with best practice standards. The audit results were presented at team meetings.

We reviewed two red baby books and noted that staff had completed relevant sections prior to discharge. This is important to ensure that all admission and development details were recorded for other health professionals to use.

**Medicines**

At the previous inspection, we found 30% of incidents related to pharmacy errors. During this inspection, staff described the actions that had been taken to reduce further errors.

Staff could easily access the medicines management policy on the intranet and described confidently their responsibilities in relation to medicine management.

The trust medicines management committee had signed up to the National Institute for Health and Clinical Excellence (NICE) guidance on good practice formulary. All new medicine was discussed before implemented into the trust, in order to assess governance and safety issues.

Senior staff told us that bespoke staff training and reassessments had been completed following medication errors.

Two trained staff checked all children’s medications prior to, and during, administration.

Pharmacists reviewed a daily report of ‘give immediately’ doses omitted in the last 24 hours. Electronic prescribing reports were being developed to audit missed doses.

The pharmacist reported controlled drug audit results directly to the ward managers, matrons and head of paediatrics.

More pharmacy technicians are undertaking medicines reconciliation training, in order to reduce the number of medication errors.

The neonatal drug room had been refurbished and air conditioning installed since the last inspection.

New controlled drug electronic learning was launched in late 2017. It included pictorial guides for staff when using the controlled drug registers.

Pharmacy had placed ‘controlled drug returns’ as an item on their performance dashboard. There was an identified lead pharmacist who was responsible for the weekly check of each clinical area.
We found medicines to be securely stored throughout the service. There was a medication room on the ward that was locked with key access. Medicine fridges were locked with key access.

Daily checks of medicine fridges were recorded for Neptune Ward, the neonatal unit, and children’s outpatients, to ensure they were within the safe temperature range. Staff checks of medications and the medication fridge temperature was consistent. Where fridge temperatures had breached the upper limit, the temperature was noted in the records and action was taken by staff.

Controlled drugs were locked securely and separately from other medicines. The nurse in charge held the master keys. A stock check of controlled drugs was carried out twice daily with two members of staff required to sign this off. We saw this had been done and signed off with no gaps from January to November 2017. We checked sixteen controlled drugs and all were within date.

We reviewed medication prescription charts across the service. Staff recorded allergies in line with NICE guidance. For all regular medicines prescribed, staff had recorded the route and frequency. No missed doses were recorded.

Pharmacy staff checked drug prescription charts daily and advised staff when they raised any concerns. Children’s services had access to the clinical pharmacy service from Monday to Friday, with access to an on-call pharmacist out of hours.

All medicines administered were double-checked by two qualified nurses, with two signatures on a prescription chart. Prescription charts included both the child’s admitted and current height and weight.

Nurses completing drugs rounds wore red disposable aprons, which signalled to others that they were not to be disturbed, reducing the risk of errors.

A ward-based pharmacist visited daily to review and check medications. Staff told us about a recent change with antibiotic use of gentamicin and the requirements for closer monitoring of the baby before, during and after the infusion.

**Incidents**

Never events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. From September 2016 to November 2017, the trust reported no incidents classified as never events for children’s services.

From September 2016 to September 2017, the trust reported two serious incidents in children’s services, which met the reporting criteria set by NHS England. Serious incidents are adverse events, where the consequences are so significant or the potential for learning is so great, that a heightened level of response is justified.

Of these, the most common type of incident reported was:

- Treatment delay meeting SI criteria with two (50% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (25% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (25% of total incidents)
Staff told us that following a serious incident which involved a child’s deterioration, the service had piloted an amended paediatric early warning score (PEWS) tool for infants up to 3 months old. This adapted tool featured a lower threshold for clinical intervention, reducing the risk of unidentified patient deterioration and would be shared across the trust.

At our last inspection, we found further development was needed to embed an open and honest learning culture. Incident management was now well established throughout the service with an open and honest culture. Staff understood how and when to report incidents and near misses. Staff told us about the outcomes of investigations into incidents. Feedback was received by emails, at team meetings, and on staff notice boards.

A paediatric study day agenda was recently altered to reflect incident reporting trends. This change was to support staff awareness and shared learning. Both the lead nurse and the matron published newsletters with learning from incident trends and complaints.

The department reported 141 incidents from July 2016 to June 2017. Of these incidents, 131 were graded as no harm, seven were rated as low harm, one was graded as moderate harm, two were graded as severe harm and none resulted in death.

The most frequently reported incidents categories were around access, admission, transfer and discharge (23%), medication (20%) and clinical assessment (14.2%).

Learning from serious incidents was shared in a variety of ways. The Risk and Patient Safety Team produced a trust wide incident newssheet, sharing the learning from serious incidents. It was sent to all clinical staff monthly and published on the trust intranet. The team also produced posters highlighting never events and identified learning. Updates on patient safety were provided at the monthly core brief and a regular patient safety update was introduced on the front page of the trust weekly Friday round up.

Senior staff shared incidents at directorate governance meetings, which had a fixed agenda item for patient safety incidents.

We reviewed a sample of incidents and found that they had been correctly graded according to risk management policy with an improvement from the last inspection. Staff gave examples of learning and service improvements following incidents. For example, following a bag of wasted medications, all drug fridge items are now signed for when delivered.

From September 2016 to November 2017, we saw one recorded application of the duty of candour in a serious incident case review. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff were aware of the principles of duty of candour and could give examples of when it would be triggered.
Mortality and morbidity meetings took place monthly and learning from complex cases was shared with staff.

**Safety thermometer**

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month; a suggested date for data collection is given, but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

From August 2016 and August 2017, data from the safety thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections within children’s services.

**Major incident awareness and training**

The service had both a major incident policy and business continuity policy. Staff showed us the major incident policy, which was attached to a wall and contained action cards for different scenarios, for example a flood or fire. There were also action cards with contact numbers and notes for the nurse in charge. All policies were available in hardcopy in case of a technical failure and staff showed us how they could easily access the intranet for updated policies. Staff completed PREVENT training each year. PREVENT is a government-led training programme, designed to identify and prevent the threat of terrorism.

**Is the service effective?**

**Evidence-based care and treatment**

Staff delivered care and treatment in line with evidence-based practice. Policies and procedures were based on national guidance such as National Institute for Health and Care Excellence (NICE) guidance. For example, staff followed the NICE quality standard (QS61) to prevent and control infection in children and young people.

The paediatric practice educator was responsible for managing and updating policies and procedures following changes to national guidance.

There were a number of evidence-based pathways for staff to follow for specific conditions, such as sepsis and cystic fibrosis. The day surgery unit had created different surgical pathways for staff to follow, dependent on the child’s age.

Standard operating procedures (SOPs) were available for a range of procedures, for example, there was a SOP for staff to follow when a child becomes critically ill and requires intensive care. The SOPs we reviewed were all up to date and had clear dates for review. Staff could access policies and guidelines through the trust's intranet. Hardcopies were available in the event of a system failure.

Policies ensured discriminatory factors including age, gender or disability, were protected when making care and treatment decisions.

The neonatal unit was working towards UNICEF baby friendly accreditation Level 3. This accreditation assesses whether staff support parents to have a close and loving relationship with
their baby. To achieve accreditation, the provider is required to demonstrate that they have met a set of evidence-based standards.

There was a comprehensive local audit schedule to monitor performance. We saw that key findings from local audits were documented, with actions for improvement. For example, in response to the results of the vital signs in children audit, additional training was provided to clinicians.

National clinical audits benchmark the quality of the trust’s services compared to other NHS trusts, and highlight best and substandard practice to drive continuous improvement across the service. The service participated in national audits including the National Paediatric Diabetes Audit; the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK); and the Neonatal Intensive and Special Care (NNAP) audit. We saw evidence that the trust used audit findings to improve the quality of care. For example, in response to audit results from the NNAP audit, the trust had updated local policies to improve compliance with the first hour of care bundle.

The service participated in the East of England HDU (high dependency unit) forum. The forum had established HDU admission criteria, using the Royal College of Nursing’s ‘time to move on’ paper, in order to improve consistency in the region and gain appropriate funding.

**Nutrition and hydration**

The service recognised the importance of good nutrition, hydration, and protected meal times as an essential part of patient care. Staff assessed and documented children and young people’s nutritional requirements using a paediatric nutrition and hydration tool.

Medical staff on the neonatal unit received a memory aid on their induction, to ensure daily fluid allowances were administered correctly and were age appropriate. Following the standard practice for fluid allowances can reduce the risk of hyperuricemia (an excess of uric acid in the bloodstream) and promote weight gain.

Children and young people had access to a dietician to support their nutritional and hydration needs. On the neonatal unit, we observed a dietician monitoring the calorie input for each patient to ensure they reached a healthy weight. There was dietetic input at the paediatric ward rounds to ensure medical and nursing staff were aware of particular patient needs.

Catering staff were able to accommodate special dietary needs, including food allergies, and had recently launched a new menu. We saw evidence that staff documented food allergies clearly in patient records.

Staff on the day surgery unit followed good practice guidelines in relation to paediatric preoperative fasting, endorsed by the Association of Anaesthetists of Great Britain and Ireland. These guidelines recommend that children should be encouraged to drink clear fluids up to two hours before elective surgery, breast milk up to four hours before, and cow’s milk, formula and food up to six hours before surgery.

The service promoted breast-feeding and was supported by a part-time infant feeding advisor. Breastfeeding mothers had access to fluids and a fridge to store breastmilk. In the National Neonatal Audit Programme 2016, 69% of babies born under 33 weeks were receiving their mother’s milk, either exclusively or as part of their feed, at the time of discharge. The service was performing better than the national average of 59%.

Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. In the 2017 PLACE assessment, patients on Neptune Ward assessed ward food to be better than the England average.
Pain relief

Staff told us that they regularly assessed and managed patient pain levels, and the patient records we reviewed supported this. Parents told us their child’s pain was well managed and that nursing staff administered pain relief in a timely manner.

Staff used the paediatric early warning score (PEWS) to assess patient deterioration. The tool included a numerical scale to assess and record patient pain.

For younger children, the service used age appropriate pain assessment tools, including a face pain rating scale and colour analogue scale tool. For infants and for patients unable to communicate their pain, staff used the FLACC (face, legs, activity, cry, consolability) scale.

Staff on the neonatal unit administered sucrose, as prescribed, to infants prior to a painful procedure, in order to reduce their pain levels. Staff observed the infant’s heart rate and respiration to determine whether appropriate pain relief had been given.

The practice educator conducted a paediatric pain audit in April 2017. The audit found that 100% of patients had a pain care plan and that 90% of staff had used a pain assessment tool. Areas for improvement, including the documentation when non-pharmacological pain interventions were used, were highlighted and an action plan had been formed.

Staff told us that the play team could help distract children when they experienced pain or when they were receiving pain relief.

There was a trust-wide, acute pain team who ensured the pain relief needs of children and young people were met.

Patient outcomes

The service regularly reviewed the effectiveness of care and treatment through local and national audits. The ward managers displayed quality performance data, allowing patients, visitors and staff to view their performance. On all wards, we saw information about workforce, safety performance and patient feedback.

Local audit programmes were used to measure outcomes for patients and drive improvements to the service. For example, in July 2017, the service conducted a paediatric consent audit. The audit results provided assurance that consent was being obtained in the majority of cases. In areas where this was not the case, action plans were implemented and clinicians were reminded to appropriately document when consent has been obtained.

This service also participated in national audit programmes to measure and promote improved patient outcomes. For example, in February 2016, the service participated in the National Paediatric Diabetes Audit. In the audit, the trust performed similar to the national average in the majority of performance indicators, with one exception. This indicator related to children with diabetes not receiving the seven care processes required to achieve optimum control over their disease. Following this result, the trust provided evidence that the paediatric service had took action to address the negative outlier, with support from the diabetes multidisciplinary team.

The service participated in the National Neonatal Audit Programme (NNAP) in 2016. The audit results show that the neonatal unit performed better than the national average on six out of the eight performance indicators. The unit developed an action plan to address areas for improvement, for example, all staff on the unit had attended transport incubator training, in order to ensure infants admitted onto the unit arrive with a safe body temperature.
The service regularly reviewed the effectiveness of sepsis management through local audits. From March 2016 to June 2017, the practice educator conducted a paediatric Sepsis 6 audit, measuring staff practice against performance indicators. The audit identified areas for improvement, for example, that a three hour clinical review is consistently documented in patient notes. The practice educator had created an action plan to improve sepsis management.

Following a serious incident around infant deterioration, the service was piloting an amended paediatric early warning score (PEWS) tool for infants up to 3 months old. The new tool will have a lower threshold for clinical intervention, reducing the risk of unidentified patient deterioration.

One way to assess the effectiveness of care and treatment is to review readmission rates. From November 2016 to October 2017, 26 children and young people were re-admitted to Southend Hospital within 24 hours of discharge. The service was therefore performing slightly better than the England average, with a low readmission rate of 0.58%.

The table below shows the rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes.

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>Southend University Hospital NHS Foundation Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td><strong>Asthma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1-17</td>
<td>11.3%</td>
<td>71</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1-17</td>
<td>*</td>
<td>28</td>
</tr>
<tr>
<td><strong>Epilepsy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>*</td>
<td>6</td>
</tr>
<tr>
<td>1-17</td>
<td>*</td>
<td>12</td>
</tr>
</tbody>
</table>

From April 2016 to March 2017, the trust had 79 children and young people re-admitted for asthma, within 12 months of discharge. The readmission rate was 11.3%, better than the England average of 16.4%.

**Competent staff**

Staff had the appropriate skills, knowledge and experience to deliver effective care and treatment.

The trust had an up-to-date policy for all new staff working at the trust. According to the policy, new staff were required to complete a trust induction within eight weeks, and a local induction within six months, of their start date. New staff we spoke with confirmed that they had completed their induction within the desired timeframe.

The service ran a preceptorship programme, ensuring that newly qualified nursing staff had a smooth induction and support from senior staff.

There were appropriate arrangements for staff supervision and appraisal. Staff identified their learning needs and development opportunities through their yearly appraisal. All staff we spoke with on inspection were up-to-date with their appraisals. Nurses told us they had been supported with revalidation. This is the process where nurses renew their registration with the Nursing and Midwifery Council. All junior doctors described feeling well supported and had regular supervision from the consultants.
From April 2016 to March 2017, 83% of staff within children’s services at the trust had received an appraisal compared to a trust target of 73%.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Individuals Required</th>
<th>Staff who have received an appraisal</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>5</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>7</td>
<td>6</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>13</strong></td>
<td><strong>10</strong></td>
<td><strong>83%</strong></td>
</tr>
</tbody>
</table>

There were comprehensive competency assessments for all new nursing and healthcare staff. Competencies included clinical skills, such as accurately assessing and recognising changes in a child’s clinical condition, and appropriate use of paediatric equipment. All competencies required sign off by a senior nurse or the paediatric practice educator.

The service ensured staff had the necessary training to deliver effective care, support and treatment. Additional training opportunities were publicised on staff noticeboards. Staff told us they were supported to pursue additional training opportunities relevant to their role, for example paediatric diabetes training. The service ran annual study days for staff to receive face-to-face refresher, high fidelity and simulation training.

On each shift, there was sufficient numbers of staff trained in paediatric life support and at least two staff trained in advanced life support. There were also five staff Qualified in Speciality (QIS) on every shift on the neonatal unit. QIS is a standard level of knowledge and skills to provide neonatal care. Staff on Neptune Ward received training to deliver high dependency care, supported by the practice educators.

The service supported medical, nursing and therapy students on placement.

**Multidisciplinary working**

There was effective multidisciplinary working across the service. The service held weekly multidisciplinary team (MDT) meetings to discuss, in detail, the needs of patients. All members of the MDT were involved with assessing, planning and implementing patient care.

Multidisciplinary teams included paediatricians, nurses, healthcare assistants, play specialists, speech and language therapists, dieticians and physiotherapists. The service had daily input from a pharmacist assigned to the ward and unit. Team members all worked from one set of patient notes, ensuring a consistent approach.

There were good working relationships between medical and nursing staff. The service had combined the daily doctor and nurse handovers into one, which supported joint team working. We observed a daily handover and ward round and saw that the consultants sought opinion from a nursing perspective for each patient. Staff actively encouraged parents to attend ward rounds for their child.

Staff on the neonatal unit requested daily updates from the central delivery suite and maternity ward about neonates who potentially required admission to the unit. Staff reported that they had good communication links with maternity services.

The community nurses were an integral part of the team and worked closely with staff on Neptune Ward to ensure care outside of the hospital setting was effective, for example in schools.
Staff made a referral if a patient required access to the wider multi-disciplinary team, for example the infant feeding advisor or tissue viability nurse.

The paediatric service had a play team, available five days a week. The team had expanded considerably in the last year and was hoping to continue to grow, in order to provide seven day services. Any department within the hospital that cared for children and young people could access the qualified play specialists.

Staff had access to psychiatric advice from a local mental health NHS trust. Children and young people requiring mental health treatment were referred to the local Child and Adolescent Mental Health Service (CAMHS).

There were transition arrangements for young people moving into adult services. The ward had created a booklet for staff to follow when supporting young people transitioning to adult services.

The Lighthouse Child Development Centre functioned as a multi-agency facility, providing children and young people with support from acute services and from within the community.

The service had strong working links with other services and agencies such as community teams, the local children’s hospice and the voluntary sector.

**Seven-day services**

Seven-day services were provided on Neptune Ward, the paediatric assessment unit and the neonatal unit. Children and young people had seven-day access to diagnostic services such as x-ray and CT (computerised tomography) scanning. For infants on the neonatal unit, the diagnostic department would bring the scanning equipment to the patient, reducing any infection risk.

The paediatric emergency department operated 8am to 9pm, seven days a week. Children and young people attending the emergency department after 9pm were triaged in the adult area. For our detailed findings on the paediatric emergency department, please see the urgent and emergency care report.

The Lighthouse Child Development Centre operated Monday to Thursday, 8am to 6pm, and Friday 8am to 5.30pm.

The children and young people’s outpatient department ran paediatric clinics Monday to Friday, 8.30am to 6.30pm. Paediatric-only orthopaedic and ophthalmology clinics ran every Thursday. The ENT (ears, nose and throat) clinic did not allocate time specifically for paediatric patients. Paediatric patients who attended the clinic would however be prioritised and seen by the consultant first.

For elective surgery, the day surgery unit ran one paediatric-only list each month. Types of paediatric surgery included general, orthopaedic, oral and ENT. On a paediatric surgery day, two paediatric nurses would support staff on the day surgery unit and a paediatric consultant would be on call, if required.

The play team was available Monday to Friday, but was looking to expand into a seven-day service. Play specialists could support children and young people in any department upon request.

Paediatric consultants were available on-site between 9am and 10pm Monday to Friday, and at weekends during ward rounds. There was a paediatric consultant on call rota for out of hours.

Pharmacy services were open Monday to Friday, 9am to 6pm, and at weekends 9am to 2.30pm. An on-call pharmacist was available out of hours. Paediatric staff had access to an emergency drugs cupboard, secured by key access, if an emergency medicine was required during out of hours pharmacy cover.
Health promotion
The service supported people to live healthier lives. The trust had a no smoking policy and only permitted smoking outside of the hospital grounds. Staff advised new parents to keep their home smoke free in order to reduce the risk of cot death and prevent chest infections.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
During our last inspection, we told the trust that it must ensure consent was discussed with patients and that this was documented appropriately. We also told the trust that it should ensure paediatric staff were familiar with the term Gillick competence. The term Gillick competence is used to describe when a child is able to consent to his or her medical treatment.

In response to these findings, an action plan was implemented. The trust then conducted a paediatric consent audit in order to provide assurance that actions put in place by the department had led to improvement and compliance. The results of the consent audit, conducted in July 2017, provided assurance that staff were following the correct procedures when obtaining consent. The audit also provided assurance that staff were aware of Gillick competence and applied this proportionately when obtaining consent from young people.

In addition to the audit, we found when speaking to staff on inspection, they understood the relevant consent and decision-making requirements, in-line with legislation and guidance.

The trust had updated their policy for consent, which outlined how staff should formally obtain and record a patient’s consent to care and treatment.

The Mental Capacity Act (MCA) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment. Information about the MCA and associated Deprivation of Liberty Safeguards (DoLS) was covered as part of staff mandatory training. Data provided by the trust showed that 98% of paediatric nursing staff and 82% of paediatric medical staff had completed the training, as of November 2017.

Is the service caring?
Compassionate care
We observed staff providing compassionate care. We saw that staff used curtains and side rooms effectively, to protect the privacy and dignity of patients.

We observed all staff to be courteous, professional and kind when interacting with patients and those close to them. We observed staff greet patients appropriately for their age, and introduce themselves by name.

All patients had an individual call bell to seek staff attention when needed. During our inspection, we found two call bells, linked to side rooms at the end of Neptune Ward, which rang quietly. This meant the calls were difficult for staff to hear and were not always responded to in a timely manner. The ward had put signs up to warn staff of this risk and placed the risk on the service risk register.

Feedback was consistently positive. The parents we spoke with said that staff were “brilliant”, “professional” and “really caring”. One parent described the neonatal unit as “the most supportive place I’ve ever been”.

Staff gave good examples of the play team going above and beyond what was expected of them. For example, the team hired a magician to attend Neptune Ward fortnightly, held a Christmas pantomime and regularly had special guests to surprise the children, including famous football players and superheroes.
Children and young people could provide feedback on the service using the pants and tops tool. The tool allowed children to inform staff as to what was ‘pants’ (bad) about the service and what was ‘tops’ (good) about the service by hanging toy clothes on a washing line. From December 2016 to November 2017, the service was rated ‘tops’ by 84 patients and ‘pants’ by three patients. From the three negative reviews, one included a positive comment about the ward and two were completed in error.

The neonatal unit, Neptune Ward and the PAU all displayed thank you cards. Comments from the cards showed that both patients and parents felt they had been treated with compassion.

Staff followed an up-to-date chaperone policy, protecting children and young people during intimate personal care.

The results of the CQC national children’s survey 2016 are displayed in the table below. The results show that the trust performed similar to other trusts for all 12 questions relating to compassionate care.

### CQC Children's Survey 2016, Southend University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were members of staff available when your child needed attention?</td>
<td>Parents/carers</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>Parents/carers</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Were there enough things for your child to do in the hospital?</td>
<td>Parents/carers</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>Parents/carers</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>Parents/carers</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>Parents/carers</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>Parents/carers</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>Parents/carers</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>Parents/carers</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>Patients aged 8-15</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Do you feel that the people looking after you were friendly?</td>
<td>Patients aged 8-15</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

### Emotional support

Staff showed a clear understanding of the importance of providing emotional support to patients and those close to them. Staff gave examples of when they had provided reassurance to patients who were anxious pre-surgery. Children and young people could visit the ward before their surgery in order to reduce their anxieties and ask questions.
Children and young people with complex needs and long-term conditions had open access to the service. This meant parents were able to contact the service at any time when they had concerns regarding their child’s health.

The neonatal unit ran two periods of quiet time each day. Staff encouraged parents to use this time for Kangaroo care, a type of care commonly used for premature babies. It involves skin-to-skin contact between parent and infant, and promotes emotional attachment and bonding. Kangaroo care can also increase rates of breastfeeding and reduce the risk of hospital-acquired infection.

The trust’s play team supported children to prepare for surgery. Play specialists used distraction therapy, including therapeutic pet visits, to help children cope with painful or difficult procedures. Before surgery, parents were allowed to accompany their child to the anaesthetic room and stay with the child until they were asleep. This ensured parents were able to provide continuous emotional support and reassurance.

Neptune ward and the neonatal unit displayed information about the local support services available. For example, we saw information about the local hospice and local breastfeeding support.

The service provided end of life care for children and young people. Staff made community support referrals and created memory boxes for parents of children receiving end of life care on the ward.

The neonatal unit had access to a bereavement support network, which provided specialist emotional support for bereaved families and anyone affected by a sudden infant death.

The chaplaincy service was available 24 hours a day, seven days a week. Chaplains from all faiths were available to offer emotional support.

The results of the CQC national children’s survey 2016 are displayed in the table below. The results show that the trust performed similar to other trusts for all three questions relating to emotional support.

<table>
<thead>
<tr>
<th>Question</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>Parents/carers</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>Patients aged 8-15</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>Patients aged 8-15</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Understanding and involvement of patients and those close to them

We saw staff communicate with patients and their relatives about their care and treatment in a way that they could understand. Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment.

Parents told us they had access to their child’s consultant to discuss their concerns.

Staff used alternative ways to communicate with patients who had additional needs. For example, patients with autism could use Makaton to effectively communicate their needs to hospital staff.
Neptune Ward, the PAU and the neonatal unit had all developed patient information leaflets providing useful information such as visiting hours, overnight stays, facilities and meal times.

Parents were treated as important partners in the delivery of care. Neptune Ward and the neonatal unit offered unrestricted access for parents and staff encouraged parents to stay with their child overnight. The neonatal unit had two parent bedrooms, prioritised for those parents with the sickest infants or for those preparing for discharge.

Parents were encouraged to be present at nursing handovers and ward rounds to enable them to be involved in the ongoing care of their child.

Neptune Ward had a bell that children could ring to celebrate the end of their chemotherapy treatment.

The results of the CQC national children’s survey 2016 are displayed in the table below. The results show that the trust performed about the same as other trusts for 17 out of 19 questions relating to understanding and involvement of patients and those close to them. The trust performed worse than the England average for two questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you given enough information to be involved in decisions about your child’s care and treatment?</td>
<td>Parents/carers</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>Parents/carers</td>
<td>8.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>Parents/carers</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>Parents/carers</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>Parents/carers</td>
<td>7.4</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>Parents/carers</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>Parents/carers</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>Parents/carers</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>Parents/carers</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>Parents/carers</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?</td>
<td>Parents/carers</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Group</td>
<td>Score</td>
<td>Comparison</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>-------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Did a member of staff give you advice about caring for your child after you went home?</td>
<td>Parents/carers</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>Parents/carers</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>Parents/carers</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did different staff give you conflicting information?</td>
<td>Parents/carers</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>When hospital staff spoke with you, did you understand what they said?</td>
<td>Patients aged 8-15</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>Patients aged 8-15</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Before the operations or procedures, did hospital staff explain to you what would be done?</td>
<td>Patients aged 8-15</td>
<td>9.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>Patients aged 8-15</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and delivered services to meet the needs of local children and young people.

The service had established effective relationships with a wide range of organisations including local commissioners, GPs, schools, mental health services and charities to address the needs of local people and improve patient access to services.

Environments specifically for children and young people, including Neptune Ward and the paediatric assessment unit had recently been redecorated, following feedback that the environment was not ‘child friendly’. Children and young people were involved in the redesign of the environment, providing artwork for the walls and creating child friendly displays.

The facilities and premises on Neptune Ward and the neonatal unit were appropriate for the services that they delivered. Neptune Ward had a playroom for children and an adolescent room for young people. The neonatal unit had a private room for mothers who wished to express breast milk.

Open visiting was available to parents on the neonatal unit and children’s ward. The service supported parents by reducing hospital parking charges.

The day surgery unit ran one paediatric-only list each month. On this day, all recovery bays would be exclusively for children and young people. Adjustments were made to ensure the environment was appropriate for children and young people, with help from the play team.

Areas that saw children and young people, but were predominantly adult based, varied, with some departments being more child-friendly than others. The adult areas with the highest proportion of paediatric attendances were in outpatients (13.5%) and the emergency department (21.4%).
Outpatient appointments, with the exception of three clinics, were held in a dedicated paediatric outpatient department. Play areas were available and were well supplied with toys and games. Clinics were held by paediatricians and staffed by nurses trained in paediatric immediate life support. Children’s pre-operative assessments were also held in the paediatric outpatient department.

There was no dedicated room on the children’s ward for the mental health team to conduct assessments.

The results of the CQC national children’s survey 2016 are displayed in the table below. The results show that the trust performed similar to other trusts for two questions relating to service delivery.

### CQC Children’s Survey questions, responsive domain, Southend University Hospital NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question</th>
<th>Sub-group</th>
<th>Trust Score</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>Parents/carers</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>Parents/carers</td>
<td>5.7</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Did the hospital change your child’s admission date at all?</td>
<td>Parents/carers</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

**Meeting people’s individual needs**

Staff planned and delivered services to meet individual needs. Pre-admission screening was used to ensure the hospital only treated patients if they could meet their needs. For example, the service did not have a paediatric intensive care unit (PICU) therefore would not admit critically ill children. Any child that deteriorated as an inpatient was stabilised and transferred to the most suitable PICU, via the local children’s acute transport service.

If a child or young person was seen in a predominantly adult based area, for example in the radiology department, staff would prioritise their care and treatment. For children with anxiety, the radiology department had a local agreement with the paediatric emergency department to utilise their play area. All departments could contact the play team to help distract children when they were being treated.

Staff did not consider the personal preferences of young people aged 16 and 17, specifically their preference to be nursed on either an adult or a paediatric ward. All young people aged 16 and 17 (with the exception of patients with a severe physical or learning disability) were admitted onto adult wards.

Specialist nurses were in post for a range of specialities, including diabetes and cystic fibrosis. They completed patient reviews and ensured patients were appropriately supported both within hospital and following discharge. The specialist nurses were available to staff for advice and training.

Staff used a flagging system to record when a patient had additional needs, including patients with autism or patients who may be approaching the end of life. At the time of our inspection, the service also used the flagging system to record if a child had a protection plan or was a looked after child. However, in December 2017, the service planned to start using the NHS Child Protection – Information Sharing Project. The project allows staff from healthcare and social services to securely share information and identify children in need from their NHS number.
The paediatric assessment unit provided open access for children and young people with complex needs and chronic illness. Open access allows patients to contact the assessment unit 24 hours a day, seven days a week, if they have any concerns relating to their chronic condition.

The play team arranged access to a school teacher for children and young people who required a longer stay in hospital.

Staff supported young people in their transition to adult services. Young people aged 15 received a care plan, indicating the most appropriate adult ward for their admission. Young people on adult wards were to be separated from adults, where possible.

There was an adolescent room on Neptune Ward with age-appropriate facilities such as video games and a DVD player.

Both phone and face-to-face interpreting services could be arranged, to support families whose first language was not English. Staff confirmed that they would know how to access these services if required. Guides for patients with a visual impairment were provided by a local charity and available on request. Patient surveys and information leaflets were available in various languages and formats.

Four paediatric staff were learning disability ‘champions’, having received additional training. For children and young people with a learning disability, the service used a variety of communication aids to support them, including easy read books, Makaton signs and sensory packs.

Staff played a NHS cartoon video to prepare children undergoing surgery. Patients were also invited to attend the ward before being admitted, in order to reduce any anxieties.

Specific dietary needs were recorded on admission. Menu options were available for patients who required special diets, for religious or cultural reasons.

The layout of the hospital meant that all paediatric areas were accessible for people using a wheelchair. The hospital had accessible bathrooms and lift access. An accessible wet room had recently been built on Neptune Ward, funded by patient’s parents.

There was a parents’ room on the wards, for parents to have some quiet time away from the main ward area. There were facilities for parents to make food and hot drinks.

On the children’s ward, overnight parent beds were available by each patient area. New parent beds had recently been introduced following a parent bed pilot. On the neonatal unit, there were two overnight rooms for parents and a dedicated bereavement room on the adjacent maternity ward.

**Access and flow**

The Lighthouse Child Development Centre specialises in outpatient care for children and young people with significant delay in multiple areas of development. During our last inspection, we told the trust that it should ensure all reasonable steps were taken to minimise paediatric waiting lists at the centre.

On this inspection, we found that paediatric waiting lists were still long, particularly for autism spectrum disorder (ASD) assessments. Receiving an ASD diagnosis can enable parents to better understand their child and can also provide access to support services.

There were two pathways for an ASD assessment; assessment for a child under five years of age, and assessment for children and young people over the age of five. The trust was not commissioned to provide the latter. Despite this, the Lighthouse Child Development Centre had 362 children over the age of five, awaiting an ASD assessment (as of December 2017).

We were told that the service leads had been in contact with the commissioners regarding this issue. In December 2016, the commissioners were informed that the trust could not hold a waiting list for a service that was not funded. No changes have been made to commissioning arrangements, in spite of the growing waiting lists. The trust has taken some action to address this waiting list, namely they have referred 80 patients to local hospitals for assessment. As of December 2017, 282 patients were still awaiting assessment.
For ASD assessments for children under the age of five, the Lighthouse Child Development Centre had 149 children on their waiting list. The trust was commissioned, and completing, 40 assessments per year. Again, the trust contacted the commissioners in December 2016 regarding the growing backlog. No changes have been made to commissioning arrangements although the Head of Paediatrics has met with the local clinical commissioning groups to discuss their concerns. Since our last inspection, there have been no significant changes to the service, in order to reduce waiting times.

In addition to the ASD waiting lists, there was also a nine week waiting list for an epilepsy assessment following a GP referral. Although this is within the NHS target of 18 weeks, NICE guidelines recommend patients should be assessed within two weeks of referral. A delayed epilepsy diagnosis can delay child development and access to treatment. Data submitted from the trust showed that from September 2016 to October 2017, children were waiting between four and 16 weeks for assessment.

The paediatric assessment unit saw children and young people following a GP referral, midwife referral, community nurse referral, a referral from the emergency department or via open access. The unit assessed, investigated, observed and treated children and young people, reducing inpatient admission.

The neonatal unit had clear operational guidelines for neonatal admissions. Neonates were defined as infants up to, and including, four weeks of age, or up to 44 weeks corrected gestational age. The neonatal unit was Level 2 and provided special, high dependency and intensive care.

Sick and premature infants were referred to the neonatal unit from both Southend Hospital maternity department and from the local community.

Neptune Ward also had operational guidelines for admitting patients. Children and young people up to the age of 15 were admitted onto Neptune Ward. All young people aged 16 and 17 were admitted onto adult wards.

For children and young people requiring a planned admission, a registrar or consultant would refer the patient and their name would go onto the waiting list. When a child or young person was admitted, the bed was booked through Neptune Ward clerk.

Neptune Ward also looked after children and young people requiring high dependency care. From January to November 2017, the ward had 114 patient admissions that required high dependency care.

From August 2016 to July 2017, the neonatal unit discharged 230 patients and Neptune Ward discharged 3165 patients. Both wards reported no incidents of delayed discharges.

The DNA rate (rate at which patients did not attend their appointment) for the paediatric outpatient department was 14%.

From August 2016 to July 2017, there were seven moves at night on the neonatal unit and five on Neptune ward.

The graph below shows that from August 2016 to July 2017, neonatal bed occupancy fluctuated between 50% and 0%. This is better than the England average of 70%. As a baby’s condition improved or deteriorated, staff would move neonates between special care, high dependency care and intensive care, to ensure the correct level of care was given.
Learning from complaints and concerns

There were clear processes for staff to manage complaints and concerns.

In April 2016, the trust launched a new complaints process, allowing for more direct intervention and early resolution. Following its launch, the trust had seen a reduction in the number of complaints requiring formal investigation.

Staff managed complaints in a timely manner. Staff logged all complaints and concerns onto the electronic recording system. Once a complaint was received, staff were expected to acknowledge a complaint within three days. As of June 2017, 100% of complaints were acknowledged within this period.

From July 2016 to August 2017, the service received six complaints. The complaints all varied in theme. As of August 2017, three of the complaints were closed and three remained open, with the longest open for 117 days. The complaint related to the attitude of staff and lack of information received.

There were procedures for sharing and learning from complaints across the service. Complaints were discussed both locally at team meetings and at a senior level at the paediatric directorate meeting. Trends would be identified and learning shared via email.

We saw evidence that the service used complaints to change practice and improve care. For example, following a complaint around disruption to feeding, the neonatal unit had introduced protected breastfeeding times.

Complaints were often resolved by arranging for the complainant to meet with staff. Interpreters could be used to assist with bringing quick resolution to a complaint.

Complaints leaflets and posters, describing the trust’s complaints procedure, were available on Neptune Ward, the PAU and neonatal unit. Parents told us they would be confident to raise a concern if necessary.

Is the service well-led?

Leadership

There was a clear leadership structure for the children and young people’s service.

The service was led by a clinical director, associate director and head of paediatrics. The matron for paediatrics and neonatal lead nurse supported the day-to-day management of paediatric services. The children’s ward, paediatric assessment unit and neonatal unit was led by a ward manager.
The paediatric matron reported to the head of paediatrics, who in turn reported to the associate director.

Medical leadership was from the clinical lead for paediatrics and neonatology.

Both nursing and medical staff reported good relationships with service leads and described managers as visible, approachable and supportive.

The trust launched a succession planning initiative in 2016. This plan identified all critical roles across the directorates and ensured that staff had support with their development.

Staff across the service told us that the service leaders were visible and approachable. Staff said they felt well supported and that the senior staff implemented change across the service.

Staff said that the matron for children and the lead nurse for neonates worked clinical shifts to support any increased capacity.

The Lighthouse Child Development Centre was overseen by the lead nurse and service manager for the outpatients department.

Staff could raise concerns and evidenced when actions had been taken, for example introducing journey boxes for each baby.

Staff had access to leadership skills and development opportunities, accessed on the electronic learning system.

**Vision and strategy**

The hospital’s vision and strategy was displayed in the ward area and was described by staff as embedded in their practice. Staff told us how they provided medical and surgical care to children and young people in a holistic and nurturing environment, to promote the child’s recovery and wellbeing.

The hospital had a clear strategy to improve services for children and young people. There was evidence of progress completed in the last twelve months and a clear progression for future developments.

The head of paediatrics told us that there were plans to continue to develop the service and to provide high quality care to children in all appropriate departments within the hospital.

We saw the service’s profile and values displayed on the governance board and staff were aware of the planned changes. One example given by staff was the submitted business case to move the paediatric assessment unit to the same floor as the paediatric emergency department. Once the business case has been approved this would address the absence of paediatric staff within the emergency department out of hours, and reduce admissions to the children’s ward.

The trust had four strategic aims; excellent patient outcomes, excellent patient experience; engaged and valued staff and financial and operational sustainability.

The trust had worked with staff and patient representatives to agree organisational values and staff demonstrated the values in their roles. The values included care with compassion, treating people as individuals, listening effectively and with empathy, delivering high quality standards, to go the extra mile and to promote partnership working to ensure safe and effective care was provided in the best interests of the patients.

**Culture**

This service’s clinical leads were proud of the positive change in culture since our last inspection. All staff we spoke with during the inspection explained that they were proud to work for the service. Staff described their managers as caring, supportive and honest.
The administration and domestic staff told us they were included as part of the team. Staff told us about how they supported each other and we saw details of a forthcoming social event. The service ran staff recognition awards for positive contributions to the service. The trust had appointed a ‘freedom to speak up guardian’. Guardians promote an open culture, allowing staff to speak up about concerns easily. Staff were aware of how to contact the guardian if needed.

**Governance**

All staff we spoke with could clearly describe the senior management structure at the hospital and discussed their specific roles and responsibilities.

The trust had a joint executive group with a governance framework which allowed the organisation to plan services and make decisions in collaboration with local NHS hospitals. While there were examples given by the chief executive of top level joint working, senior staff did not all describe shared learning across the hospitals.

The hospital maintained a robust governance structure for children and young people’s services, including a clear mechanism for effective communication via the children and young people’s service committee, the quality and safety committee and medical committee. We looked at the governance committee meeting minutes for September and November 2017, which showed improvements and changes implemented.

There was a clear governance structure in place for the service. The trust recently updated its quality governance arrangements to include risk identification, effective committees and to improve assurance with ward to board reporting.

Three senior staff told us that the trusts were working together to streamline policies across the group.

The service regularly reviewed the effectiveness of care and treatment through local and national audits. The ward managers displayed quality performance data, allowing patients, visitors and staff to view their performance regularly.

Ward staff escalated information through twice daily handovers and team meetings.

**Management of risk, issues and performance**

We reviewed the risk register for the children and young people’s service. Current risks were identified, with ratings and action required. Senior staff updated the register when a new risk was identified.

We reviewed 19 open risks on the service risk register that included staffing, resources, security, and waiting lists growing from the lack of commissioning.

The risk register was on the agenda at the children and young people forum and at quality performance meetings. Staff who did not attend the meeting received minutes or received the information as part of the monthly staff handover.

**Information management**

The information governance committee produced data quality reports every three months and produced an annual data quality report for the trust board.

A trust magazine is published three times a year to update staff and service users on the latest hospital updates and events.

Data quality reports were produced by the directorate and submitted to the information governance committee, which fed into the annual information governance data quality report.
The risk and patient safety team issued a newsletter to share all learning from incidents across the trust. The newsletter was available on the staff intranet.

There was a monthly nursing and midwifery newsletter and a newsletter issued to those involved in the sustainability and transformation programme.

Any newborn infant admitted to the neonatal unit had their data collected and stored securely on an electronic database. This database is used in all neonatal units across London and South East England to support the ongoing development of neonatal care.

**Engagement**

Nursing staff told us that they attended regular staff meetings. The meetings held shared information and learning. We reviewed minutes from meetings held from September 2017 to November 2017. These staff meetings enabled staff from children and young people’s services to discuss issues of importance or raise areas of concern. Staff shared ideas, opinions and feedback. If staff did not attend the meeting, they received feedback at staff handover, minutes on the staff board and by email.

Public feedback was sought through a variety of methods. The hospital accessed social media to gain feedback from patients, including from parents of children and young people. Patient satisfaction survey cards were available to ensure feedback from all children and young people.

The wards had a trained nurse identified as the sepsis champion and the trust had an identified lead nurse across the trust. Implementation of the sepsis pathway had been adapted after staff gave feedback to ensure that it was suitable for this service. Sepsis 6 posters were seen displayed across the departments.

The trust informed us they had a patient and carer service improvement group with a smaller subgroup held within the directorate. Any issues raised were taken to the main group for trust wide learning.

Staff attended schools and college events to promote trust membership and future employment opportunities. Staff contributed in projects within the local community including a local children’s hospice and the local football team.

Two staff had been nominated for local NHS Choice awards from this service.

The patient experience team completed a monthly performance report that was presented to the directorate governance meeting. The report included data collected from parents and children and the actions addressed within the service.

**Learning, continuous improvement and innovation**

The service use the baby buddy software application for new parents, which answered frequently asked questions.

The lead nurse showed us the draft family guide for the neonatal unit, which updated patient information in line with the neonatal network.

As part of the neonatal network, the unit undertakes research projects that contribute to national or international research.

Senior staff proudly shared examples of improvements within the service, which included an antibiotic pilot on the neonatal unit.

Staff told us how they had introduced journey boxes, which allowed parents to document their child’s life from birth and during the neonatal admission. The box included knitted bonding squares exchanged between mother and baby to promote bonding.

From December 2017, the service will use the child protection information sharing (CP-IS) project. The project allows staff from healthcare and social services to securely share information and identify children in need from their NHS number.
Areas for improvement

Action the service SHOULD take to improve
- The trust should actively manage waiting lists and communicate with commissioners to promote children’s health at the Lighthouse Child Development Centre.
- The trust should ensure medical staff comply with mandatory training.
- Staff did not consider the personal preferences of young people aged 16 and 17, specifically their preference to be nursed on either an adult or a paediatric ward.

End of Life Care

Facts and data about this service

End of life care (EoLC) encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services. The trust had 1,630 deaths between July 2016 and June 2017.

(Source: Hospital Episode Statistics (HES))

Southend Hospital provides end of life care across the trust for patients who are approaching the end of their life. This can be in an outpatient setting, but is predominantly as an inpatient, especially during the last days of life and care after death. Whilst end of life care can be delivered on any ward, specialist palliative care beds are on Bedwell and Elizabeth Loury wards. The palliative care team operates a seven-day service providing direct clinical assessment, intervention and support for the multi-disciplinary Teams (MDT). Out of hours support is provided by palliative care consultants.

Early bereavement support and ‘one-stop’ registration service in partnership with the local council is provided by the bereavement coordinator. This is part of the dedicated Bereavement Suite service.

Trust wide clinical lead provision is by the Medical Director. On-going development of EoLC is underpinned by the Trust wide EoLC working party (EoLCWP), chaired by palliative care lead clinicians. The EoLCWP strive to continually improve EoLC services and experiences of patients and families cared for by Southend Hospital. An EoLC nurse facilitator supports operational developmental needs.

Southend Hospital hosts the palliative care consultant who works across the acute trust and in South East Essex Community and is jointly funded by Southend Hospital, Castle Point and Rochford and Southend clinical commissioning groups (CCGs). They are supported by the hospital palliative care clerical team. Southend Hospital supports the management and coordination of the consultant rota for South Essex. This allows cross cover and maintains close working relationships across the NHS and voluntary providers in South Essex.

(Source: Routine Provider Information Request (RPIR) – Context Acute)

The specialist palliative care team (SPCT) received 627 referrals to the service from 1 April 2017 and 30 September 2017. Support from the SPCT for non-cancer patients had increased by 4% from the previous year (2016/17) and represented 29% of the team’s activity.

The service was previously inspected in January 2016 and was issued with a requirement notice in relation to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Premises and Equipment. Requirements to improve were made and related to the mortuary facilities not been secure or suitable for the purpose they were being used, not
all mortuary equipment was safe to use and capable of effective cleaning, a mortuary storeroom could only be accessed by a footpath used by the general public and security and night surveillance arrangements for the mortuary were inadequate.

We completed a short notice inspection of the end of life care service on 21 and 22 November 2017. We visited seven wards, including Bedwell and Elizabeth Loury, respiratory wards, the children’s unit, the Butterfly suite (in maternity services) and the emergency department. We also visited the mortuary, the chapel and the bereavement suite. We spoke with four patients and 10 patients’ loved ones. We spoke with 34 members of staff including medical and nursing staff, allied healthcare professionals, the SPCT, staff from the bereavement suite and mortuary and chaplaincy staff. We reviewed 10 patient care records and 10 ‘do not attempt cardiopulmonary resuscitation’ forms (DNACPRs) and information including policies, procedures and audits.

Is the service safe?

Mandatory training

The end of life care service had processes and practices in place to ensure that staff received effective training in safety systems.

The trust set a target of 85% for completion of mandatory training modules, with the exception of information governance and safeguarding children level 1 where the target was 95% and Prevent (Levels 1-2) where the target was 69%.

A breakdown of compliance for mandatory courses from April 2016 to March 2017 for medical/dental staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>85%</td>
<td>4</td>
<td>8</td>
<td>50.0%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>85%</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Venous Thromboembolism</td>
<td>85%</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>CPR - Adults</td>
<td>85%</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85%</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Local Induction</td>
<td>85%</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>MCA DOLS Level 1</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>MCA DOLS Level 2</td>
<td>85%</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Prevent (Levels 1-2)</td>
<td>99%</td>
<td>6</td>
<td>8</td>
<td>75.0%</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>85%</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
</tr>
<tr>
<td>Oxygen Therapy</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>119</td>
<td>131</td>
<td></td>
<td>90.8%</td>
</tr>
</tbody>
</table>

Of the 20 mandatory training modules for medical/dental staff, 16 modules achieved above the trust target. The four modules that did not reach the trust target were: Health and Safety (slips, trips and falls) with 50% completion rate, Fire Safety with 75% completion rate and Falls Prevention with 50% compared to 85% trust target; Information Governance achieved 88%
A breakdown of compliance for mandatory courses from April 2016 to March 2017 for qualified nursing staff in end of life care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>85%</td>
<td>5</td>
<td>10</td>
<td>50.0%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>95%</td>
<td>8</td>
<td>10</td>
<td>80.0%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>85%</td>
<td>6</td>
<td>10</td>
<td>60.0%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
</tr>
<tr>
<td>CPR - Adults</td>
<td>85%</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>85%</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>85%</td>
<td>7</td>
<td>10</td>
<td>70.0%</td>
</tr>
<tr>
<td>Local Induction</td>
<td>85%</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>MCA DOLS Level 1</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>MCA DOLS Level 2</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Prevent (Levels 1-2)</td>
<td>69%</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Oxygen Therapy</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>163</strong></td>
<td><strong>181</strong></td>
<td></td>
<td><strong>90.1%</strong></td>
</tr>
</tbody>
</table>

Of the 20 mandatory training modules for qualified nursing staff, 16 modules achieved above the trust target. The four modules that did not reach the trust target were: Health and Safety (slips, trips and falls) with 50% completion rate, Manual Handling – People with 60% completion rate and Infection Prevention with 70% completion rate compared to 85% trust target; Information Governance achieved 80% completion rate compared to 95% trust target.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust planned to introduce mandatory end of life care training for all staff on induction training.

**Safeguarding**

The service had systems and processes in place to protect to protect people from avoidable harm and abuse. The systems and processes were inclusive of all patients and did not discriminate against protected characteristics or patient groups.

Safeguarding adults and children formed part of the trust’s mandatory training programme. The trust required staff to complete safeguarding adults and safeguarding children levels one and two for all patient-facing roles.

The trust had reviewed and updated the policy for Female Genital Mutilation (FGM). Staff received training about FGM within the mandatory safeguarding training. The policy included risk assessments to assist with the escalation of concerns about FGM. The children’s and adults safeguarding teams shared information accordingly when there were both children and adults within the family network.

The trust had comprehensive policies in place regarding safeguarding of adults and children, including guidance on identifying domestic violence and female genital mutilation (FGM). Staff could access these policies through the hospital intranet system. The policies were up to date
and made reference to national guidance and legislation. The hospital used a red flag system for patients that had previously been subject of a safeguarding concern. Staff could access advice and support regarding safeguarding concerns could access the safeguarding team. The trust had a named safeguarding lead in the trust.

All of the staff we spoke with understood their role with regard to keeping patient’s safe and reporting any potential safeguarding concerns. A member of staff from one of the palliative care wards described how they had reported a safeguarding concern about a patient. Staff said they were encouraged to report any concern they had.

The trust set a target of 85% for completion of safeguarding training, with the exception of Safeguarding Children (Level 1) which the trust set a target of 95% completion.

A breakdown of compliance for safeguarding courses from August 2016 to July 2017 for medical/dental staff in End of Life Care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>26</strong></td>
<td><strong>26</strong></td>
<td><strong>26</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The end of life care service had an overall completion rate of 100%, which exceeded the 85% or 95% target for the Safeguarding modules.

A breakdown of compliance for safeguarding training from August 2016 to July 2017 for Qualified nursing & health visiting staff (Qualified nurses) in End of Life Care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>39</strong></td>
<td><strong>40</strong></td>
<td><strong>40</strong></td>
<td><strong>97.5%</strong></td>
</tr>
</tbody>
</table>

The end of life care service had an overall completion rate of 98%, which met the 85% or 95% target for the Safeguarding modules. The training module that had the lowest completion rate was Safeguarding Children (Level 2) with 90% completion rate.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**

The trust generally had processes in place to ensure that standards of cleanliness and hygiene were maintained.

The specialist palliative care team (SPCT) completed infection prevention control training as part of the trust mandatory training programme. Compliance for SCPT staff was 100% (April 2016 to March 2017).

Most staff dressed ‘arms bare below the elbow’ and we saw staff using personal protective equipment (PPE) such as disposable gloves and aprons, appropriately when caring for patients. The trust had undergone a trust-wide external infection prevention and control review in
November 2017 and we saw that a concern had been identified on Elizabeth Loury ward regarding some doctors not being ‘arms bare below the elbows’. The trust had an action plan in place that stated that staff had to challenge non-compliant actions and there was a plan to further brief staff via other communication methods. We observed a senior member of the ward team on Elizabeth Loury ward challenging a senior member of medical staff who had not dressed ‘arms bare below the elbow’.

We reviewed the hand hygiene audit results for Kitty Hubbard and Elizabeth Loury from June to October 2017. Both wards scored 100% for each monthly audit submission. However, Kitty Hubbard ward did not submit the hand hygiene audit for August 2017.

We spoke with staff from the housekeeping service on Bedwell who told us they had enough personal protective equipment, to enable them to do their job effectively. We reviewed cleaning schedules and saw there were appropriate cleaning audits carried out by the cleaning company. Audit results were displayed on Bedwell and Elizabeth Loury wards.

In the mortuary and on the wards we visited, equipment such as trolleys and medical equipment were visibly clean and we saw ‘I am clean stickers’ on some equipment.

The external infection prevention and control Review (16 November 2017) had identified other concerns on Elizabeth Loury related to infection prevention and control. We read the trust action plan and saw that action had been taken against all identified issues.

Environment and equipment

The design, maintenance and use of facilities, equipment and premises mostly kept people safe.

The mortuary functioned in very old buildings and the trust had identified it was in need of significant improvements. At our previous inspection in 2016, we found that the mortuary facilities were not secure and installations and equipment were worn out and unreliable. During this inspection, we found that there were some improvements and a comprehensive action plan in place to improve facilities; however, some of the delivery was reliant upon securing appropriate capital investment.

Following our last inspection, the trust recognised the aged building would continue to be a challenge and a capital scheme was devised and enabling works undertaken during 2016/17 with a full scheme requiring approval for 2017/18 and subsequent years. The full scheme involved a full redesign of the mortuary estate and senior staff told us monies were sought through a capital loan scheme.

We saw technical drawings for the proposed redesign of the mortuary although these had not been submitted for planning consent until the capital had been secured through a loan process.

The Human Tissue Authority (HTA) is responsible for regulating and inspecting all mortuaries that conduct post mortem examinations and other areas related to storing human tissue and organs after death. The HTA undertook an inspection of Southend Hospital mortuary on 13 and 14 September 2017 (a link to the report is here: https://www.hta.gov.uk/establishments/southend-hospital-11068). We reviewed the site inspection report of the mortuary from HTA.

We spoke to senior members of staff from the mortuary service and were informed the critical action identified by the HTA to improve the mortuary environment and service by 20 November 2017 had been completed. We reviewed the trust action plan for the short term and long-term rectification of the mortuary developed against CQC and HTA requirements.

We visited the mortuary facilities and saw that the mortuary was secure; CCTV had been installed and saw the lift was being repaired. We saw one of the water leaks in the service tunnel had been repaired by installing a sump pump. There were plans to repair another leak in the same way the following week. Equipment had been repaired and was capable of effective cleaning.

At our previous inspection in 2016, we highlighted our concerns regarding the concealment trolleys that were being used to transport the deceased. The concealment trolleys were rusty and
not fit for purpose. The September 2017 HTA report highlights this as a continued area of concern. Our observations and review of the trust action plan confirmed that the concealment trolleys were not yet replaced, however, they had been ordered. Staff told us the mortuary now had a bariatric trolley capable of carrying up to 50 stones.

Syringe pumps were kept in the palliative care equipment library and in conjunction with the medical equipment management services team there was a system for checking and tracking syringe pumps.

**Assessing and responding to patient risk**

The trust had an electronic system in place for collating patient data and identifying patient risk. Each member of staff was issued with an electronic hand held device to record patient observations such as an early warning score. The early warning score was based on six physiological parameters including temperature, pulse rate, level of consciousness and oxygen saturations. Alerts were automatically sent to the clinical team if patient scores were outside the normal parameters. This meant that the clinicians were alerted to any medical deterioration and patients had access to a timely clinical response.

The patient records we reviewed, showed that staff carried out risk assessments on patients receiving palliative or end of life care, including a malnutrition screening tool, prevention of falls and moving and handling.

The trust had put measures in place to ensure that outlying patients received a timely consultant review. We saw there were ‘medical outlier’ patients on Bedwell ward. We spoke to a senior member of the nursing team who told us there had been problems with getting medical patients reviewed by the medical team in the past, however the trust had allocated a dedicated ‘outlier’ consultant to review all medical patients and there had been an improvement. The Medical Director confirmed that a dedicated consultant for medical outliers had been put in place. They also confirmed there were further plans to mitigate the risks to medical outliers such as converting a surgical ward to a medical ward to create more medical beds during the 2017/18 winter period.

**Nurse staffing**

Our observations during our inspection demonstrated that nursing staffing levels in end of life care met the needs of patients. The skill mix of nursing staff met the needs of patients.

Nursing staffing for the SPCT was in line with national guidance. The Association of Palliative Medicine for Great Britain and Ireland and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse to 250 beds. Information provided by the trust stated the trust has nearly 700 inpatient beds and the SPCT had a full time lead nurse / co-clinical lead and 4.53 whole time equivalents (WTE) clinical nurse specialists to provide a seven-day palliative and end of life care service.

There was a daily ‘Safe at Southend’ meeting, where staff could raise any safety concerns about staffing to senior leaders.

The trust has reported their staffing numbers below for the period from August 2016 to July 2017. The trust had 0.6 less WTE qualified nursing & health visiting staff in post than planned as at July 2017.

<table>
<thead>
<tr>
<th>WTE Planned Staff</th>
<th>Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.7</td>
<td>8.1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
From August 2016 to July 2017, the trust reported a vacancy rate of -3.7% in End of Life Care, which means that the trust has an over establishment of 3.7%. This is lower than the trust's overall target vacancy rate of 7%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From August 2016 to July 2017, the trust reported a turnover rate of 0.5% in End of Life Care. This is lower than the trust's overall target turnover rate of 9.7%.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From August 2016 to July 2017, the trust reported a sickness rate of 1.2% in End of Life Care. This is lower than the trust overall sickness target of 3.5%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From August 2016 to July 2017, the trust told us that there were 25 unfilled shifts for qualified nursing staff within the end of life core service, of which 21 shifts were covered by bank, and four shifts were left unfilled.
(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing
The trust employed three palliative care consultants (total 2.0 WTE). There was also a trainee palliative care registrar in post.

However, consultant staffing was not in line with national guidance. The Association of Palliative Medicine for Great Britain and Ireland and the National Council for Palliative Care recommends there should be a minimum of one consultant to 250 beds. We did not find any evidence that the safety of care delivered to patients by the SPCT had been impacted by staffing. Palliative medicine has been recognised nationally as a difficult area to recruit to.

Consultants told us they were on call every one in seven weeks.

The trust reported their staffing numbers below for the period from August 2016 to July 2017. The trust had 4.0 less WTE medical/dental staff in post than planned as at July 2017.

<table>
<thead>
<tr>
<th>WTE Planned Staff</th>
<th>Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.3</td>
<td>7.3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From August 2016 to July 2017, the trust reported a vacancy rate of 31.1% in End of Life Care. This is higher than the trust’s overall target vacancy rate of 7%.
(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From August 2016 to July 2017, the trust reported a turnover rate of 0% in End of Life Care.
(Source: Routine Provider Information Request (RPIR) P18 Turnover)
From August 2016 to July 2017, the trust reported a sickness rate of 0.7% monthly average in End of Life Care. In July 2017, the trust reported a sickness rate of 8.3%.
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From August 2016 to July 2017, the trust told us that there were 13 unfilled shifts for medical staff within the end of life core service, of which all 13 shifts were covered by bank staff.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Records
Staff completed patient records appropriately and the information needed to deliver safe care and treatment was available to all relevant staff in a timely accessible way.

The trust has systems in place to share information about a patient’s care between teams, services and organisations. All the information needed for their ongoing care was shared appropriately in a timely way and in line with trust protocols.

We looked at the trust end of life care audit (April-October 2017) which set out that 96% of patients referred to the SPCT were recognised as end of life care patients in a timely manner.

Staff told us patients who were at the end of their lives were placed on an individualised care plan. ‘Last days of life care plans’ included the ability to carry out a holistic assessment of a patients physical, spiritual and physiological needs.

We read 10 full sets of notes for palliative and end of life care patients and found they were appropriately completed and met the five priorities of care (One chance to get it right, Leadership Alliance for the Care of Dying People, 2014). The priorities are:

- recognising that a person may die within the next few hours or days,
- appropriate communication in accordance with a person’s wishes,
- sensitive communication between a dying person and those identified as important to them,
- the dying person and those important to them are involved in decisions, and
- the needs of families and others important to the dying person are explored and met as far as possible and an individualised plan of care is agreed and delivered with compassion.

We read a palliative care patient’s medical record and were concerned there may have been a delay in diagnosis for one aspect of their condition. We asked the trust to review this patient, which they did immediately. The trust concluded there had not been any delay in diagnosis as there were other records that confirmed that appropriate medical interventions had taken place. However, we were concerned that cross-referencing of records had not taken place.

The trust told us they were part of the only national area (South Essex) where all specialist palliative care providers use the same clinical tool. The electronic palliative care co-ordination system enables the service to record and share patient care preferences and key details about their end of life care.

The SPCT told us they also used shared processes and systems with community services, which enabled them to share and update information on palliative and EoLC patients. The electronic patient records provided clinicians and healthcare professionals with a single shared health record used by GP’s, other primary healthcare providers, hospices and hospitals. This meant that healthcare professionals involved in a patient’s care had a single shared health record they could update in real time.
Medicines

Medicines were prescribed and administered or supplied to patients in line with relevant legislation, national guidance, and the best available evidence.

Staff prescribed anticipatory medicines for patients receiving end of life care. Anticipatory medicines are medicines prescribed for use on an ‘as required’ basis to manage common symptoms that can occur at the end of life. Medicines were prescribed by ward based medical staff or by the specialist palliative care team. Most nurses in the SPCT were qualified to prescribe medication.

The trust end of life care audit (April – October 2017) stated that prescribing needs had been assessed in 100% of cases and anticipatory medicines for all five common symptoms common at end of life were prescribed in 88% of cases. Common symptoms include pain, agitation and respiratory secretions.

We reviewed 10 patient records and found that anticipatory medicines were prescribed when appropriate. Patient weights had been recorded to ensure the correct dosage of a drug was prescribed.

The trust end of life care report 2016/17 stated that there had been improved syringe driver compliance following focused training at ward level from time of prescription to administration and monitoring syringe driver practice.

There was a dedicated team of oncology pharmacists who provided advice to the palliative care team.

The pharmacy department audited the turnaround times for the supply of medicines for discharge, but did not specifically audit the turnaround times for fast track patients. The average turnaround time for these medicines was 140 minutes for Elizabeth Loury and Bedwell wards from June to October 2017.

Incidents

Staff used an electronic reporting system to report incidents relating to end of life care. We asked staff about incident reporting and they all knew their responsibilities around incident reporting and the correct process. A member of staff on Elizabeth Loury gave an example of a recent incident they had reported.

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

From September 2016 to August 2017, the trust reported no incidents classified as never events within end of life care.

Source: NHS Improvement - STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care that met the reporting criteria set by NHS England from September 2016 to August 2017.

Source: NHS Improvement - STEIS

Senior staff shared learning from incidents with ward staff at ward meetings and through personal feedback.
We asked staff about duty of candour and they all understood the duty of candour principles and responsibilities. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

**Safety Thermometer**

Staff from Bedwell and Elizabeth Loury wards collected information for the NHS safety thermometer. However, both wards did not display this information.

Both wards achieved over 90% harm free care consistently from March to October 2017. We did not receive a breakdown of pressure ulcers, venous thromboembolism, catheter acquired infections and falls for these wards.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

**Is the service effective?**

**Evidence-based care and treatment**

The service had evidenced based policies and pathways that referenced national guidance, legislation and evidenced based practice. The policies took into account the needs of people with protected characteristics and people with mental health needs.

The service meets the National Institute for Care Excellence (NICE) standards for the use of Opioids in Palliative Care (CG140)

The trust had a ‘Guidance for End of Life Care for Adults’ document, staff had electronic access to the guidance in the intranet. The guidance was up-to-date, with version control and referenced national guidance and legislation.

Staff completed individualised care plans for patients receiving end of life care. These care plans included a holistic assessment of a patient’s spiritual, psychological and physical needs. This was in line with national guidance including The National Institute for Health and Care Excellence (NICE) guidelines on ‘Care of dying adults in the last days of life’ (2015) and the ‘Priorities of care for the dying patient’ from the Leadership Alliance for the Care of Dying People (2014).

We saw the trust’s End of Life Care Annual Report 2016/17, which stated that assessment and spirituality care documentation had significantly improved with compliance at 55%. The audit results were derived from an average of 40 patients per week. During our last inspection in January 2016, we found that the trust was poor at assessing spirituality or at least at recording the assessments.

The trust was participating in a national accreditation scheme known as the Gold Standards Framework (GSF). The GSF is a systematic, evidence-based approach to optimising care for all patients approaching the end of life.

We saw evidence that staff had completed GSF accreditation work and training and were awaiting the accreditation inspection in 2018 for Rochford and Westcliff wards. There were plans to pursue GSF accreditation for other wards such as Benfleet, Bedwell and Elizabeth Loury.

We saw that SPCT staff completed local audits to monitor evidence based care and treatment
including guidelines issued by NICE. The trust had action plans in place to support compliance with national guidelines.

**Pain relief**

Patients were assessed for pain using the trust ‘Numerical Rating Scale’. Results were recorded the nursing care plan (Last days of Life).

The Abbey pain scale was in use for patients in pain who could not verbalise including those suffering from dementia or with a learning disability. The Abbey pain scale was an instrument designed to assist in the assessment of pain.

Pain scores were recorded on a hand held device and were monitored by senior staff to ensure patients had adequate pain control. The specialist pain team also audited the pain management service outcome measures following their involvement with end of life patients.

The SPCT consultants and nurses had specialist knowledge and were able to provide guidance to staff on the most appropriate management of patient’s pain. We saw that staff were directed to consider a referral to the SPCT if pain was not controlled.

We looked at the trust end of life care audit (April-October 2017) which set out that 100% of patients cared for by the SPCT were assessed for pain.

We reviewed 10 patient care records for patients receiving palliative and end of life care and found that pain relief was prescribed.

We asked patients and their loved ones if pain relief was given and they confirmed it was.

**Nutrition and hydration**

The service met people’s nutrition and hydration needs including those related to culture and religion. Staff identified, monitored and met the needs of patients.

Nutrition and hydration needs were included in individualised care plans. We saw evidence in patient records that nutrition and hydration needs were met. The last days of life care plan included prompts for a nutritional and hydration assessment, discussion with the patient and family about this aspect of care and escalation prompts for patients that could not eat or drink.

The patient records we reviewed had a malnutrition universal screening tool risk assessment in place where appropriate.

We looked at the trust end of life care audit (April-October 2017) which indicated that 99% of patients cared for by the SPCT had their hydration needs assessed daily and 100% of patients were supported to drink and / or receive fluids if they wished.

The Oncology team comprised of two specialist dieticians who were available across the wards to provide support to patients to achieve the optimal nutritional status for each patient.

Staff from the SPCT told us they were involved with collaborative work with other specialists to implement ‘Mouth Care Matters’ from March 2018. ‘Mouth Care Matters’ is a training initiative for healthcare professionals aimed at improving the oral health of hospitalised patients.

Staff from the SPCT told us they were looking at the potential of ward staff being able to administer subcutaneous hydration to end of life care patients in line with NICE guidelines. The trust told us that a policy had been drafted and was subject to the trust’s governance processes before approval. At the time of our inspection, they had no formal capability for ward staff to deliver hydration in this way.

**Patient outcomes**
The service routinely collected and monitored information about the outcome of people’s care and treatment.

The trust participated in the End of life care Audit: Dying in Hospital 2015 and performed similar to the England average for four of the five clinical indicators. The trust scored particularly poor for “Is there documented evidence that the needs of the person(s) important to the patient were asked about?” scoring 46% compared to the national result of 56%.

The trust answered yes to five of the eight organisational indicators.

(Source: Royal College of Physicians)

The trust conducted their own audits since our last inspection using the patient outcomes set out in the End of life care Audit: Dying in Hospital 2015. In the End of Life Care Audit for the first two quarters of 2017/18, the trust met all the standards.

Reported outcomes from the local audit included 96% of patients were recognised as being in the last days of life, there was evidence of monitoring of symptoms and signs at least daily (100%) and the care plan was followed in 100% of cases when it was present and 90% of all cases.

We read the ‘Last Days of Life Care’ plan issued as a trust document in September 2015 and noted that there were prompts for documenting that the needs of the person important to the patient were asked about. We saw that in the End of Life Care Audit for the first two quarters of 2017/18, the trust had scored 93% for relatives being given opportunities to discuss a care plan. In the trust’s bereavement survey for the same period, 50% of all respondents felt that they had received an ‘excellent’ level of support from the healthcare team and 44% felt that the level of support given to them was ‘good’.

Competent staff

The service had not met the trust’s target appraisal rated for all staff. We were not assured the service met the learning needs of staff.

From April 2016 to March 2017, 68% of staff within end of life care at the trust had received an appraisal compared to a trust target of 73%. The groups that did not reach the completion rate were NHS infrastructure support with 50%, Qualified Nursing & Health Visiting staff (Qualified nurses) with 63%, Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T) with 0% and Support to ST&T staff with 50% completion rate.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th># Appraisal Required</th>
<th># Appraisal Received</th>
<th>Completion Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>2</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>7</td>
<td>5</td>
<td>62.5%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>18</strong></td>
<td><strong>13</strong></td>
<td><strong>68.4%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

In addition to the mandatory training programme we found there was a palliative and end of life care teaching programme (2017) for key staff that included junior doctors on induction and senior
nursing staff. Topics included ‘last days of life symptom control’ and ‘psychological skills’ training. The trust told us all clinical nurse specialists were involved in teaching activities including teaching ward staff as part of the GSF programme.

The service provided syringe pump training and management for registered nurses, in conjunction with the medical equipment management services team. This was to support their development needs and to ensure that registered nurse used the syringe pumps correctly and safely.

Nursing staff had completed Gold Standards Framework training. We reviewed staff certificates showing the completion of this training.

Since our last inspection, the trust had employed an end of life care facilitator. Part of the facilitators’ role had been to develop an end of life care e-learning package for roll out across trust and particularly aimed at staff at ward level that were not part of the palliative and end of life care education and teaching programme.

The trust delivered a bi-annual Cancer and Palliative Care Education Programme for key staff over seven weeks.

**Multidisciplinary working**

The service had all the necessary staff, including those in different teams, services and organisations, to assess, plan and deliver care and treatment.

The trust told us local health care partners operated a specialist palliative care support register. We observed good working arrangements between the internal multidisciplinary team (MDT) and other allied healthcare professionals.

We observed the weekly MDT palliative care meeting chaired by a palliative care nurse. This meeting was attended by the SPCT, social workers, local hospices healthcare staff, occupational therapists and hospice at home staff.

We observed patients on the palliative care support register needs and care plan being discussed in detail including their social care, pain relief and preferred place of care on discharge. MDT staff actively discussed risks and benefits of patient’s wishes and were heard to facilitate and act upon difficult requests where possible for the benefit of the patient.

However, senior staff on Bedwell ward and chaplaincy staff told us they did not attend the weekly MDT meeting.

**Seven-day services**

The SPCT provided a seven-day service and were also available to give advice 24 hours a day.

The chaplaincy service was available 24 hours a day, seven days a week. Chaplains from all faiths were available and could be accessed through the chaplaincy service employed by the trust.

The chapel was open 24 hours a day, seven days a week for patients, staff and visitors.

Mortuary staff facilitated viewings for families by appointment between the hours of 12 noon to 4pm on weekdays. Viewings were possible outside of the standard operating hours but this was
at the discretion and availability of staff on duty.

The trust carried out a bereavement survey in 2016/17 and found 50% of bereaved people felt the mortuary viewing was excellent and 50% felt it was good.

The bereavement team were available from Monday to Friday 8.30am to 4.30pm.

Health Promotion

The service has systems in place to identify people who may need extra support, including people in the last 12 months of their lives, people at risk of developing long-term conditions and carers.

The SPCT used electronic records shared with community services, which enabled the service to identify palliative and EoLC patients.

Staff from other services referred patients to the service for palliative care support.

The trust used a “#EndPJparalysis” initiative. Staff displayed posters throughout wards encouraging patients to “Get up get dressed.” Getting up and getting dressed is believed to result in a quicker recovery, maintaining normal routine and returning home quicker.

Occupational therapists had access to kitchenettes to support patients in regaining their independence in making hot drinks and snacks before discharge.

The trust utilises the services of a Specialist Advisor working for the local stop smoking service to give support and information to patients who smoke and to provide nicotine replacement where appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff generally understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (2005) and other relevant national standards and guidance.

From April 2016 to March 2017 100% of staff within End of Life Care completed MCA DoLs Level 1 and 100% of staff had completed MCA DoLs Level 2. These were above the completion target of 85% for Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training.

(Source: Trust Routine Provider Information Return)

The trust provided training to junior doctors during induction on the completion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). The training included completing the documentation to ensure a patient’s capacity was assessed during this process.

We reviewed 10 DNACPR forms and found the orders were generally completed properly. Most included records of discussions with patients and relatives regarding DNACPR decisions. One relative told us that the DNACPR had not been discussed with them and we raised this with ward staff at the time of inspection. A senior clinician was called to deal with the matter whilst we were present.

The trust’s End of Life Care DNACPR audit in October 2017 showed compliance across the palliative and end of life care patient group. Of all the patients in that group, 98.75% of patients had DNACPR forms present, 92% had resuscitation discussed with them and 98% had resuscitation discussed with their next of kin.

Staff we spoke with understood the importance of including patients and those important to them
in discussions regarding resuscitation.

We spoke to patients about consent and they told us that staff gave explanations and asked permission to deliver care.

We reviewed Mental Capacity Act and Deprivation of Liberty safeguards assessment in one set of patient medical notes and found these had been completed correctly.

The trust told us DNACPR training in relation to capacity documentation and assessment had been incorporated into the doctor’s core training.

Is the service caring?

Compassionate care

Staff demonstrated a person centred culture and respected the personal, cultural, social and religious needs of people and how this related to their care needs. Staff adapted the care to meet the individual needs of patients.

Feedback from people using the service and those close to them was that staff took time to interact with people who used the service and those close to them in a respectful and considerate way.

Staff demonstrated a sensitive and supportive attitude to people who used the service and those close to them. Staff responded in a compassionate, timely way when people experienced physical pain, discomfort or emotional distress.

Staff consistently respected people’s privacy and dignity needs especially during intimate care or examinations.

We observed staff treated patients with compassion, dignity and respect. All the staff we spoke with demonstrated they were committed to treating patients in a sensitive and caring manner.

Staff worked hard to meet patient’s wishes to bring them comfort in the last days of life. We were told by a number of staff about how the staff group had facilitated recent wedding ceremonies conducted on the ward. Staff had put together a wedding box, which included a tiara, decorations, cards and other items to make the event special. The SPCT had helped developed wedding guidance for ward teams. Staff had facilitated and coordinated events to make patients weddings special. This included arranging for the patient to be moved into a larger side room so that the person they were marrying could spend the night with the patient. Clinical equipment was removed (where possible) and the room decorated to meet the patient’s individual tastes. An example of this was decorating a tree in the room for a patient who had worked in the gardening sector. Food had been arranged by the hospital catering team that included the provision of a cake. Staff had also attended the ward in their off duty time to help with the wedding ceremonies and had supplied food.

We were also told about the facilitation of a same sex wedding that was very well supported by the catering team.

The chaplain told us they were making plans to support a patient to attend a service of blessing in the hospital chapel for one of their close relatives as the patient could not attend the external wedding service due to ill health.

The chaplain had been involved in ward weddings and had blessed wedding rings.

On one of the wards, a member of the administration team kept a box of birthday cards for patients celebrating a birthday whilst they were in-patients.

Chaplaincy, bereavement and mortuary staff were passionate and committed to ensuring that patients were cared for with dignity and respect, both before and after death.
We spoke with patients and their loved ones who told us that “everyone is fabulous” and “they cannot fault the staff”.

The hospital provided comfort packs for patients and their loved ones in all inpatient areas. The packs included, a ‘very best wishes’ note from the trust with details of chaplaincy services, overnight bed arrangements, toiletries and a pen and note pad.

Senior staff from the SPCT told us work was underway to develop side rooms to enhance the environment for patients and their loved ones. They were working in partnership with a recently bereaved person who was fundraising to deliver the ‘Sunset room’ programme. We were told one room was almost ready for use with others planned later. There were also plans to develop dedicated ward toilet facilities for families.

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

Staff told us about a patient with a learning disability who had died and the family requested that the deceased person did not remain in the mortuary. The staff in the mortuary ensured that the person was moved the same day to the family’s choice for place of rest.

The bereavement midwife was nominated for an award for her work with bereaved parents. Memory, trinket boxes, books, and support for bereaved children were available in all areas.

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The trust had conducted a bereavement survey that was detailed in the End of Life Care report 2016/17. The survey had a 39% response rate and included there was improved privacy and dignity (from 40% to 79%), an improvement in families feeling involved (from 77% to 91%) and 72% of bereaved people would recommend the hospital.

The positive themes from the survey included loving, kind and professional staff with patients well supported despite insufficient staffing.

The last days care plan included prompts for discussing care with patients and their loved ones. We read care plans that documented patients and loved ones had discussions with healthcare professionals about aspects of a patient’s care.

**Emotional support**

Staff understood the impact of a person’s care, treatment or condition had on their wellbeing and on those close to them both emotionally and socially.

Patients were given appropriate and timely support and information to cope emotionally with their care, treatment and condition.

The trust had a number of clinical nurse specialists to support patients with a range of conditions including cancer, respiratory disease and urology.

The chaplaincy service provided emotional support for patients, their loved ones and staff. There were 23 members of the chaplaincy team, which included 19 volunteers and chaplains from the Jewish, Roman Catholic, Church of England and Free Church faiths.

The chaplaincy also had access to religious leaders from the Hindu, Buddhist and Muslim faiths. We visited the Islamic prayer room and chapel. The chaplain told us the chapel could be converted into a suitable room for Jewish people reading scriptures. We also saw there was a Hindu shrine in place.
Three services were held each week; this included two Eucharist’s and evening Prayer services. A baby memorial service was held each month for anyone who had lost a baby pre or post term.

Staff helped bereaved families to access emotional support services and there was written information on all the wards we visited on these services.

Staff understood the importance of supporting their patients emotionally during their care and treatment. One ward clerk told us that patients “needed the support of everyone.”

The bereavement suite had a volunteer until 3pm Monday to Friday. The volunteer looked after bereaved families by ensuring they were comfortable in the suite. Hot drinks and information were available.

Is the service responsive?

Service delivery to meet the needs of local people

The service met the needs of the local population and provided flexibility and continuity of care.

The facilities and premises were generally appropriate for the care provided.

There were two dedicated wards for Palliative and EoLC patients, however EoLC patients could be cared for across all clinical areas and were staff were supported by the SPCT.

Staff told us patients approaching end of life were often cared for in side rooms on the wards to protect their privacy and dignity. However, the trust’s bereavement survey in their End of Life Care report 2016/17 showed a negative theme regarding the lack of side rooms available to EoLC patients. The SPCT were aware of this issue and were working with wards to improve access where possible.

There were no visiting restrictions for visitors to patients receiving end of life care. The trust told us overnight beds were available for loved ones to use so they could stay overnight if needed. The trust had purchased an additional 16 beds to add to the existing stock so that there was sufficient bed space for loved ones.

The bereavement suite was a quiet environment with separate toilet facilities and office space where bereaved people could meet bereavement officers following the death of a patient. The carpet in the suite was old and stained and was due for replacement. Staff told us the carpet was on order and due to be fitted within a few weeks.

Weekly hospital car parking concessions were available for close relatives of patients admitted for palliative care. The next of kin of patients receiving last days care were provided with three days free parking. The last days of life care plan prompted staff to tell relatives of this arrangement.

We spoke to the bereavement office staff about the timeliness of completion of death certificates. They described the process for relatives obtaining a death certificate from the bereavement office and gave us examples of timely completion particularly for relatives from the Muslim faith.

The trust monitored the time taken to complete a death certificate from the date of death. The average time to complete a death certificate, from the date of death was under 3 days. However, the average time to complete a death certificate in March 2017 was 4.2 days.

The trust had dedicated registrars from the local authority who attended the bereavement suite every day to register deaths. A fibre optic cable had been installed for the registrars and the hospital IT system relating to the registration of deaths linked directly to the local authority system. This meant that relatives had easy access to registering their loved ones death without having to attend another location in the area.

The Human Tissue Authority conducted an inspection of the mortuary in September 2017, which found that systems, process and the premises did not meet the regulations. At the time of our inspection, the trust had made improvements and they had a comprehensive action plan in place to make the outstanding improvements.
Meeting people’s individual needs

Services had been planned to take into account the needs of different people, for example, on the grounds of age, disability, gender or religion. The service had clear systems and processes in place to meet the needs of patients with complex conditions such as those living with dementia or a learning disability.

The hospital completed 532 fast track discharges from April 2016 to March 2017 to enable patients to die in the place of their choice. However, the trust reports that two thirds of deaths occur on medical wards.

We saw end of life care discharge packs on wards that included information on the hospital palliative care services, last days of life information which included changes that may happen to their loved one and other information such as support available in the community.

The trust told us they had patient and carer information available on advanced care planning on the wards awaiting GSF accreditation.

The hospital had specialist nurses in place to support the care of patients with complex needs. These included a specialist falls nurse, a learning disability nurse and a dementia lead nurse.

The trust told us any patient identified as living with a learning disability or dementia would be assessed by the relevant nurse specialists. There were relevant care plans, pathways and policies that staff utilised to enhance care for patients with complex needs.

The clinical nurse specialist supported adults with a learning disability that accessed inpatient or outpatient services. This staff member formed part of the adult safeguarding team. Administrative staff updated the flagging system on the electronic patient administration system, which notified the clinical nurse specialist of any adults with a learning disability that accessed services at the hospital. The adult safeguarding team supported patients in the absence of the clinical nurse specialist.

The trust had a dementia clinical nurse specialist who supported and patients living with dementia and staff caring for those patients. The clinical nurse specialist was notified via the flagging system on the electronic patient administration system.

The trust told us they had a pictorial guide for helping to make sure people with learning difficulties got an equal service in hospital. We read the guide and saw there were pictures to help people to communicate regarding degree of pain, eating and drinking, personal care, and other matters such as clinical procedures and discharge from hospital.

Staff identified patients living with dementia using a ‘Forget-me-not’ symbol on the patient information board. However, this was not displayed above their bed. This meant that staff could not easily identify patients who may have complex needs due to dementia.

The hospital had “This is me’ booklets which family members could complete to give staff information on the needs and preferences of patients living with dementia.

Nursing staff gave patients living with dementia a newsletter called “The Daily Sparkle” which encouraged patient engagement, orientation and reminiscence. This was a daily newsletter, which included the day’s date and features titled “On this day” and “Do you remember.”

Nursing staff encouraged relatives to bring in items that were familiar to their family member. Some patients had fleece blankets and small teddy bears on their beds. Nursing staff told us this often comforted and calmed the patient.

The trust’s Patient Advice & Liaison Service (PALS) offered support with interpreting services if patients or their relatives needed language assistance. Staff told us they accessed language
assistance by calling the switchboard and asking for the ‘Open World / New World’ translation service.

Staff in the mortuary described to us how they met the needs of people from other faiths in the viewing room.

**Access and flow**

People mostly had timely access to initial assessment, test results, diagnosis and treatment.

The trust had 32 end of life care outliers from November 2016 to October 2017. Outliers are palliative care patients who are nursed on non-specialist wards. This meant that 32 patients were not nursed on a specialist palliative care ward.

During our last inspection, we raised the issue of the trust ‘flipping beds’. Flipping beds meant palliative care patients who were due to receive booked treatment in the infusion unit on Bedwell ward were displaced to other areas of the hospital so that the infusion unit could be used for other patients not needing palliative care. The trust ceased the practice of ‘flipping beds’ after our last inspection although staff told us the arrangement was still part of the trust’s full capacity protocol but in practice it had not happened.

We requested information about how many times the ‘flipping beds’ process had been used from October 2016 to September 2017. The trust told us that this process was no longer in place.

The specialist palliative care team (SPCT) registered 324 referrals onto the palliative and supportive care register from 1 April 2017 and 30 September 2017. There was a 4% increase in support by the SPCT to non-cancer patients in 2016/17.

Following the implementation of a SPCT seven-day service, 95-97% of patients were seen by the SPCT within 24 hours of referral (2016/17).

Information provided by the trust regarding patients being discharged to their preferred place of care / death (PPC/PPD) showed that the trust achieved 89% PPC/PPD in April 2017, 100% in May, June, July, August and September 2017 and 95% in October 2017.

At the time of our inspection, the trust told us there was a fast track discharge audit underway and the data was not available until the audit had concluded and analysed.

**Learning from complaints and concerns**

From October 2016 to October 2017, there were 14 complaints about end of life care. The trust took an average of 44 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 days or no fixed amount of days for complex cases.

The complaints generally related to communication/ information to patients and relatives (written and oral).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Staff in the SPCT peer reviewed all complaints relating to end of life care to identify themes and enhance action planning and learning. Following learning from complaints, the service implemented training to registered nurses about the discharge process in the end of life study day.

Ward staff told us they discussed complaints at team meetings so they could share learning. We read ward meeting minutes (September and November 2017) and noted complaints were recorded having been discussed at the local level.

Concerns and complaints from patients and their families were recorded and shared with the End
of Life working group. The End of Life working group was part of the mortality governance structure within the trust.

**Is the service well-led?**

**Leadership**

Leaders had the skills, knowledge, experience and integrity required in their roles. They understood the challenges to quality and sustainability and they could identify the actions needed to address them.

The service had a named board level lead and a non-clinical lead for end of life care.

Palliative and EoLC services within the trust were managed within the diagnostic and therapeutic directorate. We saw the palliative care consultant and palliative care lead nurse continued to provide strong and visible leadership in parallel with local and senior leaders within the trust.

The ward staff we spoke with knew who the SPCT were and reported positive working relationships with the team whilst also informing us the SPCT were frequently visible on wards.

Mortuary staff told us they felt supported and that concerns were heard and acted upon by the executive team in a timely manner.

**Vision and strategy**

The trust had a trust wide statement of vision and values. In addition to this, the service had their own vision and strategy. The hospital was working towards the establishment of the Mid and South Essex Sustainability and Transformation Plan (STP).

The trust wide vision was: We will deliver care with compassion, which is responsive to patients' needs. Working together, we will work in partnership with our patients, colleagues and stakeholders. Professional and accountable, we will do the right things for the right reasons.

During our inspection, the trust told us they were in the process of implementing the end of life care strategy. The strategy was in line with the GSF and the local sustainability and transformation partnership (STP).

Staff within the SPCT were fully involved in implementing the new strategy. Equally, staff we spoke with were aware of the trust’s values and strategy, they could state what they were.

**Culture**

Staff were passionate about delivering good quality end of life care and ensuring patients' lives were valued and made better even when people had only a few days to live. Staff went the extra mile to ensure patients in the last days of life were looked after with the utmost care and love. An example of this is the coordination and facilitation of wedding ceremonies and the facilitation of helping patients get to events by providing the correct support and equipment.

Staff felt able to raise their concerns. The service encouraged an open and honest reporting culture for staff to safely report their concerns without fear of retribution.

The service mostly had processes in place to provide staff with the development they needed including appraisal and career development conversations.

The trust stated they had a longstanding culture of loyalty and local ownership by staff. The trust was committed to supporting staff through a period of transition across three trusts in the STP.

Local leaders valued staff and we were told about a scheme on Bedwell ward where staff were regularly nominated for an award. Patients were asked to nominate staff through a simple system when they felt staff had gone the extra mile. The staff member with the most nominations won the award but all staff were given feedback. We saw examples of this which included (about the staff
member), “Lovely nature, lovely attitude, I’d be proud if I was her parent” and “Amazing, friendly, always helpful, always smiling” and “Comforted us and had kind words and good listening skills”.

Governance
The trust had a governance framework for end of life care that included the End of Life working party and a Quality Assurance Committee.

The End of Life working party met quarterly and included representatives from the SPCT, chaplaincy, mortuary service, pharmacy, children’s oncology consultant, and local leaders from each directorate.

The trust met all six national end of life organisational key performance indicators as set out by the Royal College of Physicians.

The Clinical Commissioning Group told us the trust was working with them collaboratively to improve end of life care within the hospital. The End of Life Care report 2016/17 confirmed the collaboration.

Management of risk, issues and performance
Senior leaders were aware of priorities for end of life care service in the trust particularly training all clinical staff, improving the mortuary building, and maintaining individualised care.

The palliative care team had three trust level risks on the risk register. All of the risk entries were appropriately rated and mitigating actions had been taken to reduce the risks identified.

The mortuary had a separate risk register, which included the issues identified in the Human Tissue Authority (HTA) report following their inspection in September 2017. The trust had a comprehensive action plan to implement the changes necessary to be compliant with the HTA recommendations.

The trust provided us with a copy of their action plan for the short term and long-term rectification action plan for the mortuary along with a programme of works, technical specifications for a proposed new mortuary and confirmation of the actions they had taken to address critical issues.

The trust acknowledged they had identified an upward trend in their summary hospital level mortality indicator (SHMI) and the SHMI figure for April 2016-March 2017 was 1.19 and was ‘higher than expected’ and outside of control limits (0.89 -1.12). SHMI reports mortality at trust level across the NHS in England.

The SHMI was not included as an action on the board assurance framework or within the trust wide risk register. However, the trust told us they were continuing to follow national guidance to help identify and address the reasons behind their SHMI score, which included auditing data. They committed to publishing a dashboard to provide the outcomes of case note reviews of patients who had died. We also read the mortality action plan (20 November 2017) and standing agenda items for the Mortality Surveillance Group meetings.

Information management
Information needed to deliver effective care and treatment was available to staff in a timely and accessible way. All staff had access to policy and procedure documents electronically.

We saw that all local palliative and end of life care services were supported by the electronic patient records systems to share and update information on patients. The electronic records systems were accessed securely by all clinicians and allied healthcare professionals involved in the patient’s care.

The trust had mechanisms in place to review the quality of data used for external reports and internal and external benchmarking. The trust undertook quality assurance of data prior to any
submissions to ensure consistent data integrity and completes regular accuracy audits, which identify any weaknesses in localised processes.

The information governance committee produced data quality reports every three months (quarterly). The committee also produced an annual Data Quality report for the trust’s board.

**Engagement**

The trust held safe at Southend meetings. These meetings were held at 8.30 am daily in the hospital canteen Monday to Friday and staff of all grades were welcome to attend and raise any concerns.

Staff told us they engaged staff, patients and the wider public in events such as the ‘Dying Matters’ week. Dying matters is a national initiative and hosts an annual event to place the importance of talking about death, dying and bereavement. Staff from the SPCT told us they held the event in a public area in the hospital so they could engage as many people as possible as it was an unparalleled opportunity to get people talking and thinking.

Staff from the SPCT had also held a ‘Day of the Dead’ on 2 November 2017. This was aimed again at engaging people about death and dying to break down taboos.

The trust met the bereavement survey themes of patients and relatives being updated and well supported regularly by staff.

**Learning, continuous improvement and innovation**

Senior staff told us there were plans to host a service in outpatients for palliative care patients suffering from metastatic prostate cancer. Metastatic cancer is when the primary cancer has spread to a secondary site in the patient. The trust had plans to offer a new radioactive injection treatment that could extend a persons’ life by a few months in very specific circumstances.

The trust had introduced an 18 month rotation training programme for band 5 nurses interested in oncology, palliative and end of life care. The aim of the programme was to ensure there was a degree of succession planning but also to give nurses interested in the directorate an all-round view and experience and skill in nursing patients.

Staff from the SPCT had presented on their success with EPaCCS at a 2017 national conference to share learning with other healthcare providers.

The trust had fully engaged with the GSF accreditation programme as a way of raising the level of care to the standard of being best.

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**Outpatients**

**Facts and data about this service**

Southend University Hospital NHS Foundation Trust provides its main outpatients services at Southend Hospital. The main outpatient area at Southend University Hospital NHS Foundation Trust is located on the ground floor of the tower block building. It also provides outpatients clinics at services based at Brentwood Community Hospital and Canvey Island Primary Care Centre. The same team who oversee main outpatients manages these satellite services. We did not inspect any of the other locations during this inspection.

There are consultants, allied health professional and nurse-led outpatient clinics across a range of specialities, which are provided in the main outpatients department and in separate dedicated clinics around the hospital. Outpatient clinics are held from Monday to Friday from 8.30 am until 6pm with some late clinics until 7.30pm and regular Saturday appointments are provided dependant on specialty.
Total number of appointments compared to England

The trust had 418,852 first and follow-up Outpatient appointments from July 2016 to June 2017. The graph below represents how this compares to other trusts.

(Source: HES - Outpatient)

Number of appointments by site

The following table shows the number of Outpatient appointments by site, a total for the trust and the total for England, from July 2016 to June 2017.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southend Hospital</td>
<td>608,840</td>
</tr>
<tr>
<td>Brentwood Community Hospital</td>
<td>5,306</td>
</tr>
<tr>
<td>Baddow Private Hospital</td>
<td>496</td>
</tr>
<tr>
<td>Southend Private Hospital</td>
<td>402</td>
</tr>
<tr>
<td>Nuffield Hospital</td>
<td>310</td>
</tr>
<tr>
<td>This Trust</td>
<td>624,411</td>
</tr>
<tr>
<td>England</td>
<td>104,275,113</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of Outpatient appointments from July 2016 to June 2017. The percentage of these appointments by type can be found in the chart.
Number of appointments at Southend University Hospital NHS Foundation Trust between July 2016 - June 2017 by site and type of appointment

(Source: Hospital Episode Statistics)

The previous inspection in 2016 rated the service as requires improvement: Actions required by the Trust were:

- The Trust must ensure that learning from serious incidents in ophthalmology were shared with all outpatient departments.
- The Trust must ensure that the backlog of patients waiting for follow up appointments in ophthalmology and respiratory services were managed in a timely manner.
- The trust should take action to improve the levels of medical staffing in respiratory and ophthalmology services.
- The trust should improve uptake of audit within the outpatients department.

During this inspection, we visited the main outpatient area, heart and chest clinic, ophthalmology, diabetes, orthopaedics and fracture clinic and the renal unit.

During the inspection, we spoke with 33 members of staff including one consultant, one junior doctor, eight managers, 12 nurses, five administrative staff, three health care assistants, one social worker and two volunteers. We spoke with nine patients and two relatives of patients. We looked at the environment, we observed staff interacting with patients and their colleagues and we looked at eight patient’s records, and information including policies, procedures, and audits.

Is the service safe?

Mandatory Training

There were generally effective processes in place to ensure that staff received mandatory training. Staff completed mandatory training using electronic learning and face-to-face sessions. These delivered a range of subjects as shown in the table below.

The trust set a target of 85% for completion of mandatory training modules, with the exception of information governance and safeguarding children level 1 where the target was 95% and Prevent (Levels 1-2) where the target was 69%.

A breakdown of compliance for mandatory courses between August 2016 and July 2017 for Qualified nursing & health visiting staff (Qualified nurses) in Outpatients is shown below:
Of the 21 mandatory training modules for qualified nursing staff, 16 modules achieved the trust target. The five modules that did not achieve the trust target were Conflict Resolution with 84% completion rate, Health and Safety (Slips, trips and falls) with 55% completion rate, Safeguarding Children (Level 2) with 71% completion rate, Local Induction with 75% completion rate and Falls Prevention with 79% completion rate, compared to 85% trust target.

There were no mandatory courses listed for medical/dental staff in Outpatients. The trust did not provide mandatory training rates for medical staff as these would normally be reported within the core service for the speciality. (Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff were responsible for booking their own mandatory training. Staff received a reminder via email when they were due to complete a module. Staff that we spoke with confirmed that they knew how to access the training booking system. Two members of staff told us that attending face-to-face training was sometimes a challenge due to pressures of the rota.

On the day of the inspection, we saw there was a list available in the main outpatient staff room showing the current status of staff mandatory training. Overall training compliance rates were 87% exceeding the trust target of 85%.

**Safeguarding**

Staff understood how to protect patients from abuse and had training on how to recognise and report abuse.

There were policies in place regarding safeguarding of adults and children, including guidance on identifying domestic violence and neglect. Staff could access these policies through the hospital intranet system. The policy also included guidance for staff regarding abuse such as female genital mutilation (FGM). The World Health Organisation defines FGM as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’
All staff we spoke with were able to describe their responsibilities regarding safeguarding concerns. They were able to give examples of the types of abuse, for example neglect, physical, domestic violence, sexual and psychological abuse.

The trust employed a safeguarding lead. All staff we spoke with knew how to contact the safeguarding lead. One member of staff gave an example of a situation when they had worked with the safeguarding lead to offer advice and support around a safeguarding concern that they had.

There was information on boards throughout the outpatient areas, providing advice and guidance to staff on recognising and responding to abuse. Staff told us that safeguarding concerns and actions taken were recorded in patient notes as per the safeguarding policy.

The trust set a target of 85% for completion of safeguarding training, with the exception of Safeguarding Children (Level 1) which had a completion target of 95%.

A breakdown of compliance for safeguarding courses between April 2016 and March 2017 for Qualified nursing & health visiting staff (Qualified nurses) in Outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Trust Target (%)</th>
<th>Number trained LFY</th>
<th>Number eligible LFY</th>
<th>Completion (%) LFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>85%</td>
<td>34</td>
<td>38</td>
<td>89.5%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>33</td>
<td>38</td>
<td>86.8%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 1)</td>
<td>95%</td>
<td>37</td>
<td>38</td>
<td>97.4%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>85%</td>
<td>27</td>
<td>38</td>
<td>71.1%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td><strong>131</strong></td>
<td><strong>152</strong></td>
<td><strong>86.2%</strong></td>
</tr>
</tbody>
</table>

The trust had an overall completion rate of 86% for Safeguarding modules. Three of the four modules met the completion rate and the one module that failed to meet the 85% target was Safeguarding Children (Level 2) with a completion rate of 71%.

There were no safeguarding courses listed for medical/dental staff in Outpatients. The trust did not provide safeguarding training rates for medical staff as these would normally be reported within the core service for the speciality. (Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Cleanliness, infection control and hygiene**

The service controlled infection risk well in the majority of areas we visited. However, there were not effective systems in place to ensure that standards of cleanliness and hygiene were maintained consistently throughout all areas.

Most areas we visited were visibly clean and tidy. In main outpatient’s clinic, rooms were cleaned prior to the clinic and we saw ‘I am clean stickers’ on the doors showing that the room had been cleaned that day. All the rooms in main outpatients had been cleaned on the day of the inspection. We checked the daily cleaning schedule in two clinic rooms. Both showed that the room had been cleaned daily dating back from 1 September 2017 to the day of our inspection.

A treatment room located in the eye unit was visibly dirty. We saw dust in the grate over the door vent, under the fixed trolley and under the fridge. There was a hole in the wall behind the trolley that appeared to be plugged with a hand towel. This area appeared visibly dusty. There was rust on the right hand surface of the trolley. This presented an infection risk as staff could not clean this area effectively. There was not a cleaning rota specific to the treatment room. Therefore, we could not be assured that the room had been cleaned. We raised our concerns with senior staff and when we returned for our unannounced inspection, we found that a deep clean of the room had taken place and the room now appeared visibly clean. The hole had been fixed and a wipe clean cover had replaced the air vent. The trolley had been replaced and a cleaning rota for the
area had been implemented.

In the areas we visited all seating in the waiting areas and couches in the consulting rooms were in good condition without rips and tears and were wipe clean. However, in a waiting area in the eye unit there were greasy marks on the wall where patient’s heads rested whilst they were seated. The wall surface was painted and therefore could not be easily wiped clean.

Daily cleaning charts had been fully completed in the majority of waiting areas we visited. Laminated charts were in use in some outpatient areas and this meant that historical evidence was not available.

We saw that staff were ‘arms bare below the elbow’ and followed the appropriate handwashing procedures between patient contacts in most areas we visited. We observed an intravitreal injection in a treatment room on the eye unit. The consultant administering the injection wore surgical gloves and used non-touch technique for handling equipment assisted by a nurse. However, we observed iodine eye drops being administered by the nurse. They did not wear gloves and did not wash their hands after administering drops and wiping the patients face. When we returned for our unannounced inspection, we saw that a systematic procedure for intravitreal injections had been introduced. This was laminated and was available on the wall in the treatment room. The process identified five points during the procedure when hands should be washed and gloves worn.

Outpatient departments completed hand hygiene audits. Results showed main outpatients were 68% compliant in August 2017. This had improved to 90% compliance in September 2017. Results for the renal unit showed 100% compliance in June 2017 and October 2017. Results for ophthalmology showed 100% compliance in July 2017 and 90% compliance in September 2017.

Hand sanitiser was available at the entrances to the main outpatient area and other outpatient clinics. There was signage asking staff and visitors to wash their hands when entering or leaving departmental areas.

Environment and equipment
There were processes in place to ensure that equipment was maintained and serviced. Equipment servicing and repairs were undertaken by the trust’s clinical engineering department, who were responsible for monitoring when equipment was due for servicing. Staff were able to contact the department to highlight concerns about any items of equipment. Staff told us that they were responsive and kept them up to date with any delay via email. We checked 10 pieces of equipment and they were within service date and were electrical safety tested.

Resuscitation equipment was available on trolleys at various locations in the main outpatient area and near other clinics. Daily checks were completed and tamper proof numbered tags were used to show if the contents had been accessed. Full internal checks of the trolleys were completed weekly. We examined the checklists of two trolleys and saw that checks had been completed from August 2017 to November 2017. Consumable items nearing expiry date were noted on a check sheet to ensure replacements were made.

Utility rooms were visibly tidy and equipment stored appropriately. Four sharps bins were checked throughout the outpatient areas and all were appropriately labelled, signed and the contents were all below the fill lines. We saw that waste bins were available to enable waste to be segregated appropriately.

Personal protection equipment (PPE) such as gloves and aprons were available throughout outpatients in clinical areas.

We checked a range of consumable items including, syringes and dressings. We found all items were within expiry date and staff confirmed that processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

Assessing and responding to patient risk
There were comprehensive risk assessments carried out for patients using outpatient services.

There were processes in place for the assessment of people within outpatient clinics who were clinically unwell. Patients were initially assessed by staff in the department and then taken to the emergency department (ED) if appropriate. Staff used the national early warning score (NEWS) to assess and monitor the patient. A member of staff showed us an observation chart that was kept on the resuscitation trolley that was used when assessing the patient and during hand over to ED staff.

All staff knew where the nearest resuscitation equipment was located and described their role in a patient emergency. During the inspection, we saw this demonstrated when we visited the main outpatient waiting room and found staff attending to an emergency. The team treating the patient appeared organised and calm. Screens had been used to protect the patient’s dignity and access to the area was restricted. There was minimal impact on the rest of the waiting area.

There was a bell behind the desk in main outpatients, which staff would ring in the case of a patient becoming unwell in the waiting room or in clinic. On hearing the bell, clinical staff would come to assist with the patients care.

The trust had a process of assessing and responding to risk for patients on the waiting list. A senior staff member told us that the trust had implemented a new cancellation policy, which helped to ensure that patients were “safe to wait”. A review was required by the patients clinician before an appointment was rebooked, cancelled or the patient was referred back to their GP. This process was followed both when appointments were cancelled by the hospital or by the patient.

The rapid interface and discharge team (RAID) confirmed that they were available to offer advice to staff if they had concerns regarding an outpatient’s immediate mental health. If a patient required an urgent assessment, they were referred to the ED. Staff said they would also contact the patient’s general practitioner to relay their concerns.

Outpatient areas used an adapted version of the ‘World Health Organisation (WHO) Surgical Safety Checklist and five steps to safer surgery’ prior to performing invasive procedures such as biopsies and intravitreal injections. However, we observed a procedure in the age related macular degeneration (AMD) treatment room and although the principles of the WHO checklist were carried out this was not formally recorded. We raised it at the time of the inspection. When we went back for our unannounced inspection, we found that an adapted WHO surgical safety checklist had been implemented.

The trust audited compliance with the WHO check but the results provided did not separate procedures carried out in outpatients from other surgical procedures. The trust reported that the audit provided substantial assurance of compliance.

There were Local Safety Standard for Invasive Procedure (LocSSIPs) in place in outpatients including the breast unit, eye unit, minor operations and urology outpatients. Data provided by the trust showed that audits of these were scheduled between January and March 2018.

**Nurse staffing**

The trust has reported their staffing numbers for Outpatients below for the period from August 2016 to July 2017. The trust had 1.4 less WTE qualified nursing & health visiting staff in post than planned as at July 2017.

<table>
<thead>
<tr>
<th>WTE Planned Staff</th>
<th>Number in post as at July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>37.4</td>
<td>36.0</td>
</tr>
</tbody>
</table>
From August 2016 to July 2017, the trust reported a vacancy rate of 2.4% in Outpatients. This is lower than the trust’s overall target vacancy rate of 7%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From August 2016 to July 2017, the trust reported a turnover rate of 0.8% in Outpatients. This is lower than the trust’s overall target turnover rate of 9.7%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From August 2016 to July 2017, the trust reported a sickness rate of 4.5% in Outpatients. This is higher than the trust overall sickness target of 3.5%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From August 2016 to July 2017, the trust told us that there were 974 unfilled shifts for qualified nursing staff in outpatient service, of which 546 shifts were covered by bank, 802 were covered by agency staff and 58 shifts were left unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

There is no national baseline acuity tool for nursing staffing in outpatients. Staff that we spoke to at all levels said that staffing levels were adequate for the clinics and services that were delivered. During our inspection, we observed that staffing levels were adequate and there was an appropriate skill mix including healthcare assistants (HCAs), registered nurses and allied health professionals. The outpatient manager told us that they had one nursing vacancy in the department. The post had been advertised and interviews were scheduled.

The renal unit had two nurse vacancies. The lead nurse told us that existing staff worked extra shifts to cover.

The main outpatient senior nurse shared planning of staff allocation and staff skill mix with other members of the outpatient nurse team. The outpatient manager did duty rotas four weeks in advance. Rotas were adjusted to meet the capacity needs of the department. The number of clinics were monitored by the outpatient sister on a daily basis and any staffing issues relating to staffing numbers and skill mix were addressed. Incidents of staff shortages were escalated to the matron.

Any shortfall in staffing was covered by staff from the department. Lead nurses had set up a closed social media group which enabled them to share information around staffing and where required allocate staff accordingly.

Managers confirmed that they used established bank staff to cover vacancies and sickness. The main outpatients department did not use agency staff.

**Medical staffing**

In the outpatients department medical staffing was provided by the specific specialities that were holding the clinics such as rheumatology, cardiology, ophthalmology and audiology.

There was no reported medical/dental staffing numbers for Outpatients.

(Source: Routine Provider Information Request (RPIR) P16 Total numbers – Planned vs actual tab)

From August 2016 to July 2017, the trust told us that there were eight unfilled shifts for qualified medical staff in the outpatient service. All were covered by bank staff.
There were vacancies within the clinical teams who provided staff for the outpatient clinics specifically in ophthalmology and respiratory medicine. The trust had an on-going campaign to recruit staff to fill medical vacancies.

From August 2016 to July 2017, the trust reported a turnover rate of 0% in Outpatients. This is lower than the trust’s overall target turnover rate of 9.7%.

From August 2016 to July 2017, the trust reported a sickness rate of 4.7% in Outpatients which is higher than the trust overall sickness target of 3.5%.

Regular locum staff were used to cover outpatient clinics but we were not able to ascertain the exact number of clinics where locum staff were used from the data supplied. Staff told us that locums were covering outpatient clinic in respiratory medicine and ophthalmology.

Records
Medical records were available electronically in the majority of clinics. This meant that patients were not seen without their medical records being available and enabled clinicians to share information appropriately between departments.

We reviewed eight electronic patient records and found them to be comprehensive with access to investigation results. All had a diagnosis and management plan documented and showed evidence of discussion with the patient and family members where appropriate. All showed evidence of multidisciplinary team (MDT) input and all were dated and signed appropriately with the name and grade of clinician clearly shown. One did not have the patients’ allergies or weight recorded.

Medicines
Medicines were stored in locked cupboards and refrigerators. We checked a range of medications and found them to be in date and stored appropriately. The nurse in charge held the keys to the drug cupboards.

No controlled drugs (CDs) were stored in the areas we inspected which included main outpatients, ophthalmology and the heart and chest clinic.

There were processes in place to monitor and record temperatures of rooms and fridges where drugs were stored. For example, for two of the clinic rooms we visited we saw that daily temperature checks had been completed between September and November 2017. Fridge temperature checks were also monitored daily and this had been completed for the fridges in the two rooms we checked, however, this was not consistent throughout all clinics.

On the day of our inspection, the fridge in a treatment room in ophthalmology had been below the minimum temperature four times. This had been reported by staff but had not been addressed. The fridge was very full as the fridge in theatres had broken and the medicines had been transferred. Staff told us that this had occurred on numerous occasions. When we returned for our unannounced inspection, the fridge was not as full as some drugs from the fridge in theatre had been relocated. The fridge temperatures were now within normal limits.

Ophthalmology had seven patient group directives (PGD’s) in place meaning that nurses could administer selected medicines. PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a
predefined group of patients without them having to see a doctor. We viewed all of the PGD’s and saw that the registered nurses, pharmacist, clinical director and senior nurse signed them. All the PGD’s had a competency framework in place.

Clinicians used a mixture of electronic prescribing and paper based prescriptions. The paper prescriptions were securely stored in a locked cupboard and there was a booking out and recording process for each prescription to ensure traceability.

**Incidents**

There was a clear process for reporting incidents. Incidents were reported and investigated through the trust’s electronic reporting system.

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

From September 2016 to August 2017, the trust reported no incidents classified as never events for Outpatients.

*(Source: Strategic Executive Information System (STEIS))*

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in Outpatients that met the reporting criteria set by NHS England from September 2016 to August 2017:

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (50% of total incidents)
- Surgical/invasive procedure incident meeting SI criteria with one (50% of total incidents)

*(Source: Strategic Executive Information System (STEIS))*

The trust had reported 12 serious incidents relating to outpatients between September 2016 and August 2017. Nine related to ophthalmology. Two incidents related to patients contracting endophthalmitis (infection of the eye). Two members of staff that we asked were aware of the incidents and learning and could describe the incident and changes that had been made, which included a reminder to staff to emphasise after care to patients to reduce the risk of infection. One member of staff was not aware of the serious incidents but was aware of changes that had been made to reduce infections.

We reviewed the root cause analysis investigation report for these incidents, which established that the incidents had occurred because of poor patient aftercare post discharge. The investigations included a detailed review of events. Appropriate changes to practice were identified as a result of the investigation, which had been added to an action plan with timescales.
and persons responsible assigned to each action.

The Risk & Patient Safety Team produced a trust wide incident newsheet sharing the learning from serious incidents. This was sent to all clinical staff twice a month and was published on the trust staff intranet. Three members of staff confirmed that they received this newsletter.

All staff we spoke with understood the incident reporting process and described how they would report an incident. Staff attended weekly “CommCell's” a meeting where incidents, risks and successes were shared. There was a monthly staff meeting where staff received feedback on incidents and learning was shared. We reviewed the three sets of staff meeting minutes for main outpatients and saw that incidents were a regular agenda item.

Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Local policy and national documents for duty of candour were available via the trust intranet. Staff that we spoke with were aware of the need to be open and honest when something went wrong.

We reviewed the route cause analysis investigation for two serious incidents in ophthalmology and saw that duty of candour had been applied appropriately in both cases.

Is the service effective?

Evidence-based care and treatment

The service had systems in place to ensure compliance with relevant best practice and national guidance. Policies were aligned and referenced to national guidance such as National Institute of Health and Care Excellence (NICE) guidance.

There was a process in place to allocate published NICE guidance to appropriate clinical leads on a monthly basis. An assessment of the recommendations contained within the guidance was sent to the clinical lead to evaluate their service against the NICE guidance recommendations and provide assurance that NICE guidance was being followed.

There were treatment protocols and proformas available for staff reference in the outpatient areas we visited. All of the protocols and proformas we reviewed were up to date and linked to evidence based guidance such as NICE. The use of protocols therefore promoted care being delivered in line with evidence based guidance.

The governance unit produced a poster that was posted on the trust intranet advising staff of updates to NICE guidance.

We reviewed the trust’s clinical audit plan, which demonstrated that the trust was participating in relevant national audits in order to benefit from benchmarking and identification of service improvements. For example, the trust contributed to the national bowel cancer audit. Audit data was analysed and areas of good practice were identified. Action plans were drawn up based on audit findings to implement improvements.

Nutrition and hydration

Water dispensers were available for patients use in the outpatients departments and were clearly signposted.

There were facilities close to the main outpatient department where patients and visitors could purchase refreshments.

Staff offered patients and visitors drinks and food if they had been waiting for a long period for example if they were waiting for patient transport.
Staff reported that they always checked if a patient had specific dietary requirements, such as patients with diabetes and provided the appropriate refreshment in the event of a long wait or when waiting for transport.

**Pain relief**
Staff assessed and managed patient pain levels appropriately. We observed nursing staff asking a patient about their pain levels whilst undergoing a minor procedure. One patient was very concerned about the pain that they would experience during a procedure in the eye clinic. The nurse was very reassuring advising the patient that they would be given regular pain relief throughout the procedure.

Staff told us that they used pictorial prompt card to enable patients with communication difficulties to communicate their pain levels.

The trust had a chronic pain service which aimed to help patients to reduce their pain symptoms. Services offered included medication, injections, psychological techniques and advice on exercise and relaxation.

Two patients told us that they felt that their pain was managed effectively.

**Patient outcomes**
The trust had a clinical audit plan to ensure safe and effective care in line with the trust priorities. The plan consisted of national and local clinical audits. The national clinical audits benchmark the quality of the trust's services compared with other NHS trusts, and to highlight both best and substandard practices to drive continuous improvement across services.

Some outpatient areas took part in national audits to benchmark practice against national standards. For example, ophthalmology took part in the cataract national audit. Respiratory medicine took part in the National British Thoracic Society audit. The fracture and orthopaedic team took part in the Fracture Liaison Service (FLS) fracture audit programme.

There was a programme of local audits carried out in outpatients to monitor local practise and patient outcomes. For example, Gynaecology had carried out an audit around management of menopause in a dedicated clinic. The breast unit had audited patient experience when attending a NHS breast screening programme (NHBSP) assessment clinic.

From July 2016 to June 2017:

- The follow-up to new rate for Baddow Private Hospital was similar to the England average
- The follow-up to new rate for Southend Private Hospital was similar to the England average
- The follow-up to new rate for Southend Hospital was similar to the England average
- The follow-up to new rate for Brentwood Community Hospital was similar to the England average

**Follow-up to new rate, Southend University Hospital NHS Foundation Trust**
Competent staff

From August 2016 to July 2017, 82.6% of staff within Outpatients at the trust had received an appraisal compared to a trust target of 73%. All staff groups were above the completion target rate.

A split by staff group can be seen in the graph below:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th># Appraisal Required</th>
<th># Appraisal Received</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>8</td>
<td>10</td>
<td>83.3%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>99</td>
<td>82</td>
<td>79.6%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>82</td>
<td>59</td>
<td>75.6%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>132</td>
<td>124</td>
<td>93.9%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>41</td>
<td>31</td>
<td>73.8%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>43</td>
<td>34</td>
<td>75.6%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>406</strong></td>
<td><strong>341</strong></td>
<td><strong>82.6%</strong></td>
</tr>
</tbody>
</table>

The trust had a process of “on-boarding” whereby new members of staff attended a welcome day and then followed a local induction programme in the area they were working. Local induction included local orientation, resuscitation protocol and medical waste disposal.

The lead nurse on the eye unit told us that six new members of staff in ophthalmology received a local induction and training specific to their role. In the renal unit recently recruited health care assistants were completing a training manual to ensure that they had key competencies in place to fulfil the requirements of their role.

Due to recruitment challenges, outpatient departments had a strategy to “grow their own”. In the heart and chest clinic, a nurse told us how they had started work as a health care assistant and had been supported by the trust to undertake their nurses training.

All staff we asked were up to date with their appraisals and overall staff said that appraisals were
meaningful and identified learning opportunities. Two members of staff confirmed that they had monthly one to one meetings with their line manager where they could discuss their role and raise any concerns.

Staff in main outpatients were able to cover a variety of clinics. In the eye unit, nursing staff rotated between ward, theatre and outpatients, which meant that staff were able to cover each area and made the workforce more flexible.

Specialist nurses throughout the outpatient teams had undertaken non-medical prescribing courses to enhance their role to enable them to prescribe patients medicines.

Staff said they were provided with training in order to fulfil their job role. The trust provided training internally. Staff were able to access external courses when required.

**Multidisciplinary working**

Outpatient teams worked together to plan and deliver care and treatment. Staff in different teams and services worked together to assess, plan and deliver co-ordinated care.

There were multidisciplinary team (MDT) meetings held across all the specialties to provide effective assessment and treatment.

Clinical specialist nurses worked in clinics, including respiratory, urology and diabetes. These staff worked closely with consultants and specialist support services to improve patient care around specific conditions.

There was a dedicated diabetes centre run by a multidisciplinary team, which included joint working with dieticians, podiatrists and community services.

A patient tracking list meeting was held once a week to monitor patients on the cancer pathway. Staff from different clinical teams attended to enable decisions to be made around the patient’s treatment.

One-stop clinics were provided in a number of specialties such as urology, breast unit, gynaecology and fracture clinic. This enabled patients to attend clinics and undergo investigations and receive diagnoses and treatment where appropriate on the same day.

Endoscopy and diagnostic imaging worked together to ensure that where a patients’ endoscopic examination showed an anomaly the patient could have a computed tomography (CT) scan on the same day meaning that the patient would not have to wait for a diagnostic CT scan.

**Seven-day services**

Most of the outpatient services were provided from 8.30am to 6pm, Monday to Friday. Some specialties offered clinics until 7pm. There were regular Saturday clinics to attempt to reduce the number of patients on waiting lists.

The renal unit was open Monday to Saturday 7.30am until midnight. This allowed flexibility for patients to dialyse out of hours if their schedule required.

**Health Promotion**

There was a range of information leaflets, literature and posters for patients to read about health promotion. For example, advise about smoking cessation, exercise and the healthy heart. There was also information on mental health and wellbeing, and substance misuse.

Dieticians in the renal unit supported patients with advice on a low potassium diet. They had developed food allowance charts, recipe ideas and a guide to a low potassium Christmas.
An eye clinic liaison officer offered help and support for patients dealing with sight loss and helped them to maintain independence. Patients were referred by their doctor or could refer themselves. A charitable organisation had representatives available in the eye unit weekday mornings to offer advice about support groups and social support.

A social worker employed in the renal unit offered help to patients with a variety of issues including housing and benefits applications.

Clinical nurse specialists in urology ran a quarterly health and wellbeing clinic for patients with prostate cancer. Specialists gave talks and staff were available to offer help and advice.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Staff in outpatients completed MCA and DoLS training as part of their mandatory training. Data provided by the trust showed that 87% of staff had completed the training above the trust target of 85%.

From April 2016 to March 2017, 87% of qualified nursing staff within Outpatients completed MCA DoLS Level 1 and 87% completed MCA DoLS Level 2, compared to the trust target of 85% for Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Two members of staff described how they would support a patient who lacked the mental capacity to make a decision about their care.

Staff demonstrated an understanding of best interest decision making and knew how to seek advice when patients were not able to give valid informed consent due to a lack of mental capacity.

We observed nursing staff asking patient consent both verbally and implied before carrying out care.

**Is the service caring?**

**Compassionate care**

We observed staff of all grades interacting with patients. Staff introduced themselves, were friendly and welcoming and were quick to offer help when required.

Administrative staff greeted patients on arrival to main outpatients. Staff were friendly and helpful and would go out of their way to offer assistance.

Privacy sheets were available in consultancy rooms to cover the patient during a procedure or examination to respect their dignity.

All of the patients we spoke with told us that staff were friendly and approachable. One patient described staff as friendly and helpful another told us “the staff were friendly and the service efficient.”

We received 14 “tell us about your care” cards completed by patients. All said that staff were caring and treated them with dignity and respect.

We witnessed an incident in outpatients where a patient had suffered a cardiac arrest in the waiting room. Staff had placed a screen around the area where the medical team were treating the patient to protect their dignity. People were prevented from accessing the area.

**Emotional support**
Clinical nurse specialists provided additional support and in depth knowledge to patients with a range of conditions and disease specific information. Leaflets were provided at appointments.

An administrative member of staff told us about a time when they had accompanied a family member who had travelled alone from overseas to view a loved one in the mortuary. They told us that this person was very distressed and did not feel that they should go to the appointment on their own and so they accompanied them. They told us that it was important to “show care with a little bit of love”

A social worker who worked in the dialysis unit told us that they had supported a patient whilst they underwent a significant and life changing operation. They went to the operating theatre and supported the patient through the surgery as this person had no one else who could be with them.

Nursing staff told us that they would wait with patients if their transport was delayed after clinic had finished to keep them company and ensure they were collected safely.

A patient told us that a nurse always called them at home after treatment to check that they were recovering well and that they had no concerns.

We observed a member of the nursing staff in orthopaedic clinics providing supportive care of a patient with learning difficulties.

In the eye unit, we observed a nurse offering support to a patient who was very anxious about their procedure. The nurse took time to sit with the patient, listen to their concerns and offer reassurance.

We saw information about the availability of chaperones in the main outpatient waiting room and the waiting room in heart and chest clinic. Staff told us that they were able to provide a chaperone when it was required.

Understanding and involvement of patients and those close to them

We observed staff interacting with patients and relatives in clinic and imparting information in a way that was appropriate for the patient’s understanding. One patient told us that the consultant took time to listen to their concerns and to explain the care pathway “in a language lay people could understand.”

Patients received a copy of the letter sent to their GP following consultations. This ensured that patients were kept up to date with all decisions made about their care.

Staff directed patients to appropriate support agencies and self-help groups.

The wife of a patient who attended regular appointments in outpatients told us that staff were kind and considerate and that she felt that she was involved in her husband’s care.

One patient told us that the doctor took time to explain issues and treatment options and confirmed that they definitely felt involved in their care.

There were disease specific user groups where patients and relatives were involved in contributing to service design.

Patients in urology were offered an appointment with a clinical nurse specialist a few days after diagnosis to provide the patient with the opportunity to ask any questions and explain the treatment options and pathways. This allowed the patient time to absorb information relating to their diagnosis and ensured they were able to bring along an appropriate person to support them in that appointment.

Is the service responsive?

Service delivery to meet the needs of local people
The hospital site was accessible by public transport and there were bus timetables located at hospital entrances. There was on-site parking and appropriate drop off points around the hospital to assist patients who had difficulty with mobility. Patients told us that at times finding a parking space was difficult. One patient told us that they always arrived early for their appointment to ensure that they had enough time to find somewhere to park. Another said that they found the parking “stressful” as they were concerned they would miss their appointment.

There was clear signage directing patients throughout the hospital. Different areas of the hospital were allocated different colour schemes. The main outpatient department was on the ground floor at the front of the building. All outpatient clinics were clearly signposted and there were volunteers to assist if needed. Patients told us that they found it easy to find their way around the hospital. Most of the outpatient clinics were held in the main outpatients department, and clinics such as ophthalmology and cardiology were located in different areas of the hospital with their own reception and waiting areas. Some areas such as main outpatients had electronic check-in kiosks available as well as staffed reception desks. Volunteers were available to assist patients to use the kiosks.

On arrival in main outpatients, staff allocated patients a number and staff directed them to the correct clinic waiting area. A screen in the waiting area displayed the patient number indicating when the patient should go to the clinic room for their appointment.

Within main outpatients, the eye unit and fracture and orthopaedic clinic there was enough seating for patients and relatives. Seating was limited in the heart and chest clinic. Staff told us that on occasion people had to stand whilst waiting.

Patient advice information was available both in leaflets and on posters on the walls in all areas we visited.

Within fracture and orthopaedic clinic, x-ray rooms, physiotherapy and the plaster room were located close to each other meaning patients could access all areas easily when attending a clinic appointment.

Some specialties held tele-medic clinics for example in urology. This meant that patients did not have to attend the hospital.

The diabetic service worked closely with GP’s and community diabetic teams. The hospital clinic saw patients with complex needs such as pregnant and renal patients.

From July 2016 to June 2017:

- The ‘did not attend’ rate for Baddow Private Hospital was lower than the England average
- The ‘did not attend’ rate for Brentwood Community Hospital was lower than the England average
- The ‘did not attend’ rate for Southend Hospital was lower than the England average
- The ‘did not attend’ rate for Southend Private Hospital fluctuated around the England average

The chart below shows the ‘did not attend’ rate over time.

Proportion of patients who did not attend appointment, Southend University Hospital NHS Foundation Trust
Patients received a text message reminding them of their appointment and a request that they contact the hospital if they could not attend their appointment. Staff told us that this has reduced the number of patients that do not attend their appointments.

Administration staff advised patients about the possible result of cancelling their appointment to encourage attendance. Within the heart and chest clinic, we observed bookings staff explaining to a patient the impact of cancelling their appointment. Staff told the patient that if they did need to be seen in the future they would require a new referral meaning that they may have to wait longer to be seen.

Meeting people's individual needs
Reception staff told us they were made aware of anyone attending an appointment who had a disability, was living with dementia or had a learning disability. There was an electronic flag available on the patient record system but the booking staff usually informed them in advance. Staff said they would ensure the person was seen on arrival. They were aware that more time might be needed to undertake the examination and would not interrupt. Flexible or double appointments were available for patients with complex needs.

There was dementia friendly signage around the hospital to assist patients living with dementia. The trust had a dementia liaison nurse that could offer support if required to patients living with dementia when attending an outpatient appointment.

The trust had a learning disability nurse that could offer support if required to patients with a learning difficulty when attending an outpatient appointment.

Staff tried to ensure that patients on transport or having to use public transport were seen in a timely manner so that they did not miss their transport.

There was a translation service available for patients whose first language was not English. A member of staff in the renal unit gave an example of a Chinese patient that did not speak English. Staff worked with the patient’s daughter to develop cards with frequently asked questions to assist the patient during their dialysis. The electronic booking in system was available in multiple languages.

Patient’s information was available in braille and large print for patients with sight loss.

There was a hearing loop to assist patients with hearing difficulties. The trust could access sign language interpreters to attend appointments to support patients when required.

Wheelchairs were available near the outpatient departments for those with additional mobility needs. Volunteers were available to transfer patients if they did not have anyone with them who could assist them.
Free Wi-Fi was available for patients to access the internet.

**Access and flow**
The trust had an established process to review patients waiting for appointments, which ensured that their level of risk was assessed. This included a system that set out actions that should be taken when there was an inability to book all new and follow-up appointments within allotted waiting times and required timescales.

The trust had identified cancer waits, referral to treatment (RTT) and the backlog on the patient tracking list (PTL) as a priority and had employed an interim improvement in cancer and RTT manager who had been in post for five months at the time of inspection. PTL and RTT meetings were held weekly to maintain over site of progress.

Clinical staff and service managers attended a referral to treatment (RTT) meeting once a week where all patients waiting 35 weeks plus were reviewed to ensure that they were progressing through the pathway.

Staff told us that several patient pathways had been reviewed to improve flow through the system. For example, patients that were referred with raised prostate-specific antigen (PSA) had a telephone consultation with a clinical nurse specialist. The patient had an MRI scan before their first outpatient appointment with the consultant meaning that the consultant could advise the patient of a diagnosis and treatment options. Eighty five percent of Southend referred patients were now seen within two weeks.

Clinical teams had been running extra outpatient clinics to enable them to treat more patients. For example, in gynaecology the backlog of patients waiting had been reduced from 152 in February 2017 to 61 on the day of our inspection. Ninety five percent of patients were now meeting the 18 week RTT. The heart and chest clinic had a backlog of 130 patients. A speciality doctor had been employed to run extra clinics to see patients and the service manager told us that the backlog had reduced. Data provided after our inspection showed that the number of patients in the backlog for cardiology had been reduced by 40% between August 2017 and November 2017 and the thoracic medicine backlog had reduced by 53% in the same period. The service was running extra weekend clinics in order to see more patients. However, staff told us that if the hospital went on black alert consultants were pulled back onto the wards and weekday clinics were cancelled therefore negating the impact of the weekend clinic.

There was a backlog of 1884 ophthalmology patients waiting for appointments as of November 2017. This had reduced from 2232 in September 2017. There was an ophthalmology recovery plan in place. Senior leaders were working with the service commissioners. Patient referrals were diverted to other providers so that the backlog did not continue to increase. Staff told us that they were running additional clinic lists in the evening and weekends. Senior managers told us that they were consulting to “insource” services meaning that an external provider would treat patients utilising the hospital facilities at a time when they were not being used by hospital staff. We saw the ophthalmology action plan which listed the actions staff had told us about and monitored progress.

Clinical staff and service managers attended a patient tracking list meeting once a week where all patients on the cancer pathway were reviewed. Service managers reviewed capacity and demand in order to maximise the use of available clinic slots. Within gynaecology, the cancer performance had been 100% for the two months prior to inspection. Haematology, gastrointestinal and head and neck also had a cancer performance of 100%.

Clinicians had developed “hints and tips” to share with GP’s and hospital colleagues to help reduce inappropriate referrals. The hints and tips also provided advice to referrers regarding diagnostic tests that needed to be completed prior to referral. This meant that patients were seen by the correct specialist and would have had all the appropriate tests enabling the consultant to
make a diagnosis earlier in the patient pathway.

Clinicians were required to provide six weeks’ notice of leave in order for clinics to be cancelled or rescheduled. Leave required at short notice had to be authorised by the service clinical lead. Information supplied by the trust following the inspection showed that 4921 outpatient appointments were cancelled due to staff on leave between June and October 2017. In the same period, 1315 appointments were cancelled due to staff shortages.

Patients booked their follow up appointments at their outpatient appointment, providing it was within six weeks. Where patients required a follow up appointment greater than six weeks they were placed on a partial booking waiting list. Patients were contacted a month before their appointment asking them to confirm their appointment. Staff told us that if a patient did not make contact, the patient was discussed with the consultant and based on clinical need the patient was given an appointment or discharged back to their GP.

Staff informed patients if a clinic was running late. If the patient wanted to leave the department to buy refreshments for example there was a screen in the café outside main outpatients so people could see when they were called for their appointment.

Staff told us that in some circumstances they were unable to access the results of diagnostic investigations a patient had had at another site, which delayed the clinic whilst staff had to request records to be sent through. They could not tell us how often this occurred. Within the eye unit, not all computers had access to the hospital network. This meant that staff could not access patient’s diagnostic information and images from all computers. Staff told us that during a consultation with a patient the doctor could not access patient images and would have to review them in another area and then return to the patient in the consulting room. This was disruptive for the patient and affected the timely running of the clinic.

Booking staff told us that they were not aware that the time patients waited for their appointment was monitored by the trust. We requested data on waiting times within clinics and the proportion of clinics that started late but the trust confirmed that this data was not routinely completed for a large proportion of appointments and were therefore not able to provide this information. On the day of our inspection the patient information screen showed that 53% of patients in main outpatients were see within five minutes of their appointment time. Eight patients told us that clinics frequently ran late. One patient told us that their appointment was an hour and a half overdue. However, another patient told us that they had been seen 10 minutes before their appointment time.

From September 2016 to August 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways has been similar to the England overall performance. The latest figures for August 2017 showed 89.1% of this group of patients were treated within 18 weeks versus the England average of 89.6%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Southend University Hospital NHS Foundation Trust.

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Nine specialties were above the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>99.8%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Neurology</td>
<td>99.3%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>98.0%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>96.5%</td>
<td>87.5%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>95.1%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Other</td>
<td>93.3%</td>
<td>91.4%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>93.2%</td>
<td>84.9%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>92.3%</td>
<td>85.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>92.1%</td>
<td>88.9%</td>
</tr>
</tbody>
</table>

Seven specialties were below the England average for non-admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>87.5%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Urology</td>
<td>86.2%</td>
<td>88.1%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>86.1%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>85.1%</td>
<td>87.9%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>82.7%</td>
<td>89.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>75.8%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>69.2%</td>
<td>81.3%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From September 2016 to August 2017, the trust’s referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. There has been a steady decline in performance over the 12 month period.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Southend University Hospital NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty
Eight specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic Surgery</td>
<td>100.0%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>99.7%</td>
<td>94.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>98.9%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>98.9%</td>
<td>96.4%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>97.5%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>96.9%</td>
<td>91.3%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>93.0%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>90.0%</td>
<td>82.8%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), Southend University Hospital NHS Foundation Trust

The trust performed better than the 93% operational standard from January 2016 to June 2017. Performance over time is shown in the graph below.

(Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust performed better than the 96% operational standard from January 2016 to June 2017. Performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), Southend University Hospital NHS Foundation Trust

(Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)
Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust performed worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, Southend University Hospital NHS Foundation Trust

![Graph showing cancer waiting times](source:image)

Learning from complaints and concerns

From August 2016 to July 2017, there were 351 complaints about Outpatients. The trust took an average of 70 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be completed within 35 days or no fixed amount of days for complex cases.

The top three subjects of complaints were:

- All aspects of clinical treatment – 121
- Appointments delay/ Cancellation (Outpatient) – 87
- Communication/ Information to patients (written and oral) – 55

We saw information was available in all the areas we visited advising patients how to make complaints.

All the patients we asked told us they knew how to raise a concern or complaint.

Staff told us that they would try to resolve complaints at the time that they were raised. If they were unable to resolve the issues, they would refer the patient to a senior colleague.

The trust told us that there had been a delay in response time to complaints due to staff vacancies in the central complaints team that supported services to deal with formal complaints. They confirmed that these vacancies had been filled. The complaints annual report showed that the number of overdue complaints had fallen by 81%.
Learning from complaints was shared via monthly directorate performance reports that were reviewed and discussed at monthly performance meetings. We reviewed three sets of staff meeting minutes and saw that complaints were an agenda item. Staff confirmed that learning from complaints was discussed at staff meetings and at the daily “CommCell’s”, a meeting where learning from complaints were shared.

The Trust provided example of things that had changed because of patient complaints. These included changes made in the outpatient dispensing area to reduce noise and distractions and advise to switchboard staff about how to direct emergency calls for eye concerns.

We saw a “you said, we did” poster advising patients about changes that had been made as a response to patient complaints. For example, patients had complained that they were unhappy with delayed and aborted phone calls to the eye unit. In response, the eye unit now had a “red” phone for the switchboard to contact if staff did not answer extensions in the unit.

Is the service well-led?

Leadership

Outpatient services were part of the surgical directorate which was overseen by two clinical directors an associate director and an interim head of nursing. There were two general managers who had responsibility for outpatients. Main outpatients was led by a senior nurse. There were senior nurse leads in all areas we visited.

Leaders understood the challenges to quality and sustainability and had identified actions to address them. We met with several senior staff they were enthusiastic and proud of what their staff had achieved, they displayed understanding and appeared knowledgeable about their service and competent in their roles. For example, within urology a number of clinical nurse specialist virtual clinics had been implemented which had increased the number of patients that could access the service.

Local managers had a good understanding of the challenges in their areas and had implemented plans to improve delivery. For example within main outpatients the manager had addressed difficulties in the recruitment of nursing staff by offering nurse training opportunities to existing staff working in the trust.

All staff we spoke with knew who their local leaders were and felt supported. In main outpatients, staff told us that their manager was very proactive and supportive. They felt that they were responsive to their concerns.

Staff told us that the consultants were approachable and worked well with the teams.

A senior leader told us that the leadership team had worked hard to encourage managers to take ownership of their areas of responsibility. They said that staff had risen to the challenge and this was having an impact and improvements were being seen in cancer wait times and referral to treatment (RTT) figures as a direct result of the hard work of staff.

Vision and strategy

The Trust’s vision as confirmed in its five-year strategy (2015-2019) is to be a leading provider of seamless healthcare which supports every person that needs the Trust’s services, whether in or out of hospital to achieve their best health possible. The Trust vision was Care with compassion, working together and professional and accountable. We saw this displayed around the trust. Staff we spoke with were aware of trust vision and how their service area linked in. There was no long-term vision or strategy for the outpatient department as a whole. However, the trust had identified
one of their priorities as the redevelopment of a new eye unit in order to provide facilities to better meet patient needs.

A lead nurse in outpatient said that outpatients had a vision of growing their own staff in response to the recruitment and retention challenges of nursing staff in the local area.

Southend Hospital was part of the Mid and South Essex Success Regime. Some clinicians expressed concern that the executive teams focus on this programme distracted from issues locally.

Culture

There was a positive culture in outpatient areas. Staff said that they felt supported, respected and valued. Staff described cooperative, supportive and appreciative relationships with colleagues. The culture was centred on the needs and experience of people who used the services.

Staff we spoke with were very proud of their service and described a friendly, family like atmosphere and good interpersonal relationships.

Staff told us there was good teamwork within the teams and we observed this during our inspection. Staff worked together to resolve issues and worked flexibly to accommodate service needs. Staff told us that local managers and sisters all worked in clinic when staffing shortages required and that the whole team pulled together to provide the best care to patients possible.

In most areas we visited staff felt able to raise concerns and challenge where necessary. However, in the eye unit some staff felt unable to challenge senior staff members. When we returned for our unannounced inspection, the department manager told us that a senior manager had been to the department and spoke to the nursing staff to advise them that they would be supported to raise concerns and challenge colleagues if required. A process had been implemented where staff reported a challenge to the department manager who then assisted them to record the incident on an electronic incident form. We were also told that senior clinicians had met with the senior manager and had been advised that staff had been encouraged to challenge and raise concerns and that should respond to any challenge appropriately.

There were processes in place to provide staff with career development opportunities. Staff told us that they received regular appraisals and these included discussions around career development. Staff told us that the trust was supportive of training and they felt encouraged to undertake additional training when funding and scheduling allowed.

Governance

There were effective processes and systems of accountability within clinical directorates. However, outpatients were split over two directorates. There was no evidence that there was clear oversight and shared learning across all outpatient areas.

The Clinical Governance Committee (CGC) which was responsible for overseeing the Trust's clinical governance arrangements and to ensure robust systems are in place for managing clinical risk. This committee reported to the Quality Assurance Committee (QAC). The QAC assured the board that the trust had an effective system of risk management and internal control across the clinical activities of the organisation.

We reviewed clinical governance meeting minutes from each directorate and saw that members of staff from outpatients were represented. Two lead nurses told us that they attended directorate governance meetings where clinical risks were discussed.

Staff reported that managers shared important information during the morning CommCell meeting and at team meetings; we reviewed three sets of team meeting minutes that confirmed this. There were effective processes in place to monitor waiting lists and performance against waiting time standards. A patient tracking list was produced on a twice weekly basis to track patient progress.
and this was reviewed at weekly meetings. Clinical urgency was reviewed at the weekly meetings and capacity issues were highlighted.

The risk register for the outpatient department indicated risk to the main outpatient department only. The risk for the delay in ophthalmology follow up appointments were detailed on the surgery risk register and the delays in respiratory follow up patients were detailed on the medical risk register. Individual risks were scored correctly with appropriate dates for review.

**Management of risk, issues and performance**

There were processes in place for managing risks, issues and performance.

A quality, innovation, productivity and innovation (QIPP) commissioning programmes had been implemented for the financial year 2016 – 2017. The QIPP model identified productivity challenges in terms of finance, activity and workforce. The model had been used to reduce the number of ophthalmology patients being seen in the hospital with increased shared care in the community.

Senior leaders worked with the local CCG’s to identify support that they could give around patient activity, capacity and funding. They confirmed that finances had been secured to assist the trust in dealing with the patient backlog.

The risk register for the surgery directorate identified risks relating to outpatients including patient tracking list backlogs and ophthalmology waiting lists. Each risk was ‘RAG’ rated for the level of risk and there were identified actions to manage the risk, including clear ownership and timelines for review. The items on the risk register were in line with the concerns identified by staff in outpatients. However risks that we identified relating to the clinical environment and infection prevention and control in the treatment room in the eye unit were not on the risk register. Therefore, we could not be assured that all risks were being identified and reported.

We were provided with an ophthalmology action plan which addressed issues around capacity. The items were RAG rated, had dates for completion and dated actions.

The trust had employed an interim manager to oversee improvements in cancer waits and RTT.

There were effective processes in place to monitor waiting lists and performance against waiting time standards. A patient tracking list was produced on a twice weekly basis to track patient progress and this was reviewed at weekly meetings. Clinical urgency was reviewed at the weekly meetings and capacity issues were highlighted.

**Information management**

Staff had access to policies, standard operating procedures and patient information leaflets electronically through the document pages on the intranet. Staff confirmed that this ensured that information was easily accessible and up to date.

The directorate performance dashboards showed an overview of performance, which sufficiently covered and integrated people’s views with information on quality, operations and finances. Information was used by service leads to measure improvement by comparing performance with the previous year and displaying the trend in performance. However, there was no outpatient specific performance dashboard.
The trust was working with an external company in the development of an utilisation dashboard to assist with the management of referral to treatment times (RTTs). This system would help managers run capacity and demand figures to manage resources effectively.

**Engagement**

Managers engaged with staff at regular team meetings in all the areas that we visited. Meeting minutes showed discussion of incidents, complaints and staffing.

Outpatients used the friends and family test (FFT), which gathered data on whether patients or their families or carers would recommend the service to their friends or family. The outpatient departments FFT results from August to November 2017 varied between outpatient departments and months between 90% and 100% of patients who would recommend the service to their friends or family. The overall result for all outpatients for September 2017 was 93%.

Senior nurses in the ophthalmology team told us that they felt involved in the merger of services with Basildon Hospital. They told us that they had regular meeting with the clinical director. There were regular information sharing summits that all staff could attend. However, clinicians in respiratory medicine did not feel that they were involved in the design of services.

Clinicians engaged in ‘time to learn’ sessions with GP practices which educated GP’s around referral pathways and diagnostic tests required before a patient was referred to hospital. This helped to ensure that the patient was referred to the correct specialism and helped to develop positive working relationships with local GP practices to help deliver a better service to patients.

The urology team ran a number of focus groups to obtain patient feedback regarding changes to the service.

The trust carried out an annual staff survey to gain staff feedback. During our inspection, we saw notices encouraging staff to complete the survey.

**Learning, continuous improvement and innovation**

Service leaders and staff involved in continuous learning and improvement to deliver care to patients. Clinicians, managers and nursing staff had been involved in the review of multiple patient care pathways to improve access and flow for patients whilst being treated by the service.

Staff worked together to resolve problems and to review objectives, processes and performance. For example, clinicians had developed “hints and tips” which were available to GP’s to assist in ensuring that patients were referred to the correct specialism. This also advised referrers regarding diagnostic tests to request prior to referral.

There were systems to support improvement and innovation at work. For example the renal unit was one of only two units nationally that had employed a social worker to support patients. They worked with patients to resolve issues relating to housing, access to benefits and offered support and guidance to resources that were available to assist patients. They reported that because of support being in place around their social care needs patients that had previously been non-compliant with treatment and ended up in a health crisis were now attending regular dialysis and their health had improved.

The renal unit were using “cloud based” technology, which improved the quality of care for dialysis patients. It provided two-way communication between patients and the renal care team for patients receiving dialysis at home.