Mid Essex Hospital Services NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection, which included an announced inspection visit to the trust locations at Broomfield Hospital and Braintree Community Hospital between the 26 and 28 November 2014. At this focused inspection on 14- 16 June 2016 with an unannounced inspection on 30 June 2016, we reviewed the location of Broomfield hospital only.

This trust provides a regional specialty centre for burns and plastic surgery. We therefore included these two services as core services for this inspection. As part of this inspection we did not inspect St Peter's Hospital. The rationale for not including this service was due to the limited activity undertaken by the trust at this location. We also did not inspect critical care or children's and young people's services, as both of these were rated as good at out last inspection in 2014.

Prior to undertaking this inspection we spoke with stakeholders, and reviewed the information we held about the trust. Mid Essex Hospital Services NHS Trust had been rated as requiring improvement in a number of services and we included all these in our focused inspection. The trust had undergone a period of change with the former chief executive having left the trust and the chief nurse stepping in to this role in the interim. The trust received significant support from the NHS Trust Development Authority (now NHS Improvement) following our inspection in 2014. This support and the direction of the interim chief executive had driven significant improvements at the trust. A new chief executive had recently been appointed. The trust is also part of the Essex Success Regime which has sought to ensure that services in mid and south Essex are fit for the future. The new chief executive is currently joint chief executive at both Mid Essex Hospitals NHS Trust and Basildon and Thurrock Hospitals NHS Foundation Trust.

The comprehensive inspections result in a trust being assigned a rating of 'outstanding', 'good', 'requires improvement' or 'inadequate'. Each core service receives an individual rating, which, in turn, informs an overall trust rating. The inspection found that overall the trust has a rating of good.

Overall, we have found that the provision of care in each core service had improved since our last inspection. The trust was a caring organisation throughout, and staff were passionate about their work and caring towards patients. We rated effective, responsive, caring and well led as good as we saw many improvements in the leadership and delivery of care across the trust. We found that the burns and plastics service was providing outstanding care, which is reflected in the two outstanding ratings given. We have rated safe overall as requires Improvement, as the emergency department, medicine end of life care and outpatients had some areas that required improvements. Overall, we have rated Broomfield Hospital as Good.

- The leadership of the interim chief executive has driven significant improvements at the trust and this was evident during our inspection. Staff spoke positively of the Chief Nurse, and her role as the interim chief executive. A new chief executive had recently been appointed as part of the Essex Success Regime (The Success Regime is part of the NHS Five Year Forward View, which is a blueprint for the NHS to take decisive steps to secure high quality, joined-up care).
- Throughout the organisation staff were dedicated, passionate and cared about patients
- Whilst the trust had completed a successful oversees nursing recruitment programme, there still remained a high number of qualified nurse vacancies, which impacted on skill mix and the use of bank and agency. However, maternity had successfully recruited to midwifery vacancies.
- The emergency department was under pressure from the number of attendances. Between April 2015 and March 2016 the department had seen a 16% increase, which was double that of the England average of 8%.
- The increased number of attendances affected the flow of the emergency department. However, the department had introduced the Early Senior Assessment & Treatment (ESAT) and the "risk stamp and escalation" criteria for patients with a 45 minute delay off load (time patient arrives in the emergency department and transferred from ambulance

Summary of findings

stretcher) or delay in department for more than six hours. Both of these initiatives were working to ensure that patients were triaged, placed on appropriate pathways and re assessed when delays occurred.

- The burns service was extremely good and the service had innovative developments and plans.
- Access and flow throughout the burns service was seamless, and in the plastic surgery service significant improvement and action had taken to enhance seamlessness. However, there had been 795 plastics operations cancelled by the hospital in the last 12 months, though there were suitable plans in place which were being actioned to address this. Cancellation rates for trauma patients were not being monitored robustly
- There had been significant improvements in gynaecology with the move from Writtle ward to Gosfiled ward. Although we found general surgical outliers at the time of inspection, the numbers of outliers had reduced and there was clear criteria for outlying into a gynaecology bed.
- Overdue outpatient appointments of more than six weeks were referred to the supervising clinician for risk assessment to ensure it was safe to delay appointment. Ad hoc clinics could then be organised to meet demand.
- There were robust processes in place in relation to governance and risk assessment throughout all of the services inspected. The introduction of the "safety huddles" meant that staffing, risks, incidents and other patient safety issues were discussed with a view to reducing harm and improving the safety culture within the trust.
- The trust had responded to the withdrawal of the Liverpool Care Pathway, which had previously been seen as best practice when someone reached the last days and, hours of life. The trust used a holistic document which was in line with the five priorities of care. This care plan was called the 'Last Days of Life Care Plan'
- Trust feedback from the 2014 / 2015 national vascular registry (NVR) showed the trust had excellent outcome figures for abdominal aortic aneurysm repairs. The standardised mortality ratio was 0.7 (national average 1) which meant that survival was more likely at the trust compared to the national average.
- The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.The data provided by NHS England (September 2014 – February 2016) confirmed RTT times were in line with the England average. For general surgery 82.2% of patients were seen within 18 weeks of referral, Ear,nose and throat (ENT) 91.4%, Urology 93%, oral surgery 90.6% trauma and orthopaedics 79.6%, ophthalmology 77.8% and plastic surgery 88.8%.
- Following the inspection we reviewed the RTT data from March to May 2016 The data showed an improvement in RTT performance in three specialities. These were ENT (93.4%) urology (94.2%) and oral surgery (97%). General surgery (53.6%) trauma and orthopaedics (47.5%), ophthalmology (77.4%) and plastic surgery (71%) had seen a decline in RTT performance. However this was reflective of a national trend and the figures were still in line with the national average.
- The Sentinel National Stroke Audit Programme (SSNAP) for October to December 2015 showed the hospital achieved an overall rating of band B for both patient–centred and team-centred key performance indicators (where band A is the highest and band E the lowest).The Myocardial Ischaemia National Audit Project (MINAP) audit scores were similar to the England average in both 2012/13 and 2013/14.

We saw several areas of outstanding practice including:

- The burns and plastics services were extremely good and ensured that services users were involved and central to the innovation in services. The directorate had recently introduced an electronic live trauma database. This meant that staff had up-to-date information about the trauma service. Outcomes for patients with serious burns were comparable among the best in the world and were consistently exceptional.
- The 'trigger and response team' team were an exceptional team supporting acutely unwell patients throughout the hospital. The team were recognised throughout the hospital as being very responsive.
- The mortuary team were innovative and passionate about providing a good patient experience at the end of life.
- The trusts upper gastro-intestinal (UGI) surgery was internationally recognised and had introduced leading edge robotic technology.

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- The trust had worked to decreasing caesarean rates and had run an internal project called 'project two per cent'. The aim was to reduce caesarean section rates and promote vaginal birth. The maternity dashboard results showed that elective clinical caesarean had decreased from 12.8% in April 2016 to 8.4% in May 2016 against a target of less than 7%.This project remains on going. All staff were engaged in this project and there was clear leadership from the senior team.
- There was a dedicated 'birth reflections' clinic, which helped women who had felt that they had not experienced the birth that they had planned for, or felt levels of anxiety or stress which related to the birth experience.

Importantly, the trust must:

- The provider must ensure that HSA4 forms are sent to the Chief Medical Office, within the 14 days in line with the Abortion Act 1967.
- The provider must ensure that patient records in orthopaedic clinic are stored securely.
- The provider must ensure that medication, specifically paracetamol is prescribed clearly including route of administration.
- Ensure that staff are provided with appraisals, that are valuable and benefit staff development.
- Improve mandatory training rates, particularly in the emergency department, around (but not exclusive to) advanced adult and paediatric life support in line with the Royal College of Nursing 'Health care service standards in caring for neonates, children and young people.'
- Ensure that rapid discharge of patients at the end of their life is monitored, targeted and managed appropriately.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Mid Essex Hospital Services NHS Trust

Mid Essex Hospital Services NHS Trust was established as an NHS Trust in 1992. The trust provides local elective and emergency services to 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree.

The trust, based in the city of Chelmsford in Essex, employs 3,997 staff, and provides services from five sites in and around Chelmsford, Maldon and Braintree. The main site is Broomfield Hospital in Chelmsford, which has been redeveloped as part of a £148m private finance initiative (PFI). The trust provides the majority of services at the Broomfield Hospital site.

Our inspection team

Our inspection team was led by:

Chair: Richard Quirk, Medical Director

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including a range of consultant doctors from specialties including, emergency care, acute medical care, and general surgery, and we were also supported by a junior grade trainee doctor. We also had specialists from nursing and support backgrounds, including general nursing, midwifery and operational hospital management.

The inspection team were also supported by experts by experience. These are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The announced inspection visit took place between the 14th to 16th June 2016, with a subsequent unannounced inspection visit on 30th June 2016.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); the Trust Development Authority; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

During the inspection we spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers and pharmacists. We also spoke with staff individually as requested. We carried out unannounced visit on Thursday 30th June 2016 to the accident and emergency department, medical ward and burns and plastics. During these unannounced visits we spoke with staff, patients and relatives.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Summary of findings

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at Broomfield Hospital.

What people who use the trust's services say

The latest patient survey in June 2016 looked at the experiences of 83,116 people who received care at an NHS hospital in July 2015.

Between August 2015 and January 2016, a questionnaire was sent to 1250 recent inpatients at each trust. Responses were received from 522 patients at Mid Essex Hospital Services NHS Trust.

The survey results showed that the trust performed about the same as other trusts, in the majority of answers for example, regarding care and treatment, safe staffing levels and being treated with dignity and respect. Of the 60 questions asked in the survey, two were worse than average: written information provided after discharge and information about medications.

Facts and data about this trust

Broomfield Hospital overview:

Beds: 642

- 574 general and acute
- 48 maternity
- 20 critical care

Activity Summary:

Activity type

2015- 2016

Inpatient admissions

15,376

Outpatient attendances

655,793

Accident & emergency

(attendances)

91,047

Population Served:

The trust provides local elective and emergency services to 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree.

The trust also provides a county-wide plastics, head and neck and upper gastrointestinal (GI) surgical service to a population of 3.4 million and a supra regional burns service to a population of 9.8 million

Deprivation:

More than 50% of the wider population of Essex are in the two least-deprived quintiles. In 2015, Essex reported 6% of people living in the most deprived quintile, down from 9% the previous year.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated services at the trust as requires improvement. We found: • Medicines management practices required further monitoring to ensure that all medicines were appropriately managed prescribed and administered to ensure that patients received medicines in a timely manner. • Mandatory training rates, particularly those in advanced life support, were not in line with the trusts expectations. • Risk assessments for the management of sepsis was not consistent with the trust sepsis pathways. • Recruitment of emergency department staff remains an issue for the trust. However we also noted that: • Staff knew how to report incidents and did so without fear. Incidents were investigated and lessons learnt from these. These were disseminated across the trust. • Safety huddles were occurring in many areas increasing the mitigation of risks across the trust. • Nursing and medical staff we spoke with had a good understanding of the duty of candour. • The trust had a plan for staff recruitment to reduce the dependency on nursing bank and agency staff. **Duty of Candour** • The trust had a policy in place to ensure that staff completed their duty of candour requirements. • Nursing and medical staff we spoke with had a good understanding of the 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) ofcertain 'notifiable safety incidents'and provides reasonable support to that person). We saw a reply to a complaint letter which had been sent to a relative; evidencing the duty of candour was being upheld and an example where it had been carried out after a patient fall. • We reviewed one incident where this had occurred and saw that recommendations and shared learning were identified. Staff had received feedback at a ward meeting on the 25 April 2016.	**Requires improvement** 

Summary of findings

Safeguarding

- All the staff we spoke with were aware of the trust's safeguarding procedures for adults and children, what constituted abuse, and how to report it.
- All staff undertook safeguarding training as part of their mandatory training units.
- Staff spoke positively about the trust safeguarding team who were available to support staff with safeguarding concerns from 9am-5pm Monday to Friday.
- Rates of uptake of safeguarding training were variable and further work was required to ensure that all staff had the knowledge to underpin their actions.

Incidents

- Data from the 'Strategic Executive Information System' (STEIS) confirmed two never events (serious incidents that are wholly preventable) were reported for the surgical directorate.
- All Incidents were discussed and reviewed at directorate, departmental and ward governance meetings. Four sets of meeting minutes were reviewed, and there was evidence of incidents such as falls and pressure ulcers being reviewed.
- All staff, including bank and agency staff, had access to the trust's electronic reporting Datix system in order to add incidents.
- Staff said they reported incidents and received feedback in regard to incident outcomes. Learning from events was passed onto staff at monthly team meetings, safety huddles(daily morning hand over period for clinical staff) and through communications such as "lessons of the month".

Staffing

- All the wards had undergone a review in December 2015 of their nurse staffing levels, using the verified nurse staffing tool Safer Nursing Care Tool (SNCT), which took the acuity and dependency of patients into account.
- There were many vacancies across the trust although the trust had plans in place for recruitment in some areas.
- Agency and bank staff were used to cover for planned and unplanned shortfalls in staffing, covering vacancies and staff absences, as well as bringing specific required skills for short periods of time.
- The numbers of bank and agency staff fell in line with recruitment patterns.

Are services at this trust effective?

Good

Overall we rated services at the trust as Good. We found:

Summary of findings

- The service provided evidenced based care as identified within evidenced based clinical guidelines. Monitoring of clinical guidelines had taken place.
- Care was provided in line with National Institute for Health and Care Excellence (NICE) guidance.
- Patient's surgical outcomes were monitored and reviewed through formal national and local audit. Auditing systems had informed practice, introduced changes and lessons learnt to improve outcomes for people.
- Audit results showed that outcomes for people using the burns service were the best in England and were comparable with the best in the world.
- All nursing and support staff had either completed or were working through service specific competencies, which had been developed by managers. This demonstrated high levels of competence related to burns and specialist plastics care.
- Red and green days(part of the SAFER bundle- on whether the patient's day ahead is 'red' (a day where there is little or no value adding care or 'green' a day of value for the patient's progress towards discharge) were in operation throughout the hospital. This allowed staff to identify when interventions were required for individuals
- Corporate and local induction processes were in place for new staff.
- Patients told us that their pain was well managed and the trust wide pain team were involved in delivering pain relief on wards.
- Evidence of multi-disciplinary team working was observed.

However we also found:

- Outliers were located throughout the service. Outliers relate to patients who were situated away from the speciality they should have been admitted to. Staff identified concerns relating to frequent patient moves throughout the service and patient outcomes including care being affected..
- The trust audit results for the Royal College of Emergency Medicine (RCEM) were below the required standard.
- Training rates for the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) fell short of the trust's target of 95% for both medical and nursing staff.

Evidence based care and treatment

- Guidance from the Royal Colleges and the 'National Institute for Health and Care Excellence' (NICE) informed care, for example when treating a patient with a venous thromboembolism, pressure ulcers and when considering patients nutritional needs.

- Nursing staff told us that policies and procedures reflected national guidance and could be accessed on the trust intranet site. We saw that local policies were written in line with national guidelines.
- Evidence-based standards, which build on the World Health Organisation Surgical Safety Checklist approach, were developed and tested by clinical experts.

Patient outcomes

- Bowel cancer audit results (2015) against 11 indicators confirmed the trust performed well, with the exception of the data completeness indicator for patients having major surgery.
- The lung cancer audit (2014) identified the trust had performed better than the England average against the three indicators identified.
- The 2015 National Emergency Laparotomy Audit (NELA) identified a mixed result with two out of 11 indicators achieving 70 – 100%.
- The Hip Fracture Audit (2014 - 2015) showed that the hospital had performed better than the England average against eight indicators.
- The Sentinel National Stroke Audit Programme (SSNAP) for October to December 2015 showed the hospital achieved an overall rating of band B for both patient–centred and team-centred key performance indicators (where band A is the highest and band E the lowest).
- The Myocardial Ischaemia National Audit Project (MINAP) audit scores were similar to the England average in both 2012/13 and 2013/14.
- Results from the 2015 National Diabetes Inpatient Audit showed that trust scores have declined in 11 indicators compared with 2013, however there was an action plan in place to address this, with actions completed improving patient care.

Multidisciplinary working

- Staff told us that good multi-disciplinary working existed between the health care professionals working within surgery. For example, a 9am meeting took place on Lister ward which involved the multi-disciplinary team (MDT) where discussions about patients included their needs and impending discharge arrangements. Information about each patient was summarised on the 'Red / Green days Board', which was implemented two months ago. On a red day, the patient had no

identified intervention, whilst on a green day individual patients tests took place. Staff described this system as useful as it identified priorities, helped with patient discharge planning including estimated discharge dates.
- Patients records identified their care was reviewed daily by senior clinicians at the daily ward round and that the multi-disciplinary team (MDT) were actively involved in patients care and treatment plans.
- Ward nurses worked closely with the end of life care team and chaplaincy to ensure that patients at end of life received the necessary support and care they required.
- Occupational therapy and physiotherapy staff were given bases to work within each ward and said they were included in planning patients care.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust had policies and procedures relating to consent and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards 2009 (DoLS).
- This policy was accessible online or in paper format. This policy was in date and made clear reference to obtaining consent for both adults and children and young people under the age of 16. It clearly referenced the use of the 'Gillick competence', in which persons below the age of 16 can demonstrate capacity to consent to treatment.
- Staff said patients living with dementia type conditions were generally supported through the consent process by their relatives.
- Nursing staff and junior medical staff had a good understanding of the Mental Capacity Act.
- The trust identified that 82% to 93% of nursing staff had completed three yearly MCA training.
- Medical staff MCA training figures identified attendance between 79% to 90%. All high dependency unit staff had completed restraint, breakaway and conflict resolution as an action from an incident, this was being rolled out across the intensive care unit.

Are services at this trust caring?

Good

Overall we rated services at the trust as Good. We found:

- People who used the service and those close to them were encouraged to be involved as partners in their care. One of the many examples included; on Adult Burns Rehabilitation ward

where we saw that there was a dedicated "case manager" who oversaw patient care from admission to after discharge. This ensured that this patient had continuity of care, and this member of staff regularly checked that this patients' needs were being met and that they were involved and understood their care.
- Emotional support available to patients and people who cared for them was extensive. This included a psychologist for the directorate. Two play specialists were employed for children's burns services. There were numerous clinical nurse specialist employed who provided nurse-led care, and or, specialist tailored support for patients.
- Friends and Family test (FFT) results showed that most patients were extremely likely to recommend the hospital to friends of family based upon the service they received.
- People who used the service told us that they felt involved in their care.
- The chaplaincy service offered counselling services and these were available to staff patients and their family.

Compassionate care

- Staff consistently acted in a friendly and caring manner with people who used the service and those close to them.
- Staff responded to patient needs promptly and always knocked before entering patient rooms throughout the service.
- Friends and Family test (FFT) results showed that most patients were extremely likely to recommend the hospital to friends of family based upon the service they received.
- Patients consistently spoke positively about staff attitudes and behaviours.
- Patients, their relatives and friends told us that staff were always cheerful, helpful, thoughtful, kind and had a good attitude. One patient said, "They're a nice bunch."
- We saw nursing staff sharing appropriate humour with a patient and a nurse gently stroking a patients hand to comfort and reassure them.
- Throughout the surgical service, we saw that patient confidentiality was impacted by the use of white boards in ward areas, which identified patient names.
- Guidance was also available for staff on how they could improve the patient experience, for example, 'Shhh… Make night time a quiet time on the ward' poster.

Understanding and involvement of patients and those close to them

- People who used the service told us that they felt involved in their care.
- Patients told us that doctors and nurses had time to answer their questions. One patient said, “The Doctor explains everything to me”. We saw a nurse explaining a blood pressure reading to a patient when they asked about it and reassuring them that it was ok. On another occasion, we saw a nurse answering a patient’s questions about diabetes.
- Patients told us that they had enough information about their condition through discussions with doctors and from information leaflets.
- Physiotherapy staff said that families were involved in discharge planning processes. One example, involved families measuring home furniture to ascertain suitability. Where necessary additional equipment was provided to raise home furniture prior to the patients discharge.
- We observed staff informing a patient with learning disabilities where they would come to for their outpatient’s appointment.

Emotional support

- There was a range of emotional support available for people who used the service. On the burns and plastics service there were two nursery nurses employed per day shift, one allocated to the children’s ward and one for outpatient clinic for children’s appointments.
- The twice daily ward rounds included the presence of the burns clinical psychologist, and therefore mental health needs of patients were assessed at every round.
- The service also provided the Children’s Burn Club, which is a registered charity under the umbrella of the Mid Essex Health Trust, which was funded by the London and South East of England Burn Network. The club was open to any child or young person under the age of 18 years old that had a burn injury.
- The trust chaplaincy service provided a 24/7 multifaith service for patients and their families. This was via requested bedside visits, weekly ward visits by chaplaincy volunteers or attendance at the Multi Faith room. Patients told us that they were aware of the chaplains and several patients had spent time with them.
- A stroke specific counselling service was available to support patients and relatives affected by stroke. A relative told us they had been offered this service.
- The occupational health department offered a counselling service for staff, and staff could self-refer

Summary of findings

Are services at this trust responsive?

Good

Overall we rated services at the trust as Good. We found:

- Service planning and delivery considered the patients' needs, which meant changes to the service and how it was delivered benefited the patient.
- Support was in place for patients with learning disabilities or dementia type conditions and their families. The trust had identified a lead nurse for dementia who was also a 'Dementia Friends Champion.'
- Patients knew how to complain and we saw examples of lessons learned from complaints.
- Staff we spoke to were pleased with the new end of life care plans and felt they could individualise care.
- We saw good examples of facilitating patients dying wishes, such as seeing their pets, getting married and visiting their holiday home
- The responsiveness to the needs of bereaved relatives, by the bereavement, mortuary and chaplain staff was outstanding.

However we also found that:

- The data provided by NHS England (September 2014 – February 2016) confirmed surgical RTT times were in line with the England average, although the trust was not meeting standards in four out of seven surgical specialties. However in medicine the trust was exceeding the NHS standard.
- Staff identified concerns that patients who required social care referrals were not seen quickly, therefore delaying their discharge.
- Patients who had requested to be cared for in their own homes had experienced delayed discharges. There was no rapid discharge process in place. Patients wishing to die at home could wait five to ten days, and staff told us that there have been instances where patients died in hospital while waiting for discharge process.
- There was no formal audit process of peoples preferred place of care/death or discharge times.
- End of life care plans were not always complete. We were therefore unable to assess if care was provided in a timely manner.

- Between March 2015 and March 2016, the hospital did not meet the England NHS national target for seeing, treating, admitting, or discharging 95% of patients within four hours in the emergency department. Patients also waited longer than the England NHS average to be seen within this department.
- Surgical and medical outliers remained an issue for the trust.

Service planning and delivery to meet the needs of local people

- The trust was reviewing the way in which it delivered services to meet the needs of patients. As part of this work they took into account the work of the Essex Success Regime which was underway within the local area.
- Patient and staff feedback had been collected as part of the current upper GI cancer quality improvement project. This process engaged all staff involved in a patients pathway, from the GP to the ward staff and built a new way of working in relation to patient values and staff values.
- The glaucoma support group linked with the national glaucoma group. Improvements were made to patient's information by the group working with a patient who had lost sight.

Meeting people's individual needs

- Single sex accommodation was provided in clinical areas.
- People could access verbal and written language interpretation services through the trust. Telephone interpretation services were provided were there was a need, for example, during consultations or appointments.
- Visually impaired patients could access braille or large text documents.
- The spiritual needs of patients, staff and visitors were supported by the spiritual care and chaplaincy department.
- The hospital electronic flagging system identified when a patient with learning disabilities or autism was to be admitted / attend hospital. The learning disability specialist nurse had supported families and staff to ensure patient's needs were met and reasonable adjustments made, for example, easy-read information, longer appointments and home visits. Patients also completed a care passport to enable staff to learn about their individual needs prior to admission.

Dementia

- The trust had a proactive approach to caring for patients living with dementia.

- Two dementia specialists, one nurse and one occupational therapist provided support and advice for families and staff. Dementia champions had received specific training to enable them to support the patient and their family. Staff made referrals to the dementia team. All patients over the age of 75 years were screened for dementia following emergency admission.
- For those patient's living with dementia type conditions either the patient and / or their family were asked to complete the 'This is me' tool. This tool informed staff of the patient's needs, preferences, likes, dislikes and interests so that the patient's care was tailored to their needs. Open visiting was also available for relatives and / carers.
- The 'Patient Experience and Engagement Group (PEG)' meeting (4 March 2016) identified 100% of staff had completed level one dementia training. Since April 419, staff had completed Level 2 and 189 staff had completed Level 3 training. The first level three dementia training session was completed by doctors in January.
- The trust dementia booklet 'A guide for patients and their relatives' (May 2014) and a hospital newsletter 'Daily Sparkle' were available for patients and their families to access. We observed the dementia booklet was provided in different formats and languages on request through the patient advisory liaison team.
- Notley ward had developed a 'dementia friendly' day room for patients with dementia type conditions. The room was set up to reflect the Queen's birthday.
- Dementia friendly ward spaces included the use of pictures of historic icons, for example famous film stars or sporting legends above patient beds to help them locate their bed space. Different ward areas were painted in different colours to help patient orientation and toilet doors had pictures of toilets on them to remind patients where the toilets were.
- Dementia boxes, which contained items, such as cards, dominoes, colouring books, puzzles and fiddle mitts were available in ward areas.
- Pets as therapy (PAT) dogs came onto the wards on Thursday mornings. Patients enjoyed the interaction with the dogs and this brought them comfort and happiness.

Access and flow

- The data provided by NHS England (September 2014 – February 2016) confirmed surgical RTT times were in line with the England average, although the trust was not meeting standards in four out of seven surgical specialties. However in medicine the trust was exceeding the NHS standard.
- The trust was in the process of developing a frailty service, which would operate in the ED department. The service would be available 9am -5pm Monday to Friday with cover provided at weekends. The service aims to alleviate some of the pressures on the ED and help patients get the right care quickly.
- On day one of our inspection there were 16 medical outliers rising to 25 on day two. Staff told us that the medical outliers were medically stable patients. Outliers are visited by the medical 'Matron Of The Day' daily and consultants have a "buddy" ward and care for any medical outliers on that ward. Over the past 12 months, there were 182 instances of a surgical patients outlying on a medical ward. This was in relation to 168 individual patients.
- Discharge planning started as soon as the patient arrived on the ward. The trust had introduced a red and green day scheme to help identify those patients who were following a discharge plan. Staff told us they aim to complete discharges by 11am and that delays in transfer of care (DTOC) are usually due to difficulties restarting care at home.
- Medical bed occupancy was at 100% and had been for the previous eight months. There was one protected stroke bed. Bed occupancy was reviewed at 9am and 12 mid-day as part of the bed meeting.
- Theatres at Broomfield Hospital had a 96% utilisation. Monthly theatre utilisation varied between 53% and 96% from December 2015 to February 2016.
- Following a review of surgical services, a 19-bedded surgical emergency ward (SEW) opened in April 2015 whose remit was to admit emergency surgical patients. There was a formalised admissions policy.
- The discharge lounge could accommodate up to 14 patients. The lounge was open from 8am-8.30pm seven days per week and was staffed by one health care assistant (HCA) and one Registered Nurse (RN). Volunteers come in during the week to offer support to patients and staff by collecting pieces of equipment and transporting patients

Learning from complaints and concerns

- Complaints were discussed at trust board and the patient safety and quality committee. We saw that complaints themes

formed part of the patient experience paper reported at the trust board since January 2014. Weekly directorate complaint meetings were held between associate chief nurses, matrons and any other appropriate staff within directorates. A member of the patient advice and liaison team (PALS) and complaints team attended to discuss all active PALS and complaints cases and highlight any areas of concern.

- Key themes from complaints, compliments and feedback were discussed at the patient engagement group and relevant service user groups.
- Staff told us that they discussed complaints and fed back at ward meetings and daily safety huddles and we saw meeting minutes that confirmed this.
- Staff had arranged a face to face meeting with a patients relatives to discuss concerns and complaints, we saw feedback from this discussed on a ward meeting agenda
- An easy-read leaflet available for patients was written in word and pictorial format. Additional information about the 'Independent Complaints Advocacy Service' (ICAS) was also identified.
- How to complain leaflets were displayed in all areas to assist a patient, carer or relative if they wished to complain.

Are services at this trust well-led?

Good

We rated the well led domain at trust level as Good because:

- The longer term plans were being considered in relation to what services would look like in the future.
- Staff stated that the support of the interim chief executive had enabled them to drive improvements to services.
- The previous culture of fear had been dispelled and staff now felt empowered and owned the performance of services.
- Staff were aware of the values of the trust.
- Governance process were more robust with appropriate challenge from the non-executive directors.
- Risk and performance were monitored at all levels within the organisation.

However we also found that:

- A number of the board executives were in interim posts. Whilst this provided stability through the previous year staff expressed concern about the future. However plans were in place for recruitment to all interim posts.
- The board did not always act cohesively.

Vision and strategy

Summary of findings

- The trust vision and strategy was linked with that of the Essex Success Regime. This is in the development phase. There is to be a corporate board with local management teams on each site. There will be inevitable reconfiguration of services which will impact upon the services provided. During the periods between inspections the trust had continued to follow its previous strategy which was developed in 2011. However whilst the trust will input into the vision and strategy for the Essex Success regime it continues to aim to provide care that is safe, effective and results in an outstanding patient experience for the people of Essex whilst securing the future of acute hospital services in the Chelmsford and surrounding area that are clinically and financially sustainable.
- Whilst staff were yet to comprehend the changes involved in the Essex Success Regime they were cognisant of the aim of the trust and were driven and motivated to provide safe, effective care which drove a positive patient experience.
- The values of the trust were driven by the staff and were encompassed in the phrase "At our best we are kind, professional, positive and a team. All staff were aware of the values of the trust.

Governance, risk management and quality measurement

- When we inspected in 2014 the trust was in the process of reviewing its governance structures as the previous system was not working well. At this inspection the systems put in place in December 2014 were also in the process of being reviewed in light of changes at the senior level.
- The trusts governance system comprised of several committees covering finance and performance, remuneration, patient safety and quality, audit and charitable funds. These committees were underpinned by a myriad of committees that fed into the main committee. Senior members of the board attended a number of these committees which meant that the board executives were well sighted on all issues. The board also met frequently throughout the month to discuss issues raised at committees and with individual board members.
- We saw from review of board minutes that there was appropriate challenge from the non-executive members of the board.
- The trust had a risk register which contained the top 50 risks to the trust. These included financial, quality, effectiveness and patient impact risks. It correlated with the risks we found in the organisation. The risk register was discussed at board level and had named executive leads for all areas.

- The trust produced a monthly board performance dashboard which was separated into CQC's five key questions. This dashboard showed monthly performance over time in achieving national targets and regulatory requirements. It used a Red Amber Green (RAG) rating so that reviewers could immediately see areas for improvement. We found that some of these red areas were discussed at board.

Leadership of the trust

- The leadership of the board were visible to the staff they managed. The interim chief executive was well known and extremely visible to all staff.
- Some members of the executive team felt that the board had been on a journey over the previous year. This had not always been a smooth path. However the main body of staff were unaware of the issues that the board had had.
- There were a number of executives who were in interim and acting up roles. This had led to challenges within the board team but also for those in these roles an opportunity to input into the way in which the trust was developing.
- The senior team had some strong members and did not always work cohesively.
- The interim chief executive provided a visible and dynamic leadership role at the trust. This was clearly articulated by staff the we met with.
- The interim chief executive had not applied for the substantive role and was happy to support the new chief executive and the managing director at the trust.

Culture within the trust

- In 2014 we found that there was an underlying culture where staff were afraid to speak out. Staff just "got on with the job." At this inspection we found that staff no longer felt this way and were empowered to challenge, to drive improvements and enjoyed working at the trust. Most staff attributed this to the leadership style of the interim chief executive.
- Staff were keen to tell CQC inspectors of the improvements they had been able to make to their services.
- There was a palpable difference to the culture of the trust with many staff able to articulate what had made this difference. Whilst staff recognised that the trust was not always perfect they felt able to challenge the senior team on issues that mattered to them.
- We spoke with union representatives who said that in general their members enjoyed working at the trust. However there were some issues with the inconsistent application of some of

the human resources policies which led to disgruntlement amongst staff. In the main human resources issues were the main complaint from staff using the services of the union stewards.

- The trust senior team met the union representatives on a fortnightly basis. We heard differing accounts of this meeting and how useful it was to different parties. There was frustration from the union stewards that issues were not taken seriously at senior level and that they could suggest some quick wins for the organisation. However the management team felt that the relationship was good and that they valued the meetings.

Equalities and Diversity – including Workforce Race Equality Standard

- The trust had submitted the Workforce Race Equality Standard (WRES). The WRES is a mandatory requirement for NHS organisations to identify and publish progress against nine indicators of workforce equality to review whether employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities, receive fair treatment in the workplace and to improve BME board representation.
- In June 2016, the trust's Workforce Programme Board (WPB) agreed that it would fully involve the Equality and Diversity Steering Group with the fulfilment of the equality and diversity work-stream. .
- Data on the trust website for the year April 2015 to March 2016 shows that the trust are an equal opportunities employer with higher percentages of non-white ethnic groups being employed by the trust than percentages of within the general populations.

Fit and Proper Persons

- The trust had a fit and proper person policy which was currently under review. Each year executives were asked to make a formal declaration that they knew no reason that they were not fit and proper.
- We reviewed the staff files of recent appointees and found that appropriate checks were in place. These included references, job descriptions and checks against the fit and proper persons test.

Public engagement

- At each of its meetings the trust board heard about a patient's experience. A patient or carer was supported to share their experiences of their care from the Trust and how this impacted on them.

Summary of findings

- The trust has held patient listening events. The last listening event took place in 2015 and was attended by 353 patients. A trust action plan resulted which identified 10 themes of work. We were told of one initiative a preoperative 'Hip / Knee Club', which had received good patient feedback and had improved the patient information provided following patient feedback.
- Patient council meetings took place every four to six weeks. The biggest complaint identified by patients was noise. Staff were tasked to try to reduce noise levels and to explain to patients when noise levels may be expected to rise, for example, when moving patients.
- Meeting minutes from three 'Patient Experience and Engagement Group (PEG)' meetings confirmed patients feedback was acted upon and service improvements implemented. For example, a carer's pass was implemented for carers/ relatives of patients with dementia, cognitive impairment and end of life patients.
- Patient-led assessments of the care environment' (PLACE) provide a snapshot of how an organisation was performing against a range of non-clinical activities which impact on the patient experience of care. These non-clinical activities included, cleanliness, food and hydration, privacy, dignity and wellbeing, condition, appearance and maintenance of healthcare premises and dementia (whether the premises are equipped to meet the needs of dementia sufferers against a specified range of criteria). The ratings awarded by the PLACE team in 2015 for Broomfield Hospital were cleanliness (90.6%; national average (NA) 97.6%), food (86.4%), organisational food (92.9%; NA 87.2%), ward food (85.5%; NA 89.3%), privacy, dignity & wellbeing (79.6%; NA 86%), the environment, condition and maintenance (79.6%; NA 90%) and dementia friendly (53.97%; NA 74.5%). All 2015 scores with the exception of organisational food were below the England average.

Staff engagement

- We heard that there were many communication methods in place to keep staff up to date and engaged with what was going on with the trust.
- Staff received bi-monthly newsletters to inform them of the latest news.
- Staff said they had received good support and regular communications from their line manager and that team meetings took place.

Summary of findings

- The NHS Staff Survey 2015 staff response rate for MEHT was 3.8 (212 staff) for the key finding 'staff recommendation of the organisation as a place to work or receive treatment.' The ranking of this result in comparison with all acute trusts was rated average.
- In addition, the '2015 National Staff Survey' completed by 25% of trust staff confirmed four negative findings which related to the well-led section of the survey. These were, recognition and value of staff by managers and the organisation (trust rating (tr) 3.3, (216 staff) national rating 3.4). The percentage of staff reporting good communication between senior management and staff (24% (216 staff), the average for all trusts for this question was 32%. The quality of non-mandatory training, learning or development (both were 4.0 (145 staff)), the average for all trusts for this question was 4.03. The percentage of staff working extra hours was 77% (212 staff), this was identified as being the highest in the worst 20% of acute trusts.
- However staff spoke highly of the interim chief executive and felt that they had enabled them to promote initiatives which enhanced the patient experience.

Innovation, improvement and sustainability

- A leadership / management journal club was developed to enable staff to debate a relevant journal and encourage reflection on individual leadership and management styles and practices.
- The trusts upper gastro-intestinal (UGI) surgery was internationally recognised and had recently introduced leading edge robotic technology.
- The trust had worked to decreasing caesarean rates and had run an internal project called 'project two per cent'. The aim was to reduce caesarean section rates and promote vaginal birth.
- The chief executive now in place managed two of the trusts in the Essex Success Regime and the STP. This enabled the trust to consider the wider impacts to health and social care services across Essex. Plans were in their infancy but already took into account the services provided at each location to meet the needs of people.

Overview of ratings

Our ratings for Broomfield Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Specialist burns and plastic services	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Mid Essex Hospital Services NHS Trust

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

Outstanding practice and areas for improvement

Outstanding practice

- The burns and plastics services were extremely good and ensured that services users were involved and central to the innovation in services. The directorate had recently introduced an electronic live trauma database. This meant that staff had up-to-date information about the trauma service.
- The 'trigger and response team' team were an exceptional team supporting acutely unwell patients throughout the hospital. The team were recognised throughout the hospital as being very responsive.
- The mortuary team were innovative and passionate about providing a good patient experience at the end of life.
- The trusts upper gastro-intestinal (UGI) surgery was internationally recognised and had recently introduced leading edge robotic technology.
- The trust had worked to decreasing caesarean rates and had run an internal project called 'project two per cent'. The aim was to reduce caesarean section rates and promote vaginal birth. The maternity dashboard results showed that elective clinical caesarean had decreased from 12.8% in April 2016 to 8.4% in May 2016 against a target of less than 7%.This project remains on going. All staff were engaged in this project and there was clear leadership from the senior team.
- There was a dedicated 'birth reflections' clinic, which helped women who had felt that they had not experienced the birth that they had planned for, or felt levels of anxiety or stress which related to the birth experience.

Areas for improvement

Action the trust MUST take to improve

- The provider must ensure that HSA4 forms are sent to the Chief Medical Office, within the 14 days in line with the Abortion Act 1967.
- The provider must ensure that patient records in orthopaedic clinic are stored securely.
- The provider must ensure that medication, specifically paracetamol is prescribed clearly including route of administration. The provider must ensure that patient's weight is recorded for patient's prescribed VTE prophylaxis and follows the National Institute of Health and Clinical Excellence (NICE) guidelines.
- Ensure that staff are provided with appraisals, that are valuable and benefit staff development.
- Improve mandatory training rates, particularly in the emergency department, around (but not exclusive to) advanced adult and paediatric life support in line with the Royal College of Nursing 'Health care service standards in caring for neonates, children and young people.'
- Ensure that rapid discharge of patients at the end of their life is monitored, targeted and

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: HSA4 forms (used to notify government in termination of pregnancies carried out) were not being sent to the Chief Medical Office Department of Health.The requirement for registered medical practitioners to submit the HSA4 forms is at regulation 4 of the Abortion Regulations 1991 Patients records were left unattended and insecure and some were accessible to the public.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Paracetamol was not always clearly prescribed as some prescriptions showed both 'IV' and 'o' on the same prescription with no clear distinction between the two. There is a difference in the prescribed dose for 'IV' and oral based on a patients weight which should not be interchangeable.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Mandatory training rates, particularly in the emergency department, around (but not exclusive to) advanced adult life support and paediatric life support were significantly below the trust target, with 65% of medical staff completed advanced adult life support training and 33% completed advanced paediatric life support training, which is worse than the 80% trust mandatory training target.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care There was no rapid discharge home to die care pathway or any formal monitoring of number of patients who required fast track pathways for end of life care.