

Basildon and Thurrock University Hospitals NHS
Foundation Trust

Basildon University Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Good



Critical care

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Basildon and Thurrock University Hospitals NHS Foundation Trust serves a population of around 415,000 in south west Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point. The trust also provides services across south Essex. The trust provides an extensive range of acute medical services at Basildon University Hospital, which includes The Essex Cardiothoracic Centre and Orsett Hospital as well as x-ray and blood testing facilities at the St Andrew's Centre in Billericay. The trust employs more than 4,000 staff and has more than 10,000 public members. The trust became one of the first 10 NHS foundation trusts in April 2004.

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

We undertook a responsive inspection to the critical care unit in March 2015 in response to concerns relating to safety with staffing shortages within the critical care outreach team, areas for improvement within the effectiveness of the service, responsiveness on patient pathways and the pace at which change had been implemented. Subsequently the rating for this service overall changed from 'Good' to 'Requires Improvement'.

We returned to inspect on 16th February 2016 and inspected all the key questions in the critical care service with a view to providing a new rating. We did not undertake a full comprehensive inspection of the trust, this inspection focused solely on the general critical care unit. We found that the service had made significant improvement in the delivery of the service which we have detailed through this report, and we have changed the rating of the service to 'Good'.

The change to the ratings of the critical care service has also changed the overall trust rating for the key question of 'is the service safe?' to Good overall.

Our key findings were as follows:

- There were significant improvements made to how safe, effective, responsive and well led the service was since our last inspection in March 2015.
- Staffing levels for nursing, medical and therapies staff had improved and were at a safe level.
- The mortality ratio for the unit has reduced significantly since our last inspection where it was 1.8 and is now 1.0 on the ICNARC SMR and 0.83 on the APACHE model.
- The critical care unit acquired infection in the blood rates per 100 admissions was consistently in line with or better than the England average of four.
- The critical care unit does not currently meet the core standard of 50% of registered nurses having a recognised critical care course with 27% of nursing staff who had completed their certificate in critical care, however a number of staff were currently on the course and the rates by the end of the year were expected to reach over 50%.
- We observed good use of mental capacity assessments and deprivation of liberty safeguards during the inspection.
- The completion of DNACPR forms has significantly improved since the previous inspection with a greater awareness of what is required of the medical staff with regards to DNACPR.
- There had been notable improvements in the leadership of the critical care and outreach service.
- Morale and culture within the critical care and outreach service had improved significantly since our previous inspection.

Summary of findings

Following our inspection the trust should:

- Improve the mandatory training rates for the critical care outreach team.
- Ensure all staff receive updated equipment competency training.
- Reduce the delayed discharges over four hours from the critical care unit to the main wards.
- Reduce the number of transfers out of hours between 10pm and 7am.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Critical care

Rating

Good



Why have we given this rating?

We have rated the critical care service as good overall and noted that there has been a significant improvement to the service since our last inspection. Safety of critical care service was rated as good because there was a positive incident reporting and learning culture within the critical care unit. Staffing levels for nursing, medical and therapies staff had improved and were at a safe level. Mandatory training levels were in line with trust expectations for the critical care unit, except for the critical care outreach team where improvements in training rates were required. Critical care services were effective. Treatment and care was delivered in accordance with best practice and recognised national guidelines (ICNARC) NICE and care bundles. There was a multidisciplinary approach to assessing and planning care and treatment for patients. Critical care services were caring. Feedback from people using the service including patients and their families was very positive. Patients and their relatives were kept informed of their care and there was very clearly documented notes regarding the weekly meetings and communication that had taken place with them. Critical care services were responsive to patient's needs. Whilst the number of delayed discharges and out of hours transfers remained high there were improvements in these areas, however more work was required to improve this further. The critical care outreach team provided support to patients on the wards where higher dependency care was required, avoiding critical care admissions. The process for the investigation and learning from complaints had improved since our previous inspection.

Critical care services were rated as good for being well-led locally. There was a clear vision and strategy for the service. There was good evidence of ward to board leadership, communication and governance regarding the service. There had been notable improvements in the leadership of the critical care and outreach service. Morale and culture within the critical care and outreach service had improved significantly since our previous inspection.

Basildon University Hospital

Detailed findings

Services we looked at

Critical care

Detailed findings

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Background to Basildon University Hospital

Basildon and Thurrock University Hospitals NHS Foundation Trust primarily provides services for 415,000 people living in south-west Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle. It provides an extensive range of acute healthcare services at Basildon and Orsett Hospitals, plus x-ray and blood testing facilities at the St Andrew's Centre in Billericay. It also provides dermatology services across the whole of south Essex.

With a budget of more than £288million, last year the trust treated 77,500 inpatients and day patients, provided nearly 300,000 outpatient appointments and attended to 108,000 patients in accident and emergency.

The critical care service consists of a main critical care unit with 14 beds, of which 11 are commissioned for use. Although the trust will utilise the remaining three spaces when high demand requires it. The service also consists of a critical care outreach team who provide critical care support to patients with a higher dependency out on the wards throughout the hospital.

Our inspection team

Our inspection team was led by:

Inspection Manager: Leanne Wilson, Care Quality Commission

The team included CQC inspectors who are also specialist advisors trained in adult nursing and governance. We also received advice and guidance from a doctor in intensive care who was not with us on site.

How we carried out this inspection

We carried out this inspection in to the critical care unit as a follow up to our inspection in 2015 to assess whether improvements had been made.

For this inspection we visited the critical care unit, spoke with patients and relatives who used the service, we also spoke with nursing and medical staff and the clinical leaders of the critical care and critical care outreach service.

Detailed findings

Facts and data about Basildon University Hospital

Basildon and Thurrock University Hospitals NHS Foundation Trust primarily provides services for 405,000 people living in south-west Essex covering Basildon and Thurrock, together with parts of Brentwood and Castle Point. It provides an extensive range of acute healthcare services at Basildon and Orsett Hospitals, plus x-ray and blood testing facilities at the St Andrew's Centre in Billericay. It also provides dermatology services across the whole of south Essex.

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







With a budget of more than £280million, last year the trust treated over 80,000 inpatients and day patients, provided over 300,000 outpatient appointments and over 108,000 patients attended their accident and emergency department

Our ratings for this hospital

Our ratings for this hospital are:

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

Critical care

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

Information about the service

The critical care service at Basildon and Thurrock University Hospitals NHS Trust has 14 beds, of which 11 are funded, to provide general intensive care. These are intensive therapy unit (ITU) and high dependency beds (HDU) beds which deliver care to patients with serious life-threatening illness and for patients who are too ill to be cared for on a general ward. A critical care outreach team assists in the management of critically ill patients on wards across the hospital.

During our inspection in 2015 we found that staffing in the outreach team was depleted at the time of our inspection, there was a lack of morbidity and mortality meetings occurring within the critical care unit to learn lessons to improve safe care. We found that the effectiveness of the service required some improvement to ensure good outcomes for patients. The number of nurses with nationally recognised training was below the national benchmark. We found that DNACPR decisions were increasingly undertaken with patients or their nearest family although some further work was required to ensure that this was embedded and enacted for every patient. We saw evidence of delayed admissions and discharges and significant numbers of discharges occurring overnight which is neither beneficial for patients nor responsive to their needs. Whilst staff felt supported there was a lack of understanding of the vision for the service and leadership at the time of our inspection.

During this inspection in 2016 We spoke with 13 members of staff, three patients and three relatives.

Whilst the cardiothoracic centre also has an intensive care service we did not review the cardiothoracic centre at this inspection.

Critical care

Summary of findings

We have rated the critical care service as good overall and noted that there has been a significant improvement to the service since our previous inspection. Safety of critical care services was good because there was a positive incident reporting and learning culture within the critical care unit. Staffing levels for nursing, medical and therapies staff had improved and were at a safe level. Mandatory training levels were in line with trust expectations for the critical care unit, except for the critical care outreach team where improvements in training rates were required.

Critical care services were effective. Treatment and care was delivered in accordance with best practice and recognised national guidelines (ICNARC) NICE and care bundles. There was a multidisciplinary approach to assessing and planning care and treatment for patients.

Critical care services were caring. Feedback from people using the service including patients and their families was very positive. Patients and their relatives were kept informed of their care and there was very clearly documented notes regarding the weekly meetings and communication that had taken place with them.

Critical care services were responsive to patient's needs. Whilst the number of delayed discharges and out of hours transfers remained high there were improvements in these areas, however more work was required to improve this further. The critical care outreach team provided support to patients on the wards where higher dependency care was required, avoiding critical care admissions. The process for the investigation and learning from complaints had improved since our previous inspection.

Critical care services were rated as good for being well-led locally. There was a clear vision and strategy for the service. There was good evidence of ward to board leadership, communication and governance regarding the service. There had been notable improvements in the leadership of the critical care and outreach service. Morale and culture within the critical care and outreach service had improved significantly since our previous inspection.

Are critical care services safe?

Good



At the last inspection safety of critical care services was rated as requires improvement. At this inspection we have rated the critical care services as good for being safe because:

- There was a positive incident reporting and learning culture within the critical care unit.
- Staffing levels for nursing, medical and therapies staff had improved and were at a safe level.
- There were good arrangements for safeguarding and mental health awareness on the unit.
- Mandatory training levels were in line with trust expectations for the critical care unit
- The safety thermometer for the unit showed that between April 2015 and January 2016 that no patients had falls and there were no catheter related UTI's recorded.
- The mortality ratio for the unit has reduced significantly since our last inspection where it was 1.8 and is now 1.0 on the ICNARC SMR and 0.83 on the APACHE model, which has improved from 1.8, which meant that the mortality ratio is now well within the expected range.
- Record keeping and records management on the unit, including the completion of risk assessments, were noted to be of a good standard.
- There was a good awareness of the deteriorating patient in the unit, and examples of good monitoring awareness and escalation were identified.
- Good infection control and hand hygiene practices were observed during the inspection.

However we also found:

- The mandatory training rates for the critical care outreach team were below the trust's target of 85% in all 15 subjects that the staff were required to complete.

Incidents

- There was a positive incident reporting culture within the unit. The critical care unit reported 348 incidents between April 2015 and January 2016. Staff we spoke with were clear on what constituted an incident and how they would report this.

Critical care

- The majority of these incidents related to internal targets set by the unit including where a transfer of a patient has occurred out of hours, where a ward bed is not available when a patient is able to go to a ward and lack of bed space on critical care for patients in the hospital. Other incidents reported included medication availability and pressure ulcers and most incidents reported were recorded as near miss, no harm or low harm.
- Between April 2015 and January 2016 the critical care unit had reported one serious incident which related a blood transfusion incident. We spoke with two doctors and two nurses about this incident and all were aware of the incident and could articulate what lessons had been learned and shared regarding this event to prevent similar incidents from occurring.
- The unit had not reported any never event incidents since our previous inspection.
- The critical care outreach team had reported 15 incidents between April 2015 and January 2016 and these incidents related to the staffing levels, availability of beds on critical care and issues with care on the wards with providing higher level care.
- The unit had established educational learning meetings for nursing and medical staff relating to patient care and utilised information highlighted from care, incidents, complaints, post mortems and coroner reviews.
- Mortality and Morbidity meetings are undertaken every month within the unit and are led by the lead consultant. The meetings minutes we reviewed demonstrated that nurses attended as well as all grades of doctors and that all deaths within critical care and outreach services were discussed. Death of patients who had been admitted to critical care during any point of their admission but died elsewhere in the hospital were also discussed.
- The mortality ratio for the unit has reduced significantly since our last inspection where it was 1.8 and is now 1.0 on the ICNARC SMR and 0.83 on the APACHE model, which has improved from 1.8, which meant that the mortality ratio is now well within the expected range.

- Duty of Candour was recorded for all incidents where an impact of moderate or higher were discussed. There was evidence of Duty of Candour recorded on the incident forms recorded as an action taken.

Safety thermometer

- The safety thermometer for the unit showed that between April 2015 and January 2016 that no patients had falls and there were no catheter related UTI's recorded.
- The critical care unit have a dashboard which monitors their KPIs and performance in line with trust and ICNARC requirements. The February 2016 dashboard showed that since August 2015 the number of admissions to the unit had steadily increased from around 40 admissions per month to 60 admissions per month in January 2016.

Cleanliness, infection control and hygiene

- Our inspection of the critical care unit found that the environment and the equipment were clean.
- We examined the infection control audits for October and December 2015. The December 2015 audit followed up on the issues identified during the October 2015 review and acknowledged that all issues identified were no longer a concern.
- The December 2015 audit identified ventilation flow, a musty smell in the decontamination room and dust as the key issues. We did not identify any concerns relating to these issues during the inspection.
- We observed that staff were adhering to the bare below the elbows policy throughout the duration of the inspection, when visiting staff to the unit were not bare below the elbow we observed the staff challenge these individuals to adhere to the policy.
- There were sufficient supplies of gloves and aprons for staff to use for infection control purposes and we observed these used at all times.
- There were two cubicle areas which were separate and individual to the other areas within the unit which were utilised for isolation purposes when a patient with a suspected infection was admitted.
- The unit had no recorded cases of C.Diff, MRSA or MSSA between April 2015 and January 2016.

Environment and equipment

Critical care

- We checked 15 items of equipment including hoists, defibrillators, infusion pumps and monitors and found that all had been serviced and tested in accordance with trust policy.
- The resuscitation equipment in the unit had been checked on a daily basis for the previous three months, and records kept by the service demonstrated that all items had been checked daily including the defibrillator.
- The environment had been refurbished within the last few years and was modern. The unit had only 13 beds with 11 of those commissioned for use.
- At the time of the inspection the trust and clinical lead for the service were working on a review to determine if further beds and additional funding would be required to meet the needs of the population. Currently the critical care outreach service provided a high level of care out on the wards due to the high level of care required by patients.

Medicines

- The unit had a dedicated pharmacist who provided a service to the unit five days per week. The unit reported a good working relationship with the pharmacy team.
- We examined the medicines store and the controlled drugs records and stock and found that all were stored appropriately, all were accounted for, and all were recorded as required.
- The temperature of the medicines room was monitored and recorded and kept in line with recommendations to preserve the integrity of the medicines.

Records

- We examined the records of eight patients during the course of the inspection. The records were stored at the end of the patient's bed and were continually written on by staff members providing their care.
- The records of care kept were comprehensive and detailed with full descriptions of care provided, activity around care, test results, family involvement and multi-disciplinary team input.
- There was a dedicated section for risk assessments within the folders provided and of the eight records examined all had completed risk assessments in place for falls, pressure ulcers, malnutrition and VTE.

Safeguarding

- We spoke with three nurses and two doctors about the requirements of safeguarding and all were aware of what constituted a safeguarding concern and how they would report a concern.
- We observed two occasions during the inspection where the safeguarding team had been consulted on two patients where staff had concerns for their welfare. Both of these cases were related to concerns regarding the person's mental health and the risk that they could pose themselves. The staff we observed were empowered to call the safeguarding teams directly and to arrange the care directly informing the person in charge, which was positive.
- Where safeguarding was identified as a concern a clear plan was written in the records of the patient detailing what was required to ensure the patient was safe.
- Within the critical care service 97% of staff have received safeguarding adults training and 75% of the critical care outreach team have received safeguarding adult training.
- Within the critical care service 88% of staff and 67% of the critical care outreach team have received safeguarding children training at level 2.

Mandatory training

- Within the critical care service there was a dedicated programme for the delivery of mandatory training in the service. The department sets itself a target of more than 85% of staff receiving mandatory training.
- Of the training subjects available including safeguarding, health and safety, fire safety, learning disabilities, and VTE all were above 90%. In total 89% of staff had completed all mandatory training which was above the trust target of 85%.
- The subjects where mandatory training was not as high as expected were Moving and Handling (78%), immediate life support (57%), Dementia (81%), Adult resuscitation two yearly update (81%).
- The critical care outreach team mandatory training compliance was noted to be lower than the trust

Critical care

expected target of 85% in all 15 designated mandatory training subjects. The lowest rate was noted in moving and handling (17%), immediate life support (25%) and VTE training (36%).

Assessing and responding to patient risk

- All staff working within critical care outreach had received advanced life support (ALS) training. It was also noted that of the medical staff there were 6 consultants who were trained in advanced life support. Of the nursing staff on critical care the nurses were required to undertake immediate life support training and the overall training rates for this training course for the unit were 100%.
- The trust used the national early warning score system and recorded observations on a dedicated tool within the medical records. Where concerns were highlighted these results were escalated to the doctor in charge on the unit.
- We observed, in two of the eight records we reviewed, a clear process for escalating concerns regarding a patient's condition and potential deterioration. This resulted in clinical review and intervention with a good outcome for the patients.
- The service uses sepsis bundles in line with national recommendations, we observed two patients where these bundles were in use.
- Unit mortality in relation to severe sepsis was recorded as higher than expected when compared with similar units. The England average was around 28% and the unit averaged between 30% and 35%. Updated data submitted between September 2015 and January 2016 shows an improving trend with regards to the mortality linked to sepsis on the unit with the trend moving in line with the England average.

Nursing staffing

- The critical care unit appointed a new matron who has experience from a large teaching hospital and will be joining the team in May 2016.
- Skill mix reviews had been undertaken for the critical care unit and the critical care outreach team.

- The critical care unit currently have 2.8 WTE band 6 nurse vacancies and 5.58 band 5 nurse vacancies. The department are continually working on recruitment and are advertising for staff but were challenged with recruitment being within a close proximity to London.
- Where there are vacant shifts on the rota the unit utilise internal staff working on bank shifts and have also appointed agency staff to the unit on long term fixed contracts. These long term agency staff are inducted locally and provided with competency training on equipment, IV's and medicines to enable them to fully work on the unit.
- The staffing levels observed for the level 2 and level 3 patient ratio within the department were in line with national guidelines for the staffing of critical care units.
- The critical care outreach team reached full establishment with all posts filled enabling the team to provide seven day cover. A new manager was appointed during 2015 and has ensured that a further skill mix review will be undertaken on the critical care outreach team in 2016.
- Handovers were undertaken on the unit twice per day and are undertaken jointly between the medical and nursing staff by discussing each patient and their requirements.

Medical staffing

- The leadership of the critical care unit has changed with a new critical care clinical lead being appointed during 2015.
- The critical care unit has increased its medical staff establishment since our last inspection with seven full time consultant intensivists now employed by the service.
- There was a consultant lead who was recently appointed who will provide clinical support to the critical care outreach team. The critical care outreach team told us that the appointment of a consultant to support the team was really positive and there were plans for 2016/17 with consultant input to help improve the service.
- Consultant intensivists work in blocks of four weekdays or three weekend days to provide continuity in care.

Critical care

- The rota for consultant intensivists has been separated from the anaesthetic rota since our previous inspection, with the rota for critical care now entirely intensivist covered.
- Consultants work on the unit between 8am and 8pm Monday to Friday and currently between 8am and 3pm on Saturday and Sunday. There is an out of hours consultant on call available outside of these times.
- Handovers were undertaken on the unit twice per day and are undertaken jointly between the medical and nursing staff by discussing each patient and their requirements.

Therapies staffing

- The critical care unit has dedicated physiotherapy and occupational therapy support provided by staff with a special interest in intensive care.
- Following a successful pilot of the services staff had been permanently appointed to the critical care unit to provide occupational and physiotherapy services to patients who received care.
- The use of occupational therapy within a critical care setting is unique and less common than the provision of physiotherapy, however result of the pilot undertaken into the use of occupational therapy showed that patients believed it had improved their rehabilitation following discharge.

Major incident awareness and training

- The trust has a major incident plan which has specific action cards relating to the critical care service. These cards can be accessed through the trust's intranet page and utilised when required.
- Staff on the unit have receiving awareness training on major incidents and business continuity and are aware that they will await instructions from senior staff in the event of the major incident as per instructions from their action cards.
- The critical care unit has a business continuity plan which was being reviewed in line with the review of the service provision during 2016/17.
- The critical care unit has links with the trust wide plans on flu and winter planning.

Are critical care services effective?

Good



At the last inspection the effectiveness of critical care services was rated as requires improvement. At this inspection we have rated the critical care services as good for being effective because:

- Care within the intensive care units was being provided in line with best practice guidelines with care bundles including ventilator care bundles and central line care bundles in use.
- All patients admitted to critical care received an assessment on rehabilitation requirements in line with the NICE Clinical Guidance 83 – 'rehabilitation after a critical illness'.
- A standardised pain tool was used for the assessment of a patient's pain on the critical care unit and we observed evidence of these being completed in the patient records we examined.
- The mean length of stay per patient on the unit was consistently in line with the England average and occasionally below the England average of seven days.
- The critical care unit acquired infection in the blood rates per 100 admissions was consistently in line with or better than the England average of four.
- The critical care unit number of unit-acquired infections in the blood (per 1000 ventilator days) was consistently in line with or better than the England average of five with 12 of 20 recorded quarters since 2010 recording better results than the England average.
- The critical care unit does not currently meet the core standard of 50% of registered nurses having a recognised critical care course with 27% of nursing staff had completed their certificate in critical care, however a number of staff were currently on the course and the rates by the end of the year were expected to reach over 60%.
- Good internal and external MDT working was observed throughout the inspection.
- The completion of DNACPR forms has significantly improved since the previous inspection with a greater awareness of what is required of the medical staff with regards to DNACPR.

Critical care

- We observed good use of mental capacity assessments and deprivation of liberty safeguards during the inspection, with appropriate discussion and consultations with the safeguarding teams also observed.

However we also found areas that could be improved including:

- Of the 57 staff on the unit the majority had achieved their competencies to use the equipment, however we noted on equipment such as the Alaris volumetric pump and Alaris volumetric syringe driver that 17 (30%) had not received their competency updates within the last three years.
- Unit mortality in relation to severe sepsis was recorded as higher than expected when compared with similar units. The England average was around 28% and the unit averaged between 30% and 35%. However updated data submitted between September 2015 and January 2016 shows an improvement moving in line with the England average.

Evidence-based care and treatment

- Care within the intensive care units was being provided in line with best practice guidelines with care bundles including ventilator care bundles and central line care bundles in use.
- All patients admitted to critical care received an assessment on rehabilitation requirements in line with the NICE Clinical Guidance 83 – ‘rehabilitation after a critical illness’.
- The unit undertook a range of local audits including Levels of Care requirement, and Dental Damage during general anaesthesia.
- The critical care unit and critical care outreach team had a range of policies and procedures in place which were available to all staff on the trust intranet site.

Pain relief

- A standardised pain tool was used for the assessment of a patient’s pain on the critical care unit and we observed evidence of these being completed in the patient records we examined.
- The critical care unit was supported by the pain team between Monday and Friday and then out of hours the critical care consultants were consulted on pain levels.
- The critical care unit was in the process of implementing a review of the pain management in service to assess

how in line with the Faculty of Pain Medicine’s Core Standards for Pain Management (2015) and determine what further improvements would be required to improve the service.

Nutrition and hydration

- The critical care unit had access to the trust dietitian who visited the unit daily between Monday and Friday to provide nutritional advice to staff regarding patient nutritional care needs.
- Within the records of two patients we observed clear plans for the nutrition and hydration care for the patient including discussions with the unit staff and the family, where they were present on what would be provided.
- When a patient was awake and was able to eat, or ready to be returned to an inpatient ward, the unit were able to provide meals from the trust meal service for breakfast lunch and dinner as well as snacks when required.

Patient outcomes

- The critical care department submits data to the Intensive Care National Audit and Research Centre (ICNARC) case mix programme which meant that the unit was able to benchmark itself against other units in England of a similar size. At the inspection in 2015 it was identified that the service was an outlier on some key indicators measured by ICNARC.
- The ICNARC case mix programme for this inspection up to January 2016 showed that there had been significant improvements in the performance of the critical care service compared to other units of a similar size.
- The mortality ratio for the unit has reduced significantly since our last inspection where it was 1.8 and is now 1.0 on the ICNARC SMR and 0.83 on the APACHE model, which has improved from 1.8, which meant that the mortality ratio is now well within the expected range.
- Unit mortality in relation to severe sepsis was recorded as higher than expected when compared with similar units. The England average was around 28% and the unit averaged between 30% and 35% with highest reported rates of 50% and lows of 19% between 01 July 2015 to 30 September 2015. Updated data submitted between September 2015 and January 2016 shows an improving trend with regards to the mortality linked to sepsis on the unit with the trend moving in line with the England average.

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- The unit has a higher ratio of in hospital cardio pulmonary resuscitation levels with some improvements seen in the data over the last six months, however further review on this is required.
- The unit has fewer transfers into the unit than similar sized units within England; however the occupancy levels within the unit remain high due to a low number of beds which means that some level one and two patients are receiving care on the ward areas rather than within the unit.
- The audits showed that the majority of patients admitted to the unit were unexpected medical or surgical patients which could impact on the flow of the service when admissions are not always expected.
- The critical care unit acquired infection in the blood rates per 100 admissions was consistently in line with or better than the England average of four.
- The critical care unit number of unit-acquired infections in the blood (per 1000 ventilator days) was consistently in line with or better than the England average of five with 12 of 20 recorded quarters since 2010 recording better results than the England average.
- Between March 2015 and January 2016 the unit had 5 unplanned readmissions to the unit within 48 hours. Of the total number of admissions during this time this equates to approximately 0.9% overall.

Competent staff

- The critical care unit does not currently meet the core standard of 50% of registered nurses having a recognised critical care course with 27% of nursing staff had completed their certificate in critical care. Whilst this is lower than the previous inspection rates of 29% in March 2015 there were a number of staff waiting to complete the course and the rates by the end of the year were expected to reach over 60%.
- The trust has been challenged due to a lack of available placements at local education centres to place staff available on this training. The team had managed to secure additional placements on courses for the 2015/16 and 2016/17 courses. The unit currently has four staff members on the course and a further five enrolled and the team anticipate that their rates will go up to 40% within three months and then above 60% by the end of the year once the courses have concluded.

- The critical care unit developed a critical care specific development programme to educate and develop band five staff on the unit. The programme was designed for skills enhancement, development and progression and career planning.
- We spoke to two band 5 nurses about this programme who informed us that this programme was supportive and helped them engage with the service and provided them with opportunities for their future careers.
- All medical staff on the unit had gone through medical revalidation with the general medical council.
- Nursing staff were in the process of preparing for their revalidation this year and were being provided with information and support their managers to complete their revalidation.
- There was a clear programme of appraisals in place for nursing and medical staff with 82% of nursing and 78% of medical staff being appraised within the last 12 months. Where a staff member had not been appraised there was a clear rationale explained for this on the monitoring chart, and included reasons such as maternity leave and long term sickness.
- There were prescribed equipment competency checks in place for staff. The trust provided us with a list of staff who had been trained, assessed and then deemed competent to use the equipment within the critical care unit. Of the 57 staff on the unit the majority had achieved their competencies to use the equipment, however we noted on equipment such as the Alaris volumetric pump and Alaris volumetric syringe driver that 17 (30%) had not received their competency updates within the last three years.

Multidisciplinary working

- The trust is part of the Essex success regime and sits within the remit of Essex where there are agreements in place for the transfers and repatriations of patients who live within the area. The arrangements support the transfers of patients between services where required. The trust has links with teaching hospitals including one in East Anglia and one in London to provide additional specialist support if required.
- The critical care unit has arrangements in place for close MDT working with the specialists from the critical care unit within the cardiothoracic centre on site and arrange for transfers between the two units as appropriate.

Critical care

- There is a good relationship with staff on the wards and theatres with the critical care unit with staff routinely contacting the critical care service for advice.
- We observed good working internal multi disciplinary meetings with teams from the mental health trust, safeguarding, therapies, nutrition and dietetics and dementia specialists during our inspection.
- The critical care unit was an open unit at the time of the last inspection, which meant that the critical care consultants were not in charge of the patient's care. At this inspection the critical care consultants were the responsible consultants for the patients and liaised and worked closely with the various specialties to deliver a patient's care. We observed this during the inspection with visits to the unit from interventional radiology, urology and renal specialties.
- The critical care outreach team were available seven days per week and support was provided twenty four hours per day. The staffing levels within the critical care team had stabilised and the rota was adjusted to provide full cover.
- The critical care outreach team had an allocated consultant appointed to support the leadership of the service but also offer critical care advice to wards and departments where sought on clinical concerns.

Seven-day services

- The rota provided by the critical service meant that a consultant was present on the unit between 8am and 10pm Monday to Friday and from 10am to 6pm on Saturdays and Sundays. There were plans to increase this as recruitment of medical staff increases the capacity of the rota. Seven day support was provided through an on call rota by consultants who would attend the unit when required.
- The critical care unit had access to diagnostic services including x-ray, CT and MRI scans seven days per week 24 hours per day if required.
- Physiotherapy and occupational therapy support was being provided five days per week with plans to increase coverage to seven days per week being written. The service did provide consultation or out of hours support if a patient specifically required this level of support and the therapy staff worked around their hours to accommodate the needs of the patients.
- There was a dedicated pharmacist for the critical care service who provided cover to the critical care unit five days per week with on call and onsite support provided at weekends if required through the pharmacy department.

Access to information

- All medical records required by the critical care unit were readily accessible and available through the medical records department.
- Staff had smart cards to access the various records systems available electronically, and we observed staff routinely accessing diagnostic and pathology systems during the inspection to access the information they required.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards)

- At our previous inspections the completion of do not attempt cardio pulmonary resuscitation orders (DNACPR) was identified as an area of concern with DNACPRs not being completed in line with resuscitation council UK guidelines.
- Since the inspection in March 2015 the service has audited the completion and use of DNACPRs on a monthly basis to improve how this is undertaken and the audit results for the last three months identified between 91% and 100% of forms and decisions being completed in line with the guidelines.
- We examined the DNACPR forms of three patients on the unit and found that all had been completed in line with resuscitation council UK guidelines.
- Within the care records of the patient the service had a dedicated section for discussions and communications with the family in relation to their relatives care. This included detailed recordings of discussions regarding decisions on whether or not to resuscitate. The completion of these records was a positive improvement since our last inspection.
- During the inspection there was a patient on the unit who lacked capacity and was identified as requiring a deprivation of liberty safeguard. The full assessment for the need for this safeguard had been completed and the DoLS had been issued urgently with a further follow up request sent to the local authority. This meant that the DoLS was undertaken in line with best practice.
- Of the eight records we examined three patients had been identified as not having the mental capacity to

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make decisions regarding their care and treatment. All of these patients had appropriately completed mental capacity act assessment in place for routine treatment and personal care and also mental capacity assessments to act in the person's best interest regarding their care.

- There was detailed notes recorded in the records for the patients who had families to explain these decisions to the family of the patients which was positive.

Are critical care services caring?

Good



Critical care services were rated as good for being caring because:

- We spoke with three patients and five relatives during our inspection of the critical care unit, all of whom were very complimentary and positive about the care that was received.
- Counselling, holistic emotional care and support was provided to patients and relatives who used the services.
- Patients and relatives had access to a range of trust specialist nurses to support and guide them through their conditions, such as cancer, dementia, respiratory or bowel concerns.
- Patients and their relatives were kept informed of their care and there was very clearly documented notes regarding the weekly meetings and communication that had taken place with them.

Compassionate care

- We spoke with three patients and five relatives during our inspection of the critical care unit. All reported to us that they felt well cared for and that the staff had been, "excellent", "wonderful", "so kind" and "lovely. No concerns were raised with us from anyone we spoke with during the inspection about the care they or their relatives were receiving.
- Staff were compassionate and caring towards all patients. We saw staff talking to patients, even if they were heavily sedated to explain all aspects of care being delivered.

- We observed staff taking time to communicate with a patient who was too unwell to talk; staff interpreted their response and body language and provided care accordingly.
- Curtains were drawn when providing personal care and staff always introduced themselves to patients prior to delivering care, even if they were sedated.
- Prior to the inspection we had not received any concerns or complaints about the critical care unit since our previous inspection regarding the care that people were receiving.
- The last inpatient survey published relating to NHS hospitals related to 2014 and did not reflect the care currently provided by the service.
- The trust undertook a range of patient and public engagement roles to receive feedback from patients regarding the care provided by the trust. The trust provided us with the results of these surveys which did not identify any concerns relating to the care provided in the critical care unit.
- Recent survey results showed that 100% of friends and family would recommend this service to others.

Understanding and involvement of patients and those close to them

- We saw staff taking time to welcome relatives on to the wards and provide detailed updates on the progress in the care of their relative. We spoke to five relatives as part of the visit and all informed us that staff took the time to support them and answer their questions.
- One relative informed us that they had a weekly meeting with the consultant as a minimum and received an update on their relatives condition and plan of care. This meant that they felt included in the care and that they understood what was going on.
- We were also told about how staff took time to explain every procedure to them, as well as to the patient (even though they were unconscious) and would tell relatives what they should expect to see when they next came back.
- We examined the records of eight patients on the unit and all had a dedicated section within the records for family and patient communication. This was a record of the weekly discussions held with the families and/or patients and included what was explained and what was asked of the clinical teams.

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- The records of the conversations with relatives was well documented and clear for all other professionals who reviewed the notes. The record of notes was consistent with what the relatives told us.

Emotional support

- The service had access to the range of clinical nurse specialists employed by the trust including Dementia, stoma care, chronic obstructive pulmonary disease (COPD) respiratory nurses and cancer nurse specialists.
- Part of the care planning for patients who are in critical care includes monitoring for the signs of anxiety or depression. Where a patient is identified as showing signs of either then a referral for further assessment and support is requested to help the individual.
- The critical care unit offers counselling and support to patients who have been through traumatic events or critical illnesses to support their recovery and wellbeing.
- Relatives of patients were also offered counselling support throughout the course of an admission and were invited for further follow up support following a person's discharge or death.
- The service had links with the local mental health trust, the internal bereavement services and counselling services to support the needs of patients and relatives who required support.

Are critical care services responsive?

Good



At the last inspection the responsiveness of critical care services was rated as requires improvement. At this inspection we have rated the critical care services as good for being responsive because:

- The unit was now closed and access and flow was now overseen by the critical care team, which was a positive improvement from the last inspection.
- Whilst the population per head of bed was under the recommendation, the critical care outreach team provided support to patients on the wards where higher dependency care was required, avoiding critical care admissions.
- There was dedicated support and reviews for patients in the service who had The Speech and Language Therapy (SALT) needs.

- Follow up clinics were offered to patients following their discharge from the hospital. This included for breathing assessments for those who were ventilated during their admission.
- The service had a flexible approach to visiting times for families, and also ensured that they met and spoke with the patients (where possible) and their families at least twice per week to talk about the plans of care.
- Staff had access to a language line which was available for translation support 24 hours per day. When staff had arranged meetings with family as part of their weekly meetings they would try to ensure a translator was present where needed.
- The process for the investigation and learning from complaints had improved since our previous inspection. There was now a clear process in place for learning from complaints.

However we also found areas that could be improved including:

- The critical care service delayed discharges out to the ward areas within four hours has continued to increase due to bed occupancy and capacity issues within the hospital.
- The number of discharges taking place between 10pm and 7am remained high.

Service planning and delivery to meet the needs of local people

- The service was undertaking a review of the capacity provided within critical care. The service had recognised that having 14 beds for use was small in comparison to the hospital capacity of almost 600 beds.
- The lead consultant and medical director shared their ideas for the service which would be incorporated into the review for discussion with Commissioners on how they plan to deliver a service which meets the needs of the local people.
- The service plan for delivery was aligned with the vision and strategy for the service and is being addressed strategically to ensure that it is financially beneficial for the trust and the Essex health economy.

Meeting people's individual needs

- Staff had access to a language line which was available for translation support 24 hours per day. When staff had arranged meetings with family as part of their weekly meetings they would try to ensure a translator was

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present where needed. There was also support within the team who could speak a variety of languages and this aided the delivery of translation support for the unit.

- The unit had good links with the learning disabilities nurse. The nurse was being called pro-actively when a patient was identified to have a learning disability and an individualised care plan being formulated as a result.
- Staff on the critical care unit liaised frequently with the lead nurse for Dementia who frequently visited the unit when requested to see a patient with Dementia or provide advice to staff on caring for someone with Dementia in a high dependency setting.
- Patients were invited to a follow up clinic with plans in place to include a review on breathing following the use of a ventilator, access to psychological support if needed, discussions about the care and their experience to help their recovery.
- There was dedicated support and reviews for patients in the service who had The Speech and Language Therapy (SALT) needs. This included support with food intake following ventilator use as well as the use of a variety of communication aides which could help people who had undergone tracheostomy procedures.
- There was a flexible approach to the visiting times for the unit. Whilst there were set times, in the event a patient was unstable or unwell or a relative particularly wanted to stay with them during their time in critical care as much as possible they were allowed to do so by staff.
- The relatives had the use of a relatives room as well where they could get refreshments and make phone calls when they needed to.

Access and flow

- We were informed by the leads for the unit that patient flow remained their top challenge within the critical care unit. The internal delayed discharges have not improved since our previous inspection and have remained constant at between 60 and 80 per quarter. The reports we reviewed linked this to hospital bed capacity exceeding 100% at times throughout the previous year.
- Whilst this has not improved this is consistent with other units of a similar size in England, and was evidenced through ICNARC that the service was in the middle range for delayed discharges and was not an outlier for delayed discharges.

- Bed occupancy for the critical care unit was consistently around 80% for the beds available. The data provided showed that occupancy had remained at this level for more than 15 months. Bed occupancy had only gone below 80% on one occasion during this time.
- The unit formally became a closed unit in February 2016 following recruitment to further medical posts. This meant that the care for the patients was the responsibility of the critical care unit and not medicine or surgery. This was identified as a concern during our previous inspection and is a notable improvement.
- Consultants from specialties now refer patients into the critical care service for consultation and assessment for admission. This has changed the admission criteria for the unit which has positively reflected on the bed occupancy rates for the unit.
- The critical care unit has 14 beds of which 11 are commissioned for use. The trust serves a population of 405,000 who may be in need of critical care services which equates to approximately one bed per 28,900 people.
- The recommendation is 11.5 critical care beds per 100,000 which means that the trust is significantly short of the recommendation of 46 beds recommended, this is also not financially realistic for a trust of this size. The clinical leads are developing plans to align with the Essex Success Regime to review capacity within the trust for critical care services for consideration.
- The critical care unit achieved the 95% target of admission to the unit within four hours for three of the last six months, but was consistently above 80%, which was positive and in line with trusts of a similar size.
- The number of discharges from the unit happening between 10pm and 7am has reduced since our previous inspection but still remained high. At the last inspection there were between 30% and 60% of discharges taking place between 10pm and 7am. On this inspection we found that this had reduced to an average of 20% to 30%, however this was still high.
- Non clinical transfers in was consistently below the England average.
- The mean length of stay per patient on the unit was consistently in line with the England average and occasionally below the England average of seven days.

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- The clinical leads for the service recognised that delayed discharges and out of hour discharges remained a concern for them but they were working to reduce them, however they were impacted by the low bed capacity in the main hospital.

Learning from complaints and concerns

- The service had seen a significant reduction in the number of complaints received regarding the critical care service since the last inspection. The unit had received four complaints since the previous inspection and all had been appropriately investigated.
- At the last inspection it was identified that there was a lack of process for learning from complaints. At this inspection we found that there was a clear process for sharing information and learning from complaints through staff meetings, governance meetings, one to ones and through information boards in the seminar and staff room.
- The Care Quality Commission had also received no new concerns about the critical care service since April 2015.

Are critical care services well-led?

Good



At the last inspection the leadership of critical care services was rated as requires improvement. At this inspection we have rated the critical care services as good for being well led locally because:

- There was a clear vision and strategy for the service. The strategy was still being developed and being considered in line with the needs of the health economy in the Essex Success Regime.
- There was good evidence of ward to board leadership, communication and governance regarding the critical care service.
- There had been notable improvements in the leadership of the critical care and outreach service with the appointment of new service leads. This was supported by improved governance processes and improved performance.
- Morale and culture within the critical care and outreach service had improved significantly since our previous inspection.

- There was processes in place for patient engagement and acting on the feedback provided to improve the service.
- The clinical lead had positive and innovative ideas for the future of the service within the unit but also on the wards, these ideas if put into practice could have a positive impact on the safety of patients across the hospital.

Vision and strategy for this service

- There was a clear vision for the service, which was well articulated by the clinical lead. The strategy which supported the vision was still being developed and being considered in line with the needs of the health economy in the Essex Success Regime. This strategy required defining and embedding within the service in the near future.
- The trustwide executive team were aware of the vision and plans for the service and were supportive of reviewing any plans and strategies that will be put forward to benefit and improve the service.
- Staff we spoke with in the unit were aware of the vision for the service and informed us that they were included in this to provide ideas for how to improve the service.

Governance, risk management and quality measurement

- At the previous inspection there were concerns noted with the lack of frequent meetings taking place regarding quality, risk, mortality and morbidity on the unit. The risk register was also not reflective of the risks identified in the service.
- At this inspection we found that the critical care service held regular monthly governance and audit meetings. We reviewed the minutes of the governance meetings that were held monthly and observed that there was good representation from medical and nursing staff at these meetings and that the attendance rates were increasing. We saw examples of incident reporting, infection control, critical care KPI monitoring and mortality and morbidity.
- The service had a risk register which identified that staffing levels for nurses, training on the critical care qualification and capacity and flow out of the unit and into the main hospital were the top risks for the service. From our inspection it was evident that the service was aware of where its risks were and were clear on how these were being addressed.

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- There was a process of monitoring risk at each governance meeting, and it was evident that the risks in some areas were reducing particularly around nurse staffing with improvements in recruitment, as well as securing additional placements for staff on the critical care course with a local university.
- The critical care unit has set up a range of key performance indicators which allow them to monitor their progress with achieving improvements in care delivery on a monthly basis. This included delayed discharges, out of hours transfers, seeing a consultant within 24 hours of admission and readmission rates. This was a positive improvement since our previous inspection because it enabled the service to continually monitor their quality and risk within the service.
- Through speaking with the Chief Executive and the Medical Director on the day of inspection, during a presentation by the team it was clear that the senior team within the trust were aware of the risks in the unit and there were clear lines of reporting and accountability from the critical care unit to the board in place.
- Whilst the leadership of the service had improved, further time was needed to allow the leadership team, style and management processes to become embedded within the service. This will hopefully demonstrate robust and cohesive working, and in the long term evidence their journey to becoming an outstanding local leadership team.

Leadership of service

- At the previous inspection we found that there were concerns with how the service was led, with a disengaged clinical workforce and a lack of nursing leadership.
- At this inspection we noted that there was a new clinical lead, new lead for the outreach service from a nursing and medical perspective, and a new matron had also been appointed and was scheduled to start in May 2016. Whilst the Matron had not yet started they were undertaking engagement days with the service to provide a presence and meet people before starting.
- The nursing leads who were covering the service in the interim, until the new matron commenced their role, worked closely with the clinical lead and the executive team to deliver change in the service.
- We spoke with 12 staff members about the changes and the leadership of the service and all reported to us that they felt that there was a positive approach to leadership, now and that the service was moving in the right direction.
- A lead consultant had been appointed to the critical care outreach team and the team informed us that whilst this was a new development this was positive in terms of clinical input leadership and support to help drive and improve the service.
- A new lead nurse had been appointed to the critical care outreach team; this was an improvement since the previous inspection where there was a notable gap in nursing leadership. The lead informed us of their plans to improve and develop the service which was positive.

Culture within the service

- At the previous inspection the culture of the service was poor with morale amongst the staff on the critical care unit and in the critical care outreach team being poor.
- At this inspection we found that there had been a significant improvement in the culture and morale of the service. Three staff members who were here during our previous inspection spoke to us about the difference in the service and said it had really improved.
- We observed interactions between the leadership team and the staff within the unit with regards to escalating concerns and care of patients during the inspection and the staff speaking to the leaders were observed to be comfortable in raising anything to the seniors on duty without hesitation.
- There was a clear process for the undertaking of duty of candour on the unit. Staff knew to escalate where an event had occurred and Duty of Candour may be required. The unit routinely undertook being open conversations with families.
- In the records of two patients we observed in the patient and family communication section being open conversations recorded in detail, where information regarding care had been shared. One related to a medicines omission on a ward and one related to a safeguarding and deprivation of liberty matter. The notes of these discussions were detailed and comprehensive about what was discussed.

Public engagement

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- The critical care unit routinely hold patient focus groups and relative focus groups to seek feedback on the service. There are public meetings which are held through the patient experience team to gain feedback on the experience of the service for improvement.
- We reviewed the action plan and comments which were provided during these meetings. Feedback included provision for relatives including tea and coffee facilities and a place to rest. The trust has demonstrated that it has acted on the feedback by providing tea and coffee facilities and a place where families can rest.

Staff engagement

- Since the previous inspection the trust has undertaken a range of staff engagement activities including team building, staff focus groups and staff meetings and one to one meetings to understand what the key issues were for the service.
- The service have produced an action plan and undertake regular pulse surveys to understand where staff still have concerns. We reviewed the action plan, which had been updated with monthly actions. The

actions on improving job prospects, leadership, career pathways and development are all being actioned and this demonstrated that the trust were listening to staff feedback.

Innovation, improvement and sustainability

- The critical care KPI dashboard was an innovative way of sharing the performance with all in the trust and the trust executive team to be open about where the critical care service was achieving targets and where they were not. Where this related to other services it supported a new line of engagement with the service to improve multi disciplinary working.
- The service clinical lead had innovative ideas with regards to the management of the critical care and high dependency patients in the future. This plan included the upskilling of ward staff to provide dedicated beds for high dependency patients. This idea was innovative and could benefit the trust in the future and improve the safety of patients in the ward areas and reduce the likelihood of unplanned admissions to critical care.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- Improve the mandatory training rates for the critical care outreach team.
- Ensure all staff receive updated equipment competency training.
- Reduce the delayed discharges over four hours from the critical care unit to the main wards.
- Reduce the number of transfers out of hours between 10pm and 7am.