Care Quality Commission

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By Email

Clare Panniker
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Date: 15 February 2017

Dear Clare

Re: CQC inspection of Southend University Hospital NHS Foundation Trust

Following the feedback meeting with Fiona Allinson, Head of Hospital Inspection and Beth Malster, Inspector, on 9 February 2017 with Yvonne Bulcher I thought it would be helpful to give you written feedback of our preliminary findings as highlighted at the inspection and given at the feedback meeting.

As you know, the key questions we ask during our inspection are whether the Southend University Hospital NHS Foundation Trust is currently providing safe, effective, caring, responsive and well-led services in ED, medicine and surgery. A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. This letter does not replace the draft report we will send to you, but simply confirms what we fed-back on 9 February 2017 and provides you with a basis to start considering what action is needed rather than waiting for the draft inspection report.

Our approach

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Southend University Hospital NHS Foundation Trust.

The following organisations provided information NHS Improvement, the clinical commissioning group (CCG); NHS England; Health Education England (HEE) and the local Healthwatch.

The inspection team was led by Fiona Allinson, Head of Hospitals Inspections at the CQC.

As part of the inspection we:

- Interviewed senior representatives of the trust
- Inspected clinical areas.
- Provided verbal feedback on 9 February 2017.

An overview of our preliminary findings

The preliminary findings that we fed back to you were:

Areas of good practice:
Within ED

- Since our last inspection, the trust has installed a controlled access system in the paediatrics area to restrict any unauthorised access to clinical areas. This prevented any unauthorised access and we observed staff within the paediatrics area following the security protocols correctly and challenging anyone calling to enter the department.
- Patient record keeping was of a very good standard, allergies, national early warning scores (NEWS) and paediatric early warning scores (PEWS) were all clearly documented.
- There were several established systems to ensure good clinical governance and monitor performance, clinical governance, mortality, and morbidity and infection control.
- All patients we spoke with acknowledged a caring and positive culture within the ED and were happy with their experience of care and treatment despite the delays they may have experienced.
- Staff spoke very highly of the clinical lead, associate director and matrons and said that these staff were approachable, and listened to their concerns.
- The ED had created a Trauma Assessment Centre (TAC) as an extension of the fracture clinic, where patients were streamed directly to be seen for treatment.

Within Medicine:

- There was a positive culture around incident reporting in the medical service. Staff we spoke to understood how to report incidents using the electronic reporting system. Staff told us they received feedback on incidents they reported and we saw evidence of ward managers discussing incidents at team meetings. Managers sent a ‘weekly round-up’ to all staff, which included details of investigations and learning points from incidents.

- Nursing staff, allied health professionals and junior medical staff described good working relations with consultants in their speciality teams. Staff consistently described consultants as “approachable” and “supportive.”

- Senior staff on Benfleet (Stroke) ward were focused on building a positive culture among staff. For example, the ward manager told us about a training session they organised with a ‘National Patient Champion’ who came to talk to staff to boost morale and identify actions for improving communication between staff. We saw documentation of this session in team meeting minutes and the ward manager told us about actions that had come from this training. A junior member of staff on Benfleet ward told us they had attended a focus group about staff culture, which made them feel more appreciated.

- We saw examples of staff working together to meet patients’ individual needs. For example, the learning disability specialist nurse gave us an example of how care had been coordinated for a patient with a learning disability to ensure that they received all necessary care in a way that minimised their anxiety during hospital admission.

Within Surgery:

- Emergency surgery ambulatory care service, which accepts referrals from GP’s, A&E and community nursing helping to prevent hospital admissions. Winners of the hospital hero award in October 2016

- Ambulatory wound unit on Balmoral ward taking referrals from community, podiatry, GP’s as well as wound care for discharged patients. Focused on early intervention and admission avoidance.

Whilst we found no areas of significant concern some of the areas that could be improved included:

- There was a disconnect between the senior management team and the workforce and a lack of appetite to change. Staff felt that they were not always supported to change and that change took a long time.
- There were concerns around the extension to SAU which was behind doors so sight of these patients was limited. We also found that there were approximately 12 patients to one toilet in this area.
- Some wards reported issues with outliers being seen by the correct team. I am aware that there is a buddying system being discussed and this will assist this issue.
- There were no named pharmacists for surgery. Reconciliation of medicines was not done in a timely manner. An example was found that in February only 10% of patients had had their medication reconciled within 24 hours.
- The stroke unit staff were unclear if they still operated as a HASU. They told inspectors that they did at times. Senior staff told us that there was no HASU.
- At times in the stroke ward nurse to patient ratios was 13:1 and in Benefleet the ratio was3 to 4: 25 patients.
- There was conflicting information about the BAMBS unit medical staffing. We were told by staff that they had put forward a plan for changes but that these

had been dismissed. However the medical director appeared unaware of this plan during his interview.

- There are challenges within the consultant body which impact upon the patient experience and capacity of the hospital. There was little evidence of a plan in place to address these. However impacts were seen through the lack of specialist nurse and capacity issues within outpatients.

All evidence collected will be used to inform the report and on which we base our judgement of ratings. As the draft report is being written and evidence considered there may be more issues which we would like you to consider. If this occurs I will be in contact with you. We will not be undertaking an unannounced inspection as the teams felt that they had all the information they required. However if during the report writing process something crops up I will be in contact with the team at Southend.

A draft inspection report giving full details of all the individual clinical services inspected will be sent to you in due course for factual accuracy. I am also copying this letter to colleagues at NHSI and NHSE as initial feedback.

Could I take this opportunity to thank you and the team for the arrangements that you made to help organise the inspection, at short notice, and for the cooperation that we experienced from your staff. Everyone from the most junior staff to the senior team was most accommodating and very open to our questions.

I am sure that we will have further discussions but if you have any further queries at this stage please do not hesitate to contact me.

Yours sincerely

Fiona Allinson

Head of Hospitals Inspection

c.c. April Brown, NHSI

Andrew Pike, NHSE

Mark Heath, Inspection Manager CQC