Mid and South Essex NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Mid and South Essex NHS Foundation Trust was formed on 1st April 2020 following the acquisition of Mid Essex Hospitals Services NHS Trust and Basildon and Thurrock University Hospital Trust by Southend University Hospital NHS Foundation Trust.

It is one of the largest hospital trusts in England, serving a regional and national population for some tertiary services.

The combined organisation provides acute and some community services across three main hospitals:

- Southend University Hospital
- Basildon University Hospital
- Broomfield Hospital

The trust also runs some community services and a number of smaller satellite units, allowing people to be treated as close to home as possible.

The trust has around 1800 in-patient beds over 3 main sites and other community sites.

The trust has over 15,000 members of staff.

The trust had experienced significant challenges over the past 18 months due to the COVID-19 pandemic. There was significant redeployment of staff at the trust during that period to support staff in critical areas. Services had to be redesigned and moved at short notice.

At the time of our inspection, the number of patients admitted to the trust with COVID-19 had significantly reduced from the peak in early 2021.

Our findings

We carried out an unannounced inspection of the following acute services provided by the trust:

- Urgent and emergency care at Southend University Hospital.
- Medicine at Basildon University Hospital because we received information giving us concerns about the safety and quality of the services,
- Maternity services at Basildon University Hospital, Broomfield Hospital and Southend University Hospital because we received information giving us concerns about the safety and quality of the services.
- Surgery at Basildon University Hospital, Broomfield Hospital and Southend University Hospital because we received information giving us concerns about the safety and quality of the services.

We also inspected the well-led key question for the trust overall.

Inspections of medicine, urgent and emergency care and maternity used our focussed methodology whilst surgery core services were inspected in full.

We did not inspect several services previously rated requires improvement because this inspection was focused only on services where we had concerns. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

This is the first time we have rated the trust leadership. We rated them as requires improvement because:

- Whilst we have aggregated ratings at Southend Hospital and trust, we have not aggregated ratings at Broomfield Hospital and Basildon Hospital as they are new services provided by Mid and South Essex NHS Foundation Trust. Well-led is the overall trust-wide rating, not an aggregation of services ratings
- We rated all eight services inspected as requires improvement.
- Patients were not always protected from harm. Not all staff had received mandatory training and there had been nine Never Events at that the trust. Records were not always accurate and kept securely.
- Staffing was a challenge across the trust both for nursing and medical staff with shifts regularly below planned numbers.
- People could not always access the service when they needed it and receive the right care promptly.
- There was a mixed culture at the trust. Staff did not always feel supported and valued.

However:

- Service generally provided care and treatment based on national guidance and evidence-based practice. Staff monitored the effectiveness of care and treatment. Staff generally worked together as a team to benefit patients. Key services were available to support patient care.
- Staff treated patients with compassion and kindness. Staff provided emotional support to patients, families and carers to minimise their distress. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

How we carried out the inspection

Our findings

We carried out this inspection on various days throughout July, August and September 2021. We visited areas relevant to each of the core services inspected and spoke with a number of patients and staff.

During the inspection we visited numerous clinical areas across the three hospital sites.

We spoke with staff members of various speciality and profession including, consultants, doctors, therapists, nurses, healthcare support workers, pharmacists, patient experience, domestic staff and administrators.

We spoke with 71 patients throughout the departments and reviewed 49 patient records.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

Basildon University Hospital

Medicine

- The same day emergency care (SDEC) service had developed an admission avoidance pathway for COVID-19 patients to allow them to be monitored safely at home. This pathway could be adapted for other respiratory conditions.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Basildon University Hospital

Medicine

- The trust must ensure that risk assessments are completed on all patients. (Regulation 12 (1)(2)a)
- The trust must ensure that mandatory training is completed in line with trust targets and line managers have oversight of compliance. (Regulation 18(2)a)
- The trust must ensure that staff appraisals are completed in line with trust targets. (Regulation 18(2) a)

Surgery

Our findings

- The service must ensure staff complete mandatory and safeguarding training in line with the trust target (Regulation 12 (2) c)
- The service must ensure that equipment is maintained and serviced in line with trust policy (Regulation 15 (1) e)
- The service must ensure risk assessments are completed and acted upon appropriately (Regulation 12 (2) a)
- The service must ensure the service has the right number of medical and nursing staff (Regulation 18 (1))
- The service must ensure that medicines are stored securely (Regulation 12 (2) g)
- The service must continue to improve the referral to treatment times for patients (Regulation 12 (2) i)

Maternity

- The trust must ensure that compliance with mandatory and safeguarding training is in line with trust targets. (Regulation 18 (2) (a)).
- The trust must ensure that all equipment is checked in line with policy to ensure it is suitable for use. (Regulation 12 (2) (e))
- The trust must ensure that there are adequate numbers of staff to meet the demands of the service, including dedicated triage midwives and supernumerary coordinators. (Regulation 18 (1))

Southend University Hospital

Urgent and emergency care

- The service must ensure that staff complete mandatory training to trust targets to maintain safe care. (Regulation 12 (2)(c))
- The service must ensure that NEWS2 scores are completed as per policy and that all scores are calculated and recorded within one system. (Regulation 12 (2)(a)(b))
- The service must ensure that patient records are kept up to date, legible and accurate. (Regulation 17 (2)(c))
- The trust must ensure that there are effective systems in place to ensure safe and timely transfer of critically ill patients, in the event of lift failures. (Regulation 15 (1)(e)(f))
- The trust must ensure that medicines are stored, administered and recorded in line with guidance. (Regulation 17 (2)(b))
- The trust must ensure that comprehensive and relevant audits are undertaken within the department. (Regulation 17 (2)(b))
- The trust must ensure that its' risk register is up to date, contains details of mitigating actions and all risk relevant to the running of the service. (Regulation 17 (2)(b))

Surgery

- The service must ensure staff complete mandatory and safeguarding training in line with the trust target (Regulation 12 (2) c)
- The service must ensure that equipment is maintained and serviced in line with trust policy (Regulation 15 (1) e)
- The service must ensure that fire doors on the surgical assessment unit are not propped open (Regulation 15 (1) c)

Our findings

- The service must ensure that medicines are stored securely and not left unattended (Regulation 12 (2) g)
- The service must ensure that risk assessments are completed appropriately and acted upon (Regulation 12(2) a)
- The service must ensure the service has the right number of nursing staff (Regulation 18 (2) a)
- The service must continue to improve the referral to treatment times for patients (Regulation 12 (2) i)

Maternity

- The trust must ensure that compliance with all mandatory training is in line with the trust target. (Regulation 18 (2) (a)).
- The trust must ensure that cleaning records are kept up to date. (Regulation 12 (2) (h))
- The trust must ensure that all equipment is checked in line with policy. (Regulation 12 (2) (e))
- The trust must ensure that there is a robust process in place for triaging women. (Regulation 12 (c) (a))
- The trust must ensure that there are adequate numbers of staff to meet the demands of the service, including midwives and supernumerary coordinators. (Regulation 18 (1))
- The trust must ensure that anaesthetists are present at multidisciplinary team handovers in line with trust target. (Regulation 17 (2) (a))
- The trust must ensure that medicines are stored securely. (Regulation 12 (2) (g))
- The trust must ensure that women's records are maintained securely. (Regulation 17 (2) (c))

Broomfield Hospital

Surgery

- The service must ensure staff complete mandatory and safeguarding training in line with the trust target (Regulation 12 (2) (c)
- The service must ensure that risk assessments are completed and acted upon appropriately (Regulation 12 (2) (a)
- The service must ensure that the service has sufficient medical and nursing staff to keep patients safe (Regulation 18 (1)
- The service must ensure that patients records are secure at all times. (Regulation 17(2) (c))
- The service must ensure that medicines including controlled medicines are stored securely (Regulation 12 (2) (g)
- The service must ensure that policies are reviewed and updated regularly and reflect best practice. (Regulation 17 (2) (a)
- The service must continue to improve the referral to treatment times for patients (Regulation 12 (2) (i)

Maternity

- The trust must ensure that compliance with all mandatory and specialist role training is in line with the trust target. (Regulation 18 (2) (a)).
- The trust must ensure that there is a robust process in place for triaging women. (Regulation 12 (c) (a))

Our findings

- The trust must ensure that there are adequate numbers of staff to meet the demands of the service, including midwives and supernumerary coordinators. (Regulation 18 (1))
- The trust must ensure that there is a robust process for all multidisciplinary team handovers. (Regulation 17 (2) (a))

Action the trust SHOULD take to improve:

Basildon University Hospital

Medicine

- The trust should ensure all equipment is monitored and maintained.
- The trust should ensure that the governance structure is fully embedded.
- The trust should ensure that patient records are maintained securely.
- The trust should ensure medicines are stored correctly and securely.

Surgery

- The service should ensure that patients mental capacity assessments are completed and recorded in a timely manner.
- The service should ensure that policies are reviewed and updated and ensure that staff access the most recent policy guidance.
- The service should ensure that all staff have an annual appraisal.
- The service should ensure that staff have access to information required to manage patients care in a timely manner.

Maternity

- The trust should ensure that staff follow safe and effective hand hygiene in line with infection prevention and control policies.
- The trust should ensure that staff adhere to the uniform policy and refrain from wearing watches and jewellery.
- The trust should ensure that carbon monoxide monitoring is completed in line with national guidance.
- The trust should ensure that the leadership structure is fully embedded.
- The trust should ensure that all staff, including preceptors have robust systems in place for support.
- The trust should ensure that the governance structure is fully embedded.
- The trust should ensure that processes for monitoring risk are embedded.
- The trust should ensure that all staff complete specialty specific training and have annual appraisals.

Southend University Hospital

Urgent and emergency care

- The trust should ensure that all staff have access to safeguarding training and that the training is completed.

Our findings

- The trust should ensure that all safety critical equipment such as resuscitation trolleys are checked daily and recorded appropriately.
- The trust should consistently monitor patient pain scores and act upon the information.
- The trust should ensure that all staff have access to clinical supervision.
- The trust should ensure that all staff participate in the annual appraisal process and address the appraisal backlog in the timeframe specified in action plans.
- The trust should keep staff updated about any changes or learning through team meetings with minutes available for those staff member that could not attend the meetings.

Surgery

- The service should ensure that policies are reviewed and updated to ensure that staff access the most recent policy guidance.
- The service should ensure that all staff have an annual appraisal.
- The service should review the practice of the administration of morning medication on Shopland and Castlepoint ward.
- The service should ensure that a mental health risk assessment is completed on the surgical assessment ward.

Maternity

- The trust should ensure that carbon monoxide monitoring is embedded in line with national guidance.
- The trust should ensure that the leadership structure is fully embedded.
- The trust should ensure that all staff, including preceptors have robust systems in place for support.
- The trust should ensure that the governance structure is fully embedded.
- The trust should ensure that processes for monitoring risk are embedded.
- The trust should ensure that incidents are investigated and closed in a timely manner in line with trust policy.
- The trust should ensure that all staff have a valid appraisal in line with the trust target.
- The trust should ensure that staff trained in newborn screening are available at all times.

Broomfield Hospital

Surgery

- The service should ensure that infection control and prevention audits are completed and used to monitor performance.
- The service should ensure that all cancelled procedures are rebooked as soon as possible following cancellation.
- The service should ensure that staff have access to information required to manage patients care in a timely manner.

Maternity

- The trust should ensure that carbon monoxide monitoring is completed in line with national guidance.

Our findings

- The trust should ensure that the leadership structure is fully embedded.
- The trust should ensure that all staff have robust systems in place for support.
- The trust should ensure that the governance structure is fully embedded.
- The trust should ensure that processes for monitoring risk are embedded.
- The trust should ensure that staff have access to all necessary information to enable them to complete their roles.
- The trust should ensure that all staff have a valid appraisal in line with the trust target.
- The trust should ensure that all staff trained in newborn screening are available at all times.

Is this organisation well-led?

This was the trusts first inspection. We rated it as requires improvement because:

- There was a mixed culture within the organisation with negative effects on a number of staff. NHS staff survey results were worse than the England average.
- In the preceding 12 months there had been a high volume of whistle-blowers within the trust, the majority being in maternity.
- Staff had mixed views regarding the visibility and approachability of senior leaders at the trust.
- Learning from incidents needed improvement, particularly sharing learning across different sites. Our staff survey showed that this remained a concern for staff. This was particularly required due to the high number of never events in the preceding 12 months.
- There was not consistent response from senior leaders about responsibilities and accountabilities for managing some risk within the organisation.
- All leaders described the trust being on a journey but not all articulated the vision for the trust following its creation in 2020.

However:

- Leaders had the skills and abilities to run the trust.
- The strategy was focused on improvement and sustainability of services and referred to working with providers within the wider health economy to improve patient pathways, however, not all leaders articulated the vision.
- Staff were focused on the needs of patients receiving care.
- Leaders operated effective governance processes, throughout the trust and with partner organisations. The new governance structure required further embedding.
- Leaders and teams used systems to manage performance. They predominately identified and escalated relevant risks and issues and identified actions to reduce their impact, though there had been significant issues in maternity in 2020 that were not addressed in a timely way.
- Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Our findings

- Leaders encouraged innovation and participation in research and strived to be influences on improved patient outcomes.

Leadership

Leaders had the skills and abilities to run the trust. They understood the priorities and issues the trust faced. Staff had mixed views regarding the visibility and how approachable trust leaders were. They supported staff to develop their skills and take on more senior roles.

- The leadership team had the capability to deliver high-quality services, which included an experienced group of non-executive directors. They understood the priorities and issues they faced. The trust had recently appointed an executive chief operating officer which was a new post.
- There was an experienced group of non-executive directors (NED) at the trust with complimentary skills who had clear sight of the challenges of the organisation. Board papers showed appropriate challenge of the executives. Non-executive directors chaired the board sub committees such as quality governance. The NED's we spoke with had appropriate support to carry out their role and told us their voice and challenges were heard. NED's each had a lead role within the organization.
- There was a strong focus on staff wellbeing amongst the executive team and supporting them over the coming months and years.
- The executive team took on additional responsibilities external to the trust. Over the last preceding year, the trust had also led on the COVID-19 vaccination programme amongst others. Executives at the trust including the chief executive had been involved with the STP prior to it becoming an ICS.
- Accountability and decision making was beginning to be devolved to care groups for decisions related to their scope of services. This was supported by the new governance framework and processes. Care group leadership we spoke with told us about their responsibilities and the autonomy within their role. The executive team considered and planned the organisational development support required to support this process and the care groups.
- A number of senior leaders reflected that the executive team had 'found their feet' following the long process of bringing the trusts together.
- Staff we spoke with during the core service inspections across the three sites provided mixed views regarding the visibility of the senior leadership team, including how approachable they were. This was also supported by the staff survey we conducted.
- A leadership framework was being developed alongside a talent management programme aiming to support development and that there would be a succession plan in place for staff across the trust.
- We reviewed nine personnel files in line with Fit and Proper Persons Requirement: Directors (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014 and found appropriate employment checks had been made and that declarations had been made.

Vision and Strategy

The trust had a strategy for what it wanted to achieve though not all leaders articulated the vision. The strategy was focused on sustainability of services and referred to working with providers within the wider health economy to improve patient pathways.

Our findings

- We heard a consistent message from the leadership team that the trust was on a significant journey including the lead up to and formation of Mid and South Essex NHS FT. There was recognition that some aspects of bringing the three trusts together could only happen following the formation of the new legal entity and that had been challenging alongside the COVID-19 pandemic. The team were clearly passionate about working for Mid and South Essex and were working well together.
- The chief executive was able to give a very clear vision for the organisations future and developing high quality services for patients. However, not everyone we spoke with were able to articulate this as clearly. Further work is required to share the vision through internal communication channels.
- The organisation had developed strategic objectives in July 2020 for the first time as a combined trust and had four strategic objectives including being an adaptive, well led, high performing, innovate organisation; delivering high quality, responsive safe services; being an employer of choice and being effective and efficient with resources. The strategy was described as a dynamic document and outward looking that supported working with the ICS and other partners.
- Each objective had defined outcomes, measure, and deliverables to ensure that the strategy was implemented, and each objective was underpinned by a set of approaches such as being digitally enabled, data driven and sustainability.
- Strategies for other elements of the organisation such as quality and the people strategy were in draft and had been paused due to the COVID-19 pandemic.
- The trust launched its values in September 2021 following extensive consultation with staff; the values were Excellent, Compassionate and Respectful.
- Several of the senior leadership team told us that the organisation was in transition, but the executives were ambitious.
- Staff we spoke with were aware of the new values of the trust and all could describe the journey towards a single trust. However, not all staff were clear about the vision or future direction of the organisation.
- The executive team were focussed on the importance of quality and spoke about the opportunities presented by the single organisation and the developing ICS. There was a clear focus on providing services that were safe and delivered in a way that suited the people who used services.
- There had been a number of consultations in relation to service changes which the leadership recognised caused some uncertainty. Some care pathways were being reviewed due to demands on services and to ensure safe, effective care. Some staff told us that communication had been poor around this and we had received several contacts in relation to the changing services.

Culture

There was a mixed culture from staff regarding feeling respected, supported and action taken on feedback they gave. Staff were focused on the needs of patients receiving care. The trust had undertaken significant work to support staff, but further work was required.

- There was a mixed perspective from staff regarding feeling respected, supported, and valued. Staff were focused on the needs of patients receiving care.
- Trust leaders spoke clearly about compassion for the wellbeing of staff and the need to be inclusive, empathic, and compassionate. The leadership was clearly focussed on their colleagues and there had been a number of initiatives across the organisation to support staff during the pandemic and more broadly.

Our findings

- Trust leaders recognised that staff were tired and, in some cases, 'burnt out' from the demand on services during the pandemic. There was support in place for staff for their physical and mental wellbeing though staff and leaders remained concerned about the demands on them and the service.
- The trusts performance in the NHS staff survey was mixed. For the most recent survey in 2020, when collated into themes, the opinions of trust staff were worse than the England average with the exception of 'Safe environment – Violence' which was the same as the England average. This represented a deterioration on previous years. Leaders told us that the results were due to the recent merger. There were a number of action plans in place to address the issues highlighted in the survey as well as reviews to identify best practice and any barriers to progress.
- Workforce Race Equality Standard (WRES) information showed that the trust performed poorly. As the trust merged in April 2020, there were only four indicators from this period, and they couldn't be compared to previous years. The difference between the experience of BME and White staff was significant for the four indicators of: staff experiencing harassment, bullying or abuse from patients, relatives, and the public in the last 12 months; staff experiencing harassment, bullying or abuse form the staff in the last 12 months; staff believing that the trust provides equal opportunities for career progression and staff experiencing discrimination at work from a manager or other colleague.
- We had received a high number of whistle blowers across the organisation. Between August 2020 and August 2021, we received 43 whistleblowing enquiries. There were whistle blowers from maternity services, medicine, urgent and emergency care, and some community services. The majority of whistleblowing information during the period was from maternity services. Themes included staffing, culture, support, governance, and patient safety. A number of whistle blowers told us they did not feel confident in raising concerns within the organisation and some feared retribution for speaking up. Inspections of maternity services in 2020 at Basildon Hospital confirmed the whistleblowing information and we took enforcement action in response.
- Freedom to speak up champions were in place across the care groups to support the work of the freedom to speak up guardians. The external guardian service had 207 contacts between April 2020 and March 2021. The main themes were COVID-19 related (23%), management issues (22%) and bullying and harassment (19%). The guardians report for 2020/ 21 stated that the trust had a higher than average number of concerns being raised though this was seen as a positive reporting culture.
- The concerns raised with the guardians reflected the results from the 2020 NHS staff survey as well as data in the WRES.
- We carried out a survey of staff working in maternity, theatres, and surgery as part of this inspection. We received 203 responses in total and responses were mixed. Of the questions we asked 41% of staff strongly disagreed or disagreed that they felt safe to report concerns. This was particularly the case for staff at Basildon University Hospital and those working in maternity across the trust.
- 48% of staff said that when they do speak up, feedback is not acted upon by senior management. This was felt across all three sites, especially at Basildon, and was a particular issue for staff working in maternity. Respondents from Basildon University Hospital overwhelmingly answered that communication between senior management and staff wasn't effective. This may be in part because respondents don't know who the senior managers are as 15% of respondents either strongly disagreed or disagreed to the question *"I know who the senior managers are here"*.
- 50% of respondents strongly disagreed or disagreed with the question that the organisation manages change well. This was particularly the case for Basildon University Hospital and staff from maternity and theatre. Staff were positive about duty of candour; Overall 75% of respondents stated they were encouraged to be open and honest when things went wrong. At site level, 63% of respondents from Basildon agreed with the statement compared to over 75% at Broomfield and Southend.

Our findings

- Staff were also positive about being encouraged to report incidents; 91% of respondents agreed that the organisation encouraged them to report errors, near misses or incidents. However, there was some variation when asked about the organisation taking action to prevent incidents happening again. Basildon Hospital performed the poorest for this question with 61% agreeing compared to over 75% at the other sites. 74% of respondents said they were given feedback in response to reporting incidents, with 10% disagreeing with the statement. Theatre was the service with the smallest percentage of respondents agreeing that they are given feedback (61%).
- 86% of respondents agreed or strongly agreed that they heard about learning from their part of the organisation. However, there were differences between the sites as 18% of respondents from Basildon disagreed. Staff at Broomfield were the most positive. Respondents did not feel that there was as much cross site learning especially at Basildon where 51% strongly agreed or agreed that they heard about incidents that happened in other parts of the organisation and learning from them. Again, maternity and theatre were the poorest performers however, Theatre staff felt the least like they know about cross site learning.
- Staff at Basildon University Hospital felt less valued than those at the other two sites, although around 40% of staff at Broomfield and Southend also did not feel valued. On the whole, maternity staff felt the least valued out of all three services. When broken down to site level, maternity staff at all three sites felt the least valued.
- There was recognition that the three main sites had different cultures and different ways of working due to their history as individual trusts. There was a focus on taking the strengths of the diversity whilst recognition of the challenge of consistency across the trust.
- The EDI strategy had been approved in July 2021 and had been formulated with network groups.
- Duty of candour was applied at the trust though performance was mixed according to trust data. For example, compliance with evidence of the initial verbal discussion at Basildon for the sample was 57% (8 of the 14) however, in all cases conversations were followed up in writing and of nine at Southend Hospital, only 56% had the discussion followed up in writing. We were told there had been some breaches as identified by the trust at Southend Hospital which the senior leaders had put down to the understanding of some staff. A programme of work was in place to address this.

Governance

Leaders operated effective governance processes, throughout the trust and with partner organisations. Whilst a new governance structure had been put in place, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- Leaders operated effective governance processes, throughout the trust and with partner organisations. Staff were clear about their roles and responsibilities and had opportunities to meet, discuss and learn from the performance of the services.
- There had been a significant change to governance structures and arrangements following the trust formation in 2020. The trust had been divided into care groups with clearly defined leadership and structures. All of the senior teams we spoke with were clear about the structure, roles and responsibilities and matrix management and could explain how it functioned to ensure safe, high-quality services. As the structure was very new, further work is required to embed the new structure and processes within the organisation. Care groups were held to account on a monthly basis through performance and accountability meetings.
- At the time of formation of the trust in 2020, senior leaders had not taken steps to ensure the proper registration of the new entity with us. As such, the trust was improperly registered until May 2020.

Our findings

- There was a clear scheme of accountability and delegation, which set out the executive responsibilities with clear delegated limits.
- Some legacy services were under resourced prior to merger and there were plans in place to bring some of these services in house to improve effectiveness and cost saving.
- The trust gave a good account of embedded financial governance at board, committee, and divisional leadership levels
- The trust leadership team has a high level of confidence in the chief financial officer (CFO) and finance leadership, and the assurance provided back through the finance reporting routes
- The trust has taken a lead role within the ICS in relation to finance with the trust CFO becoming the Finance Director for the system. This has been actively encouraged by the trust leadership team and a single system financial strategy is being developed
- The most significant risk facing the trust and the ICS is financial sustainability. The trust has commissioned a report on the drivers of the financial deficit which has been used to develop the financial sustainability strategy
- The relationship between finance and quality appears strong and clinical sign off is required at an executive level for all quality impact assessments
- The merger has not yet delivered the expected benefits, but the finance team is aligned to support the matrix structure.
- The council of governors were sighted on the risks the organisation faced as well as being adept at identifying opportunities. The governors we spoke with were clear about their role and felt listened to by the senior leadership. They expressed some frustration with their allocated time at the end of board meetings and that it did not afford them sufficient space to be fully involved.
- The care groups were held to account at monthly meetings with the staff governors, however, the trust had only six staff governors for more than fifteen thousand members of staff.
- Information regarding workforce was regularly reported to the board. Board subcommittees such as the people committee had good oversight of the workforce metrics and risks and appropriate information was sent on to the board.
- The board assurance framework (BAF) outlined strategic risks to the organisation and were aligned to the strategy. There was evidence of scrutinising of the BAF by NED's, board subcommittees and executives.
- During our core service inspections, we found a lack of consistency in some services such as maternity with the three main sites working in different ways. Despite significant issues we identified at Basildon maternity unit in 2020, there was not strong evidence of learning from the concerns at Basildon. We were told by staff that the focus had been on Basildon at the potential detriment of the other two sites.
- Practice development midwives had only been meeting across sites since the April 2020 and had not done so prior to the creation of the trust.

Management of risk, issues, and performance

Our findings

Leaders and teams used systems to manage performance. They predominately identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, there was inconsistent responses from senior leaders about responsibilities and accountabilities in relation to risk.

- Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions.
- The identification, documentation and understanding of risk was generally captured with good processes for clinical and patient risk.
- There was an 'issues' log for 'here and now' problems and also risk registers for longer terms or more strategic risks. Risks considered low to moderate were managed at the care group level with high risks going to the risk and compliance committee before going to board/ corporate risk register.
- The corporate risk register clearly defined actions required to address and/or mitigate the risk as well as arrangements for review and appropriate oversight as well as a named risk owner. All leaders we spoke with identified the risks that were being managed through the corporate risk register.
- Local risk registers were reviewed monthly at the care group performance review meetings. There were clear actions and mitigations as well as a named person responsible for the risk. Risks were escalated in line with trust policy.
- There were pharmacy risk registers for each main site. Each risk had an owner and assessor and were regularly reviewed.
- However, we heard some conflicting accounts in terms of responsibilities and accountabilities for quality and safety in the organisation and where these lay. Resolution of this will be essential to addressing some of the risks in the organisation such as the high number of never events that have occurred.
- There had also been delays in investigations of serious incidents in the previous year, senior leaders told us that further development was required to improve the timeliness of investigations.
- Incidents scored as 'moderate' or above were reviewed daily the executive review group for early identification of potential serious incidents.
- We were concerned as to the high number of never events at the trust. There had been nine never events in the year preceding the inspection. A number of the never events had commonalities. Our core service inspection showed that staff were not always able to put into practice the changes they wished to make such as a change to the WHO checklist.
- Our staff survey showed that not all staff felt learning was shared well across the organisation though some senior leaders told us it had improved over the preceding three years.
- The trust had mixed performance for healthcare associated infections. The trust was in the bottom 25 per cent of trusts for the number of MRSA bacteraemia cases with ten between June 2020 and June 2021.
- The trust predominately identified and escalated relevant risks and issues and generally identified actions to reduce their impact. However, in the preceding year we had taken enforcement action on two occasions in relation to maternity services in June and September 2020 when risks had not been fully identified and actions taken to address them. Senior leaders told us that processes had been embedded to ensure that a similar risk would be addressed in a timely way. From the findings of the three maternity inspections we were not assured that the trust had the necessary actions in place to manage the risk the demand was driving,

Our findings

- There was a positive incident reporting culture across the services we inspected. Action plans following investigation of incidents were clear. However, we noted not all learning from incidents was shared across the entirety of the trust and this was supported by our staff survey.
- There were ongoing challenges to manage the number of people requiring treatment at the trust. Referral to treatment times were mixed and patients told us prior to the inspection that they could not always receive care when they needed it. There was a recovery plan in place to improve access to treatment.
- The learning from deaths policy was currently being updated for use across the three sites and outlined the learning from deaths and mortality review for the organisation.
- Plans were in place to ensure the trust could cope with unexpected events.

Information Management

The trust collected reliable data and analysed it. Data or notifications were consistently submitted to external organisations as required. However, there were multiple systems in use at the trust which some staff found frustrating.

- Executives told us that information systems were a challenge for the trust. Whilst there was a significant amount of data and metrics available to the board and care groups, historically there was a number of different systems on each site which produced information that was not consistent, for example two sites had been using one type of incident reporting system and the third site adopted this unified system on the 1 July 2021. Whilst some systems were being unified, there remained different digital and paper systems across the trust,
- Work was underway to harmonise information including policies across the three sites. Inconsistent or different policies were identified as a risk and there was a plan to harmonise these across sites by December 2021.
- The trust had an improving supply of data and leaders we spoke with told us the quality of the information they received had improved over the last 12 months. NED's told us that they had sufficient information to carry out their role and hold leaders to account.
- However, audit results we reviewed did not always reflect what we found on the core service inspections or other evidence we reviewed. Due to this, we were concerned that governance and information flows were not always robust.
- There were a wide range of data and performance indicators and metrics including data quality audits and reviews to assure the quality of the data.
- Across our core service inspection, we found that staff used a variety of systems to record patient details, observations and care plans. Staff told us of their frustration with these issues and managers acknowledged that information quality management was more challenging with the mixed systems.
- From information we reviewed, there were arrangements in place to protect data from cyber threats.
- Detailed reports were generated for quality improvement, monitoring and assurance and discussed at board level.
- Most staff who completed route cause analysis investigations had completed the relevant training. For the last three months, 47 of 59 investigations had been completed by someone with the required training and a further seven had been completed by a person supported by another with the required training.

Engagement

Our findings

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- Trust leaders told us that communications had improved over the last 2 years following investment in communications senior managers and daily and weekly communications to staff. They acknowledged that communications needed to be more sophisticated for a large complex organisation. Other leaders we spoke with expressed frustration in that they could not easily email specific groups of staff and continued to be reliant on cascading information in a more traditional way.
- The trust engaged with patients, staff, the public and local organisations to plan and manage services and worked with other stakeholders in the local and regional system. As our inspection showed, some staff did not feel as engaged as others and there was further work required to improve this. All staff we spoke with recognised the need to change rapidly in the preceding 18 months in response to the COVID-19 pandemic.
- There was a patient engagement and experience strategy in place. There were a number of ways the trust engaged with staff from formal consultation to more informal routes such as the daily briefing held at each main site and was well attended.
- The trust was engaged with the local integrated care system with a focus on developing services for the future. The senior leadership team were committed to working in partnership to ensure safety and sustainability of services.
- Governors we spoke with told us that the trust engaged well with them, and they were sufficiently supported to carry out their role.
- The trust was undertaking actions to improve how Friends and Family Test (FFT) data was captured including giving different options to provide feedback. Response rates varied and were in some cases were low with outpatient's response rates of between 10 and 20 percent though some other inpatient response rates were as high as 30 percent. Responses were generally positive but there was some variation between sites. FFT data was analysed for themes and trends with actions determined in response to them.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research and strived to be influences on improved patient outcomes.

- There was a focus on research and innovation to improve patient care and offer different treatment options.
- There was an innovation programme at the trust focussed on new ideas and improving quality by supporting people to put into action their ideas. The team had seen medical and director level leadership as well as other members of staff.
- Since 2020 the Mid and South Essex Future Improvement Board had a number of workstreams including quality, digital, workforce and culture and leadership, which was executive led and aimed at rapid improvement.
- There were numerous innovate practices across the organisation including the intern programme for local people with a learning disability with a plan for them becoming permanent members of staff.
- Leaders were able to demonstrate learning from safeguarding reviews, incidents and complaints to improve patient practice. At our core services inspection we found that local leaders were aware of the complaints for their area and took action to address concerns.

Our findings

- The trust had developed a governance handbook for use across the organisation, which gave information as to frequency of meetings and set agendas for example that gave a clear framework for governance and aimed to improve consistency across the trust.
- We reviewed 14 complaints across the trust and found of those we reviewed, complaints were responded to on time and in line with trust policy.
- Leaders were able to demonstrate learning from safeguarding reviews, incidents and complaints to improve patient practice.
- The trust had ten accreditations across a range of services. This included the Joint Advisory Group on GI Endoscopy (JAG), Gold Standards Framework Quality Hallmark Award in End-of-Life Care and Commissions for the Accreditation of Rehabilitation Services amongst others.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Requires Improvement →← Dec 2021	Requires Improvement ↓ Dec 2021	Requires Improvement →← Dec 2021

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Southend University Hospital	Requires Improvement ➔➔ Dec 2021	Good ➔➔ Dec 2021	Good ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔ Dec 2021	Requires Improvement ➔➔ Dec 2021
Basildon University Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Broomfield Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ➔➔ Dec 2021	Good ➔➔ Dec 2021	Good ➔➔ Dec 2021	Requires Improvement ➔➔ Dec 2021	Requires Improvement ➔ Dec 2021	Requires Improvement ➔➔ Dec 2021

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Southend University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Services for children & young people	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Critical care	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Surgery	Requires Improvement →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Requires Improvement →← Dec 2021	Requires Improvement ↓ Dec 2021	Requires Improvement →← Dec 2021
Urgent and emergency services	Requires Improvement →← Dec 2021	Not rated	Good Mar 2020	Not rated	Requires Improvement →← Dec 2021	Requires Improvement →← Dec 2021
Outpatients	Good Mar 2020	Not rated	Good Mar 2020	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020
Maternity	Requires Improvement →← Dec 2021	Requires Improvement ↓ Dec 2021	Good Mar 2020	Good →← Dec 2021	Requires Improvement ↓ Dec 2021	Requires Improvement ↓ Dec 2021
Overall	Requires Improvement →← Dec 2021	Good →← Dec 2021	Good →← Dec 2021	Requires Improvement →← Dec 2021	Requires Improvement ↓ Dec 2021	Requires Improvement →← Dec 2021

Rating for Basildon University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement ↑ Dec 2021	Requires Improvement ↑ Dec 2021	Not rated	Good Dec 2021	Requires Improvement ↑ Dec 2021	Requires Improvement ↑ Dec 2021
Surgery	Requires Improvement Dec 2021	Good Dec 2021	Good Dec 2021	Requires Improvement Dec 2021	Requires Improvement Dec 2021	Requires Improvement Dec 2021
Medical care (including older people's care)	Requires Improvement Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Requires Improvement Dec 2021	Requires Improvement Dec 2021
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Broomfield Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement Dec 2021	Good Dec 2021	Good Dec 2021	Requires Improvement Dec 2021	Requires Improvement Dec 2021	Requires Improvement Dec 2021
Maternity	Requires Improvement Dec 2021	Requires Improvement Dec 2021	Not rated	Good Dec 2021	Requires Improvement Dec 2021	Requires Improvement Dec 2021
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Southend University Hospital

Prittlewell Chase
Westcliff On Sea
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www.southend.nhs.uk

Description of this hospital

Southend University Hospital is part of the Mid and South Essex NHS Hospitals Foundation Trust which was formed in April 2020. The hospital is located in Southend at Prittlewell Chase site, and has outlying satellite clinics across Southend-on-Sea, Castle Point and Rochford, and Orsett Hospital. There are 737 inpatient beds.

As Southend University Hospital is the registered location for the Mid and South Essex Hospitals Trust, this report will contain information regarding the whole services, and trust wide initiatives. The Southend site is the only site that has previous ratings, due to this being the acquiring organisation in the merger.

This inspection was completed as part of our routine regulatory action and to follow up on the safety of maternity services following regulatory action being taken at the Basildon site. We inspected Urgent and Emergency Care and Medical Care due to concerns around the management of risks and patient safety.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities.

During this inspection, we visited a number of wards and departments, including the emergency department majors and minors cubicles, resuscitation bays, triage room, rapid assessment and treatment areas. We also inspected the paediatric emergency department, and clinical decisions unit.

Within surgery, we inspected Trauma and orthopaedics, Ophthalmology, Oral and maxillofacial surgery (OMFS), Ear, nose and throat (ENT), Urology, Breast surgery, Vascular surgery and Colorectal surgery.

Within Maternity services we visited the antenatal and postnatal wards (Margaret Broom 1 and Margaret Broom 2), the consultant led central delivery suite (CDS), and the midwifery-led birthing unit for women.

At this inspection, we rated Urgent and Emergency Care (UEC) as, requires improvement for safe and well led. We did not rate effective or responsive and did not inspect caring as this inspection followed our focused methodology.

We rated Surgery as requires improvement for safe, responsive and well led and good for effective and caring. This inspection followed our comprehensive methodology.

We rated Maternity services as requires improvement for safe, effective, and well led. We rated responsive as good and did not inspect caring as we followed our focused methodology.

Our findings

The overall rating was Requires Improvement because:

UEC:

- Mandatory training compliance was not in line with trust targets.
- Not all staff had completed safeguarding training.
- Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- Staff did not always complete risk assessments for each patient swiftly to remove or minimise risk to patients. Staff did not always identify and act quickly upon patients at risk of deterioration.
- The trust did not always maintain critical equipment within the premises infrastructure well to keep people safe.
- Staff did not keep detailed records of patients' care and treatment. Records were not clear or up-to-date, or stored securely and easily available to all staff providing care.
- The service was not always managing medicines safely.
- Staff did not always assess and monitor patients regularly to see if they were in pain.
- Managers did not always appraise staff's work performance and did not hold supervision meetings with them to provide support and development.
- Waiting times were not always in line with National standards.
- Leaders did not demonstrate that they understood or managed the priorities and issues the service faced. They were not always visible and approachable in the service for staff. Staff did not feel supported.
- Staff did not feel respected, supported or valued. The service did not have an open culture where staff could raise concerns without fear.
- Staff did not always have regular opportunities to meet, discuss and learn from the performance of the service.
- The service did not identify or escalate relevant risks and issues or identify actions to reduce their impact. Leaders and teams did not use systems to manage performance effectively.
- The service collected data and analysed it. Staff could find the data they needed, to make decisions. The information systems were integrated and secure.
- Leaders did not always engage with staff actively and openly

Surgery:

- Staff did not always keep equipment and the premises visibly clean.
- The design, maintenance and use of facilities did not keep patients safe, we had concerns about the environment in the newly opened surgical assessment unit. Equipment was not always maintained in all areas we visited.
- The service did not have enough nursing and support staff with the right qualifications, skills, training and experience.
- The service did not have enough medical staff with the right qualifications, skills, training and experience.
- Records were not always clear, up to date, or stored securely.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients varied.

Our findings

- Governance processes were not embedded.
- Staff felt that there was a lack in consistency between electronic and paper records.

Maternity:

- Mandatory training compliance was not in line with the trust target.
- There were gaps in cleaning records.
- Annual equipment checks were not always completed.
- There was not a robust process in place for prioritising women in triage.
- The service did not always have enough maternity staff with the right qualifications, skills, training, and experience.
- Anaesthetic representation at handovers was not consistent.
- Women's records were not always held securely.
- Not all staff had an appraisal within the last year.
- The leadership structure was undergoing significant change and was not fully embedded.
- There was a mixed culture amongst staff with an apparent disconnect between midwives and matrons. Staff did not always feel respected, supported or valued.
- Trust wide governance structure was under review and not embedded.
- Processes for monitoring risk were under review, were not fully embedded and some data was either not collected or was not sufficiently robust to enable informed decisions or oversight.

However:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Surgical and maternity service staff completed and updated risk assessments for each patient and remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Our findings

- The service made sure staff were competent for their roles.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Local leaders were visible and approachable in the service for patients and staff.
- Local leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Maternity

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, compliance was not in line with the trust target.

Midwifery staff received mandatory training in line with their role. Training was provided either in person or via online training, depending on the topic. For example, basic life support and manual handling training was completed in person whilst equality and diversity was completed online.

We saw that the trust clearly allocated training according to roles and responsibilities, for example, staff who were nonclinical were required to complete a different level of manual handling to those who were clinical. As part of the merger into the Mid and South Essex NHS Foundation trust, mandatory training had been reviewed to produce a standardised level of training for each role. This was in the process of being implemented when we inspected.

Compliance for midwives mandatory training was below the trust target of 85%. Overall trust wide mandatory training compliance was reported as 69.8% in May 2021 in the trusts board papers. Following the merger of the trusts, the service was going through a data cleanse to determine what training was/had been completed across all sites. Reports did not identify any topics with particularly poor compliance.

Staff reported that training had been difficult to complete due to restrictions on face to face training in response to COVID-19, and due to reduced staffing numbers. There had also been restrictions on training in response to staffing levels and period when training had been ceased. There was a trajectory for compliance which was reported to the trust board monthly as part of the governance meetings. Full compliance was expected by March 2022.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism, and dementia. The team worked collaboratively with the mental health team to support women.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training needs were recorded centrally, and managers prompted staff to completed training or booked sessions for them when staffing allowed.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Midwifery and medical staff received training specific for their role on how to recognise and report abuse. Training compliance for safeguarding adults training was reported as being 93.7% for nursing and midwifery staffing which was above the trust target of 85%. Medical staff compliance with safeguarding adults training was also above the trust target at 92.9%.

Safeguarding children training was completed at different levels depending on the staff members roles and responsibilities. Trust data showed that staff compliance with safeguarding children level one was 93.3% for nursing and midwifery staff and 92.6% for medical staff. Safeguarding children level two compliance was 91% for nursing and midwifery staff and 100% for medical staff. Safeguarding children level three training was reported as being 79.3% for nursing and midwifery staff and 92.9% for medical staff.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Risk assessments were completed, and any concerns were escalated appropriately.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were given examples of when referrals had been made and actions that had been taken in response to concerns or feedback. We saw clear records within women's notes detailing any safeguarding actions taken, including referrals and discussions with safeguarding leads.

The service had safeguarding midwives who supported staff with any concerns. We saw that there were clear safeguarding policies which described escalation and reporting processes. Safeguarding midwives reported that they regularly met with peers from across the trust and that they discussed cases. The types of concerns were reported as being similar across the patch.

Staff followed the baby abduction policy although staff reported that they had not completed a baby abduction drill to test the efficiency of the process. Staff also had access to the mental health midwives who were able to support then with managing patients.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves, and others from infection. They kept equipment and the premises visibly clean. However, there were gaps in cleaning records.

Ward areas appeared clean and had suitable furnishings which were well-maintained.

Equipment and clinical areas were the responsibility of the midwifery team and checklists were in place to prompt staff to clean all items. We saw that there were some gaps in cleaning checklists, with no evidence of oversight of the process. However, we saw staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Cleaning audits were completed and reviewed by service leads to ensure standards were maintained. Cleaning audits showed that compliance was above 90%.

We saw that staff infection control and prevention audits showed good compliance. For example, trust data showed that hand hygiene audit compliance was 100% for April to June 2021.

Ward cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that there were dedicated cleaning staff who completed checklists and confirmed that cleaning schedules were completed. Cleaning scores were displayed on ward notice boards.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that hand sanitiser was available on entry to clinical areas and across all units. Staff were prompted to maintain good hand hygiene and visitors were encouraged to sanitise their hands on arrival to the departments. Staff were observed wearing PPE when completing clinical tasks. Trust data showed that hand hygiene audits were completed monthly and the service achieved 100% compliance in April, May, and June 2021.

The service had implemented several processes in response to COVID-19, which included the checking of every visitor's temperature on entry to the department and partners completing lateral flow tests prior to attending the department. Staff and visitors were required to wear face masks.

The service reported no cases of hospital acquired bloodstream MRSA infections of C. Difficile in the six months preceding the inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, annual equipment checks were not always completed.

The service had suitable facilities to meet the needs of women and their families. The maternity department was located in a dedicated area, which enabled all services to be co-located. On arrival to the department, visitors reported to reception and were signposted to the relevant clinical area.

The delivery suite consisted of 11 rooms, with a four bedded extended care area for higher risk women. There was a dedicated theatre adjacent to the delivery suite with a second theatre room which was being used for COVID-19 positive women for delivery.

There was a four bedded midwife lead delivery suite and a bereavement suite which was designed to enable whole families to stay for longer periods of time.

Opposite to the delivery suite was the antenatal and post-natal inpatient areas (Margaret Broom one and two) and fetal medicine unit (Kypos Nicolaides). All departments were secure. Access was permitted through pass controlled doors.

There was direct access to the neonate unit and theatres which facilitated access in an emergency.

The design of the environment followed national guidance. Rooms were sufficiently sized to enable treatment and any adjustments such as the introduction of a birthing pool.

The service had enough suitable equipment to help them to safely care for women and babies. Staff carried out daily safety checks of specialist equipment and we saw that resuscitation equipment was checked daily and following any

usage. However, we saw that annual equipment maintenance checks were not always completed. There were a number of pieces of equipment across all departments which were not in date including suction machines and blood pressure monitoring devices. The trust told us that this was in response to issues with accessing equipment during COVID-19 and there were plans in place to ensure equipment was checked.

Women could reach call bells and we saw that call bells were responded to quickly.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, attendance at multidisciplinary team meetings did not always include anaesthetists and there was not a robust process in place for prioritising women in triage.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. We reviewed eight women's records and saw that risk assessments were completed for each woman on admission or arrival to the unit, using a recognised tool. Risk assessments were completed and detailed clinical findings, however there was not always clear evidence of what action was taken in response to these findings.

Staff knew about and dealt with any specific risk issues. We saw that venous thromboembolism (VTE) assessments were completed for all inpatients and consideration was taken for risks such as sepsis, depending on the woman's clinical presentation.

Potential risks to pregnancy, for example domestic abuse were considered by the teams and the service had covert processes for highlighting any risks within women's notes. We saw that questions about risks, were not always recorded within the woman's record.

We saw that carbon monoxide (CO) monitoring was not always recorded within women's records. Risks associated with smoking were planned to be recorded at the initial assessment, and at 36 weeks. The service audited staffs recording of CO, which showed an increase from 25% to 100% for CO measurements at initial assessment and 5% to 33% measurements at 36 weeks. There was an action plan in place to improve monitoring which included training and spot checks.

Staff completed modified early obstetric warning score (MEOWS) as necessary to monitor women's conditions. Some records were paper based in delivery areas and electronic in inpatient areas. We saw that paper records showed that MEOWS were calculated and escalated appropriately. Audits were completed monthly to ensure compliance and data for April to June 2021 showed 87% to 90% compliance with recording and calculating observations accurately. Any abnormal MEOWS readings were escalated automatically to the critical care outreach team.

There were clear escalation processes for doctors to call for support from consultants in and out of hours. For example, we saw the clinical conditions for escalation to a consultant briefing which described the process for escalating concerns for conditions such as eclampsia, maternal collapse, post-partum haemorrhage or concerns with MEOWS over six. The briefing also details the need for a consultant for specific types of high risk procedures and ongoing briefing/ handovers.

Maternity

Staff shared key information to keep women safe when handing over their care to others. We saw that written and verbal handovers of care were detailed and considered all aspects of care. Shift changes and handovers included all necessary key information to keep women and babies safe. The midwifery handover contained details of the current inpatients and any expected attendances, details of any staffing concerns and any ward management issues that needed addressing, such as requesting medicines.

We saw the multidisciplinary team (MDT) handover and saw that both contained sufficient information to plan care and treatment. The MDT handover was well attended, with the exception of the anaesthetist. There was clear discussion about the days planned caseload and anything pending. The meeting did not follow a structure but was sufficiently detailed to enable the oncoming team to understand fully.

Triage was completed by any midwife available. We saw that there were two ledgers for the triage area, one for elective admissions and another for self-referrals or urgent attendances. Women were prioritised according to their symptoms, as either red, amber, or green priority. If women attending were all recorded as being red rated (requiring urgent review), there was not a system to identify who needed to be escalated first. We saw that ledgers were left unattended containing women's details, and we were told they were removed at night. The service was in the process of introducing the Birmingham Symptom-specific Obstetric Triage System, however this had been temporarily placed on hold in response to pressure with staffing. Staff had completed the training, however, had not implemented the system due to high activity.

Triage was completed by midwives working in Margaret Broom one, although there was no assurance that women were seen within 15 minutes of attending the department. The trust reported that they currently did not monitor the time taken for women to be seen by a doctor. The admission template has prompts to identify any changes since the last communications with the woman. Once seen, women were directed to the most appropriate location for their treatment, for example, women found to be in labour would be transferred to the delivery suite. Despite this, we did not see any incidents referring to delays in treatment.

Once discharged, we saw that women regularly contacted the ward with any concerns regarding their, or their baby's health. There was a file containing telephone contacts detailing the person making the call, the concern and details of any advice given. It was not clear what was done with this information or if there was oversight to ensure that multiple contacts were escalated. Staff told us that something was done, but they were not sure what or by who.

The coordinator had oversight of activity across all clinical areas and assisted with the management of patient flow. For example, they were able to highlight women in triage who required a bed elsewhere and discuss with the team locally to facilitate this.

There was one dedicated theatre team for elective procedures. We were told that in the event of an emergency, theatres would provide a second operating department practitioner, however the elective team would usually stop the elective list to support the emergency activity.

The service used the World Health Organisation (WHO); five steps to safer surgery checklist for all theatre procedures. We saw that the steps were followed and audited monthly to confirm ongoing compliance. Audits observed showed 100% compliance with the checklist.

Fresh eyes were routinely completed and clearly recorded in women's notes. There was a buddy system for reviewing continuous cardiotocography (CTG) records, to ensure appropriate escalation. Compliance with CTG competencies and training was 98% for midwives and 100% for medical staff.

The service had 24-hour access to mental health liaison and specialist mental health support. There was a dedicated mental health midwife who was accessible to staff offering advice and support where necessary.

There were processes in place to protect babies and prevent abduction. All babies were required to be accompanied by a midwife when leaving the clinical area. We saw that staff challenged any visitors and confirmed identify before enabling access.

Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training, and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. Staffing risks were mitigated to reduce the risks of potential harm.

The service did not have enough midwifery staff with a number of shortages caused by vacancies and COVID-19 isolating restrictions. The service had several processes in place to address the shortfall in staff which included the use of non-clinical midwives such as specialist midwives and ward managers, registered nurses and increase in midwifery support staff.

During inspection we saw that the number of midwives and midwifery support assistants did not match the planned numbers. There was a deficit of two midwives in the delivery suite and one midwife on a long distance transfer. There were also staffing shortages within the Margaret Broom one and two wards resulting in the ward manager working clinically**.**

Although there had been concerns relating to staff shortages raised with CQC prior to inspection, during our visit we saw that there were sufficient staff to meet the demands of the service. However, this was because staff had been moved from non-clinical roles to work clinically. We were given examples of where ward managers and specialist midwives worked clinically instead of completing office days or completed their normal activity.

Managers adjusted staffing levels daily as able, according to the needs of women. We saw that leads flexed their working days to ensure adequate cover and matrons and ward managers completed clinical task to help team's workloads. We were told that non-clinical staff covered breaks and worked clinically if there were any deficits.

Despite shortfalls in staffing, at the time of inspection we did not see any evidence of patient harm. Staff told us they were continually short staffed, and that the service was unsafe, however, could not give example of where there had been harm as a result. Staff could give examples of where the quality of the service or their support had been lacking, including delays in care and reduces ability for detailed assessments or answering questions. Staff were frustrated from working on reduced numbers, and that staffing impacted on their ability to complete their normal roles.

The service used bank and agency midwives where possible. Managers used bank and agency staff and requested staff familiar with the service where possible. Managers made sure all bank and agency staff had a full induction and understood the service. There was an agency induction folder which detailed aspects such as fire safety, how to escalate concerns and contact details.

Although the ward manager could adjust staffing levels daily according to the needs of women, midwives reported that there had been a decrease in uptake of bank and agency shifts in recent weeks. Staff felt this was in response to staff being tired and the ability for people to travel following an extended lockdown.

Maternity

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support assistants needed for each shift in accordance with national guidance. Data showed that there had been an uplift in midwifery staffing numbers in November 2020. This was equal to around 10% of the previous establishment. Staffing levels were reported as being the biggest demand on managers time, with flexible working and constant reviews of available staff to cover demands

The service had completed an extended recruitment campaign to secure midwives who were about to qualify. The service was expecting 11 new staff members. Although staff were pleased with the planned new team, they were concerned that staff were not as experienced placing additional pressures on the midwives in charge. There was a plan to recruit qualified nurses to the team with an aim of one nurse per shift, which would enable additional support for midwives for non-midwife specific tasks.

Matron's and the head of midwifery provided an on call service out of hours and told us they regularly attended site to support teams clinically. They had also planned to increase the number of clinical shifts worked following inspection in response to additional self isolating demands amongst the teams. Whilst this helped with some of the pressures on staffing, it did impact their ability to perform their roles and management tasks were impacted by the leads working clinically.

The service had introduced the safer staffing tool which calculated the impact of staffing deficits. We saw that data for April to June 2021, which highlighted that staffing met acuity for 53.8% of the time, with a shortfall of two midwives 15.4% of the occasions recorded (75.6% of total shifts). The impact of staffing shortages was noted as being delays in accepting transfers, and delays in treatments. The data was not fully accurate as staff did not always complete the tool, which meant that data did not always accurately capture information. Leads reported that compliance was improving following prompts.

The service had a low vacancy rate in comparison to the national average of 17%. The overall trust vacancy rate for midwives for May 2021 was reported as 8.4% which was an improvement from 14.3% in Aril 2021.

The service had a lower turnover rate than the national average of 12%. The turnover rate of midwives was reported as 8.5% in June 2021. This was lower than the five months preceding the inspection however, there had been a gradual increase in the turnover of staff since December 2019.

The sickness rate for nursing and midwifery staff was higher than the trust target largely in response to COVID-19. Trust data showed that the sickness rate was reported as 6% at the time of inspection. Staff told us that sickness had been impacted by COVID-19 with a number of staff shielding and having to self-isolate. This had dramatically increased in the weeks immediately preceding the insepction.

The staff birth to midwife ration was reported as in line with targets for March to May 2021. Trust data showed that the ratio was 1.26 in March, April, and June 2021 and 1.23 in May 2021. This was in line with the trust target of below 1.3. The service monitored one to one care for women in labour. Audit data showed that with the exception of March 2021, from January to June 2021, women received one to one care. In March, the service achieved 98.4% compliance with one to one care.

Continuity of carer to women ratios were monitored by the service and we saw that trust data showed that the continuity of carer team had on average 36 women to each midwife This was similar to services across the trust.

Stand-alone birthing unit ratios were slightly higher than continuity of carer services with the community site at Southend reporting a ratio of one midwife to 86 women.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction. However, anaesthetic representation at handovers was not consistent.

The medical staff matched the planned number. The service had enough medical staff to keep women and babies safe. The service had ten consultants four of which covered gynaecology. There were sufficient numbers of registrars and senior house officers (SHO) to ensure that there were doctors available in all clinical areas. There were four whole time equivalent GPs in addition to the medical establishment.

The service had a good skill mix of medical staff on each shift and managers reviewed this regularly. There were two doctors available 24 hours per day, including a registrar and a SHO. Trust data showed that consultants were present on the clinical delivery suite in line with recommendations for April to June 2021.

The service had vacancy rate of 13.65% for medical staff at the time of the inspection which was equivalent to 5.03 whole time equivalent (WTE) medical vacancies across all grades. Any uncovered shifts were covered by locum staff and managers could access locums when they needed too. Managers made sure locums had a full induction to the service before they started work. The locums were usually in post for extended periods which enabled them to become familiar with the service, processes, and policies.

The service always had a consultant on call during evenings and weekends. Doctors reported that the on call was one in eight, and they were happy with this provision. There were clear escalation processes for consultants to come into the hospital and doctors told us consultants were always responsive.

The service had a dedicated consultant anaesthetist, and registrar. During insepction we saw that anaesthetic staff was absent from the handover, however this was reportedly due to traffic and the registrar attending the ward to review a patient. On review of the handover record we saw that there had been gaps with anaesthetist attendance regularly. Handovers were generally poorly recorded apart from the morning handover which was detailed and clear.

The service turnover rate for medical staff was reported as 26% for June 2021. Doctors told us that they were in the process of recruiting and had a good response from adverts.

Sickness rates for medical staff were low and reported as 1% at the time of inspection.

Trainee doctors reported that they felt supported in their roles and were able to develop.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, women's records were not always held securely.

Women's notes were comprehensive, and all staff could access them easily. We saw that records were complete and reflected regular assessments and reviews. Staff wrote clear descriptions of care given and planned.

When women transferred to a new team, there were no delays in staff accessing their records.

The trust audited women's records to ensure that there were personalised care plans in place. Trust data shows that there were plans in place for 96 to 99% of all women's records reviewed in April to June 2021.

Records were not always stored securely. We saw that notes trolleys were often left unlocked which meant they could be accessed by unauthorised persons. We also saw that some information was held on clipboards in clinical areas. For example, women's details were held in the triage area on the wall. This meant that some information may be accessible.

All computers were locked when not in use preventing unauthorised access.

On discharge from hospital, women's GPs were sent information regarding any inpatient stay including, details of any risks, procedure/ treatment given and any follow up required.

We saw that fundal height was not always recorded in centimetres in women's records. Fundal height is one method of measuring the growth of the baby and used as an indicator to identify the baby's position.

Key information was shared electronically with women's GPs. The electronic system used, enabled staff to choose information being shared securely with GPs, including discharge summary's, delivery summaries or pregnancy records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. We saw five prescription charts and saw that medicines were given in line with prescriptions with no omissions. Medicine charts were electronic in inpatient areas and we reviewed five prescriptions and saw that they were completed appropriately.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We saw that medicines were largely stored in locked cupboards in treatment rooms. Although there was one occasion where the treatment room was unlocked on Margaret Broom one and the medicine cupboards were unlocked. This was escalated to the staff who took immediate action to address this.

Stock was managed by the pharmacy department and stock rotated to prevent expiry before use. Medicine fridges had temperatures checked daily to ensure they were safe for the storage of temperature sensitive medicines.

Staff followed current national practice to check women had the correct medicines. Women were asked to confirm their identity prior to any administration and where necessary two midwives checked and administered controlled drugs.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely.

Maternity

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff told us that they reported incident using the new electronic report tool.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. We saw that the service had reported 174 incidents from May to July 2021. Incidents reported largely related to clinical occurrences, such as transfers, shoulder dystocia, post-partum haemorrhages, however, we also saw seven incidents relating to staffing shortages.

Incidents were reviewed daily by the risk team and the senior leads. During the meeting, risks were graded and allocated to the most appropriate person to complete any investigations.

Trends in reporting were reviewed by the risk and management team, and the service reported an increase in the number of incidents reported for the same period the previous year. Themes from incidents were also highlighted to inform practice. For example, the risk team reported an increase in the number of post-partum haemorrhages (PPHs), however, noted that this was largely due to the change in clinical practice where all swabs were now being weighed which gave staff a more accurate recording of blood loss and therefore the number of PPHs had increased.

The service had no never events in the year preceding the inspection.

Staff reported serious incidents clearly and in line with trust policy and all incidents were investigated thoroughly. Where appropriate women and their families were involved with investigations, and we saw that if necessary, incidents were reported to the Healthcare Safety Investigation Branch (HSIB). Staff gave us examples of how they had been involved in recent cases.

Staff received feedback from serious incidents and their investigation, both internal and external to the service. However, reported that they did not always receive feedback about other incidents reported. Managers debriefed and supported staff after any serious incidents and were given examples of when the senior team held debriefing support sessions for all involved.

The risk team had been reconfigured as part of the hospitals merger, and as a result there had been some gaps in the team. The service had two risk midwives who worked closely with the clinical teams. One of these posts had been recruited into in the weeks preceding the inspection and the role had been temporarily covered by one of the ward managers.

All serious incident investigations were reviewed by the non-executive director safety champions, this ensures oversight at board level of incidents, and their investigation outcomes.

Is the service effective?

Requires Improvement 

Maternity

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies and saw that they were largely in date and all followed national guidance. Those policies and guidelines which were not in date were in process of being reviewed as part of the merger to Mid and South Essex NHS Foundation trust (MSE). All policies were planned to be amended to be an MSE version to facilitate standardisation across the hospital sites.

Staff told us that they could easily access policies and guideline which were held centrally and available via the intranet. Policies referring to emergency admissions were also available in paper format to ensure easy access. Staff told us these were replaced any time there was an updated version.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives, and carers. We saw that staff considered any additional support needed by women and their families.

There was an audit programme to confirm staff compliance with policies. For example, we saw that World Health Organisation: safer surgery checklist audits were completed monthly alongside local audits such as hand hygiene audits.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. This included the saving babies lives bundle which was reviewed at each governance meeting. Data showed that the services had varied outcomes against all elements. For example, in element one (smoking) the service achieved 100% for conversations with women about smoking, and referrals to smoking cessation support. However, did not always record carbon monoxide (CO) monitoring, with 10 to 30% in February to April 2021 audits.

Clinical leads reported that they achieved nine out of the ten Clinical Negligence Scheme for Trusts (CNST) safety actions. The exception was the implementation of transitional care which the teams were working towards.

Outcomes for women were positive, consistent, and met expectations, such as national standards. We saw the key performance indicator report for the October to December 2020, showed that compliance was in line with targets. The only exception was antenatal screening which achieved 69.5% against a target of 75%. This was a recognised pressure and recorded on the service risk register. Managers and staff used the results to improve women's outcomes. We saw that audit data informed discussions at performance meetings giving leads areas to target work in response to findings.

The service performed similar to other trusts in the NHS Maternity survey published in January 2020. The trust scored 8.9/10 for labour and births, 8.7/10 for staff during labour and births and 7.8/10 for care in hospital after birth. The trust had one score for skin to skin contact which was better than other trusts (9.7/10).

Trust data showed that from January to July 2021, the service had 1.5 to 2.8% unexpected admissions to the neonate intensive care unit. This was lower than the trust target of less than 5%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers shared and made sure staff understood information from the audits. Performance dashboard were displayed across clinical areas and staff openly discussed performance and compliance with targets.

Improvement is checked and monitored. Service leads met regularly to review performance and identify areas for further development. We were told of several improvement plans; however, these were hampered by the focus on staffing and ensuring safe cover.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, not all staff had an appraisal within the last year and new-born screening training compliance was low.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of women. Although mandatory training compliance was below the trust target there was provision by the practice development midwives to ensure that staff had clinical skills necessary to perform their roles.

Managers gave all new staff a full induction tailored to their role before they started work. New staff were provided with an induction programme. However, we were not assured that there was a robust process for newly qualified midwives. Some preceptors did not feel informed or supported. They told us that they did not know who their mentor was or who to seek support from. One preceptor told us that they had not had any meetings with their mentor since joining the team and there was no formal process for development. This impacted on their morale and they felt a burden to the team as not developing and required support, form the team.

Managers made sure staff received any specialist training for their role. For example, Practical Obstetric Multi-Professional Training (PROMPT) was completed regularly by all staff and training compliance was reported as being 100% for consultant and medical staff, 87.5% for anaesthetic consultants, 96.6% midwifery staff and 100% for theatre nurses.

Trust data showed that 27% of staff were trained in new-born screening and in July 2021, cardiotocography (CTG) training had been completed by 98% of midwives and 100% of doctors, which was better than the trust target of 90%.

Managers had an appraisal framework; however, compliance was not in line with trust targets. Staffing shortages had impacted on staff's ability to complete appraisal. Staff appraisal rates at the time of inspection were recorded as 87% for nursing and midwifery staff which was slightly below the trust target of 90%. The medical staff appraisal rate was 100%. We saw that there was a planned trajectory of full compliance within the women's and children's care group for March 2022.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Doctors reported being able to attend training sessions and felt supported.

Doctors had protected time for training, which was supported by the consultants. We were given examples of speciality specific training session which included cardiotocography (CTG) and mandatory training. Some consultants took on additional lead roles in areas of clinical interest such as fetal medicine and maternal medicine. Part of this role included the clinical teaching of their chosen topic and the insurance that polices, and processes followed the latest guidance

Medical revalidation was completed by 100% of consultants and trust doctors as of July 2021.

The clinical educators supported the learning and development needs of staff. There were three practice development midwives who worked within the service, they were responsible for the ongoing training of staff and the preceptorship of new midwives. However, their role had been impacted by COVID-19 and the reduced staffing pressures. There was also little evidence of shared learning across the whole service as we were given examples of how newly recruited midwives undertaking preceptorship were not following a robust programme, which had been implemented at the other two hospital sites.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge where possible. We were given examples of where additional support had been given to individuals to support their objectives however, training had been impacted by the pressures of safe staffing.

Multidisciplinary working

Doctors, midwives, and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff reported and we saw that there was positive multidisciplinary team (MDT) working. Conversations were respectful and inclusive. We heard that doctors were very supportive of midwifery staff and acted accordingly when there were staffing pressures, taking on additional tasks.

Staff held regular and effective MDT meetings to discuss patients and plan their care. There were a minimum of three MDT handovers, Monday to Friday, and these contained information such as a summary of activity, including the number of postnatal beds in use, number of elective procedures planned and learning and messages for the week. The handover did not follow a standardised process and were not always attended by the full team. For example, we saw that there were gaps in attendances by anaesthetists. Records showed that anaesthetists regularly missed MDT handovers, with ten absences recorded out of 13 records.

There were also gaps in the recording of meetings. The morning MDT meetings were consistently recorded however, those occurring later in the day showed some gaps in information and attendances.

We were told that the service also held daily trust wide meetings to identify areas of increased pressure and agree on actions to take in response to them.

Staff worked across health care disciplines and with other agencies when required to care for patients. We were given examples of when women had been referred to other agencies or teams for support. For example, midwives referred women for mental health assessments when they showed signs of mental ill health illnesses or depression.

Maternity

The service completed Avoiding Term Admissions to Neonate Intensive Care Units (NICU) ((ATAIN)). We saw that ATAIN meetings were held monthly and involved the review of care and treatment of babies admitted to NICU. These were completed to identify if there were any lapses in care and to identify any areas for learning.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards daily. Women are reviewed by consultants depending on the care pathway

Staff could call for support from doctors and diagnostic tests, 24 hours a day, seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw that consent was always recorded for clinical interactions with women or their babies.

Consent for clinical procedure such as caesarean sections were clearly documented and held in women's records. Consent forms gave details of risks and clearly recorded discussions with women.

Is the service responsive?

Good 

Our rating of effective stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service had been working collaboratively with their peers across the Mid and South Essex NHS Foundation Trust since their merger. There was an appreciation that service ran slightly differently and that there was a need to standardise some practices.

The service worked collaboratively with the peers across the Local Maternity and Neonatal Service (LMNS). Teams met regularly to discuss national guidance and share experiences.

Facilities and premises were appropriate for the services being delivered.

Maternity

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Women using the service were able to make decisions about the type of birth they wanted. The service provided a midwife led birthing unit and home births for low risk women. Staff reported that these were used more frequently for low risk women, seeing an increase in numbers of deliveries over the last few months. The service reported that there had been 39 births in the suite in June but had seen 60 deliveries in July 2021. The service also reported a consistent 5 to 8% home births and trust data showed that for April to June 2022, between 4.1 and 5.9% of deliveries were at home.

The service had two established continuity of carer teams, who provided consistent midwifery support through the woman's three stages of the pregnancy (pregnancy, labour, and post-natal care). Trust data showed that the service achieved continuity of carer for 12 to 15% of women from April to June 2021. This as lower than the trust target of 35% but recognised to be in response to staffing challenges with COVID-19 and the movement of staff to support inpatient areas.

The service reported a slightly higher percentage of caesarean sections (c-sections) with between 30.8 to 37% reported for April to June 2021. This was higher than the trust target of 28.6%. The number of c- sections had been consistently higher than the trust target and this was being reviewed by the team to understand the reasons.

Service data showed that 96% to 99% of women had a personalised care plan in place from April to May 2021.

Women could access support when necessary. For example, women could access a breast-feeding specialist midwife. Trust data showed that breast feeding initiation was completed around 73% to 78% for March to May 2021, which was higher than the trust target of 70%. Similarly, breast feeding at ten days was above the trust target of 75% for the same period, achieving 78% to 96%.

The service had information leaflets available in languages spoken by the women and local community. We saw a broad range of languages including Albanian, Punjabi, and Polish. Where necessary, staff were able to access interpreters or signers when needed. The service tracked patient information leaflets to ensure that they were in date and reflected best practice. We saw that in April, there was one obstetric leaflet out of date with 20 due for review within the following six months.

The trust wide friends and family test results for maternity services showed that from February to May 2021 women were 76.3 to 86.4% satisfied with the care they received on the post-natal ward and would recommend the service to their friends. The birth score was 91.9 to 94% for the same period and birth response rate was 15.3 to 18%.

Friends and family data showed that in March 2021 the service received a positive response in the friends and family test for 98% within the birthing unit, and 88% within the post-natal inpatient ward (Margaret Broom). The response rate was 38% and 26% respectively.

The service had a portable birthing pool which could be used in the event that a room with a pool was not available or if the woman changed her mind about using one.

The service had a dedicated bereavement suite which was suitable for the use of the extended family if necessary. Staff were respectful of the needs of women and their families and provided some home comforts to make the experience less clinical.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service delivered around 300 babies each month. Trust data showed that there were 311 babies born in March, 292 in April and 288 in May 2021 at the hospital. Staff reported that there had been an increase in babies being delivered over the weeks preceding the inspection.

The service routinely monitored the types of delivery and recorded this on a dashboard. Trust data showed that 57% to 61.6% of all deliveries for April to June 2021 had been normal vaginal deliveries (NVDs). Elective and emergency caesarean sections (C-sections) were reported as being consistently around 30%. For April to June 2021, elective C-sections were 16.1%, 14.6% and 18.8%. The trust target was less than 12.6%. Emergency C-sections were reported as 14.7%, 17%, and 18.8% against a target of less than 12.6%, for the same period.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Women attending the hospital were triaged and allocated to the correct pathway. Triage was routinely completed within 15 minutes of arrival to the department.

Managers and staff worked to make sure women did not stay longer than they needed to. Once women were deemed fit, they were encouraged to go home.

Managers worked to keep the number of cancelled appointments/treatments to a minimum. We were told that clinical pressures and emergencies sometimes impacted on elective cases which meant that women sometimes stayed in hospital slightly longer than planned. Staff told us that women may be moved to the following day for a procedure, although this was rare.

The service moved women only when there was a clear medical reason or in their best interest. Women were cared for in the most appropriate area for their clinical condition.

Staff supported women and babies when they were referred or transferred between services. We saw that there was a clear transition between services with staff accompanying women to the new area. When babies were transferred to neonate intensive care units, women were able to accompany them.

Managers monitored transfers and followed national standards. Staff reported all transfers of care through the incident reporting system, and these were escalated where necessary for investigation.

Service data showed that there were no diversions of the service to another provider and no closures of the service for April to June 2021.

Learning from complaints and concerns

Maternity

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Staff understood the policy on complaints and knew how to handle them. Where possible concerns were addressed at the time. Staff escalated to the midwife in charge or matron when issues arose, enabling concerns to be addressed immediately.

Managers investigated complaints and identified themes. Concerns were usually around treatment plans and communication.

Complaints were generally managed in line with the trust policy for response times of 20 days. Service information showed that from April to June 2021, there had been four complaints.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. However, the leadership structure was undergoing significant change and was not fully embedded.

The service was managed by a clinical director and a general manager who worked across all three sites. The director of midwifery post was currently vacant, with interviews pending. This planned triumvirate was replicated at each site with a medical lead, head of midwifery and a service manager. The teams were supported by matrons and ward/ unit managers.

Due to the merger to Mid and South Essex NHS Foundation Trust, the team was not fully established and had undergone considerable changes. They had been working collaboratively with their peers; however, the formal structure had only been in place for a few months. We saw that teams had started to work collaboratively with an aim to have standardised process across all sites, however, this was very early in planning with minimal formal processes in place which was slower than expected considering the time staff had known the merger was pending.

During inspection, service leads were knowledgeable of the risks, performance and development needs of the service. There was a cohesive plan to address concerns and a shared understanding of individuals roles and responsibilities in ensuring the service developed.

Staff reported that although they knew their peers across the trust, they had not met with them or completed joined up projects. The teams had started a trust wide heads of maternity and matrons' meetings and held weekly trust wide meetings to share information around activity and pressures.

Local leadership, such as heads of midwifery and clinical leads were well established, and we were told that local service leads were accessible, and supportive. Midwives were particularly positive about the head of midwifery who did everything she could" to support the team.

Staff were less positive about matrons and ward managers, with staff telling us that they were not as supportive and did not always act when midwives raised concerns. There was a disconnect between midwives working in clinical areas and the ward managers and matrons, with a lack of understanding about roles and responsibilities.

The service leads reported directly to the trusts senior leadership team (SLT) and there were clear escalation pathways and meetings for reviewing performance. Progress against national and local targets were monitored by the SLT with daily reporting on progress and activity. The service leads were held to account for performance.

Staff told us that trust wide service leads and the SLT were not always visible, accessible, or supportive. However, following concerns being flagged with the SLT regarding increased pressures within the service, we were given multiple examples of how the SLT had acted in response to concerns raised by staff. They had introduced regular team meetings to discuss concerns, offered support groups and took action to address some of the concerns raised. For example, the SLT had introduced a maternity service wide financial incentive to staff to work additional hours and increased hourly rates of pay.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The service was going through a significant period of change following the merger. However, leads were aware of the impact of change and had a clear vision of where they wanted to be. The vision was shared across all services and staff were familiar with the aims.

Service leads were clear about their aims and recognised that there was significant work that needed to be done. They told us that they wanted to embed new ways of working before taking on additional challenges, so were implementing changes initially based on safety.

The service had aligned the vision and strategy to the Local Maternity and Neonatal Service (LMNS) and leads spoke about collaborative working with the LMNS and other stakeholders to develop services.

Culture

Staff were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. However, there was a mixed culture amongst staff with an apparent disconnect between midwives and matrons. Staff did not always feel respected, supported or valued.

There appeared to be a disconnect between midwives and matrons. Staff told us they thought matrons could be more supportive, with regards to concerns with staffing and they felt pressured. Recent plans to move additional services to the site had caused some animosity between the midwives and local leads.

Despite the apparent disconnect, midwives worked collaboratively with their peers and adopted practices to support each other within the ward or department. Staff told us that they felt overworked and had concerns about the impact of staffing on women's health. We saw that when staff were feeling overwhelmed colleagues took time to comfort and encourage them. All staff were respectful of each other.

Some staff felt that there was a focus on the delivery suite which meant that other clinical areas suffered from repeated short staffing and lack of support from leads. Staff appreciated the level of risk but felt that staff should rotate through departments regularly to ensure that everyone understood the pressures within each area.

Staff told us that they went to the head of midwifery instead of the matrons. Service leads told us that they were aware of the issues that were being raised by staff and were attempting to address them, however, recognised that there was no quick solution. There were support processes in place which included pastoral support.

We heard that the senior leadership team had planned to move some services to the hospital to try to reduce pressures on the other hospital sites. This had generated significant concerns from staff who were already feeling under pressure and overworked. This impacted negatively on staff's morale. Midwives spoke about how their workload was not being considered by managers and how there were no plans to provide additional support. Matrons confirmed that some of the communications could have been managed better, and that there were clear plans in place to address staffing. Staff recognised that staffing impacted on the quality of the service, feeling that there was an inability to meet demands in a timely manner.

Some staff told us that there had been a focus on the Basildon site and that they felt they had been 'forgotten' in the development of services. Although they understood the reason for development and risks, some staff felt that the focus meant that they had not been given equal opportunities or that their service had been developed. We also heard that there had been minimal cross site working, with teams only recently having the opportunity to meet/ work together. For example, the practice development teams were established, but did not appear to work collectively. For example, there were different induction programmes for new midwives and different levels of involvement with service planning.

We completed a staff survey which showed that across the trust, maternity staff did not feel safe to report concerns (47%), did not feel that managers would act on staff feedback (66%) and did not think that communication between senior management and staff was effective (64%). Our survey also showed that 66% of staff felt that they were not valued by the organisation, 58% of staff did not think that changes were implemented well and 76% of staff felt there were unrealistic pressures on them.

However, 71% of staff felt that they were encouraged to be open and honest with service users when things went wrong, 66% of staff felt that action was taken when an incident or near miss occurred, 76% received feedback following incidents, and 65% agreed that they heard about incidents across the organisation. 63% of staff also felt supported by their work colleagues.

Governance

Leaders operated effective local governance processes, and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. **However, the trust wide governance structure was under review and not embedded**.

Maternity

There was minimal evidence to show group working prior to the merger of the trusts. Each site had a different governance structure and processes in place. This meant that work completed to escalated risks at the Basildon site had not been replicated on the other two sites, even though they may have had similar concerns. For example, attendance at multidisciplinary team meetings. However, since the merger, the service was developing a trust wide governance structure.

Since the recruitment of the governance and risk team, the service had started to map out meetings and reporting lines across each site, in an aim to identify what information was collected on each site and where it went. This process was reported as being lengthy and was planned to be completed by the end of October 2021. In the interim, local governance structures remained in place.

We saw that there were a number of clinical and governance meetings which followed set agendas, and reviewed activity, performance and discussed plans for the service. Meeting minutes showed that they were well attended by a variety of clinicians including the local risk manager, clinical leads, matrons, heads of midwifery and ward managers. Information was shared regularly with the trust board. Service leads reported directly to the board at performance meetings and held weekly update meetings, where service leads were held to account for the service and its performance.

Minutes were standardised outlined discussions and review of any serious incidents, their investigations and outcomes, compliance against any action plans, any learning or themes, details of complaints or feedback, and a review of the risks and guidelines. The meeting was informed by the maternity dashboard which gave clear indicators of where performance was in line with trust and national targets. Meeting minutes were clear and gave sufficient detail to enable the updating of individuals if they were not present.

In addition to the service wide meetings, we saw that there were team and staff group meetings, such as coordinators meetings. Discussions at these meetings were similar to those of the formal governance meetings and allowed for information to be cascaded to teams. We also saw that meetings discussed midwife led projects such as the implementation of Birmingham Symptom-specific Obstetric Triage System (BSOTS) and training sessions. Meetings were held monthly and appeared well attended.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service used social media to share information which staff reported was a good way of communicating.

The trust had developed an evidence log in response to the Ockenden report, this identified areas where the trust was already compliant with the recommendations of the report and highlighted where work was to be completed.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, processes for monitoring risk were under review, were not fully embedded and some data was either not collected or was not sufficiently robust to enable informed decisions or oversight.

Maternity

The trust had recruited a risk and governance team since the merger and the team were beginning to develop trust wide risk management processes. At the time of inspection, each hospital site, was working slightly differently, which meant that each site would go through a transition to a new way of working. Work completed at Basildon in response to concerns raised following their inspection were being reviewed and potentially planned to be replicated across the service. However, this was very much in its infancy.

The trust had rolled out an updated version of the electronic incident reporting tool which also allowed the management of risks and access remotely. This had meant that there was one standardised process for reporting, reviewing, and grading incidents and the oversight of risk.

The service had a detailed risk register which covered all sites. Any risks above a risk rating of 12 were escalated to the trust wide governance and risk meetings and added to the corporate risk register to ensure trust leads were aware of the main risks across the organisation.

The service compiled a monthly report detailed performance and compliance which was presented to the trust board. We saw that the care group board reports detailed activity and performance against key performance indicators. For example, reports outlined the number of serious incidents and their investigations, harm reviews completed, compliance with national audits. We were told that the senior leadership team challenged performance and held the leads to account for their actions and service performance.

The service had a detailed risk register which covered all sites. Risks were clearly described along with any mitigation. Each risk was scored appropriately and escalated to the trust board if deemed a significant risk. There was a robust process for reviewing the services risk register. Risks were discussed at meetings, and mitigation put in place where possible. We saw that the top risks in March 2021, were the reduction in resuscitation training compliance due to the inability to access training, poor IT (Information Technology) support and the reconfiguration of the risk and governance team.

Risk management meetings were held monthly and detailed any new incidents requiring review, including transfers of care, review of ongoing investigations and any serious incidents. Meetings were attended by representatives of the multidisciplinary team.

The team escalated to the senior leadership team daily, any issues or concerns with either staffing or activity. Any concerns would then be discussed as part of trust wide meetings, identifying where any support could be obtained.

Some processes implemented to monitor risk were not fully embedded. We saw that staff had been asked to complete the safer staffing tool to enable oversight of staffing risks and pressures. However, these were not always completed. We also saw that some data was not captured, for example, audit of triage times. This meant that there was not clear oversight of activity within the service.

Staff completed daily safety huddles which were used to share information about current risks or incidents. The huddle also included the review of incident reports and a discussion of the ratings/ grading, and who would be responsible for investigating.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

There had been an investment in the improvement of the digital infrastructure to enable the service to operate more effectively. We were given examples, where incident reporting had improved to enable staff to access the system across any location within the trust, and how community midwives had better access to information systems.

All staff were co located to ensure that there was clear communication. Information collected was in a standardised format, although there was a move towards a Mid and South Essex NHS Trust standard in the future.

Staff were working towards a standardised guidelines and processes with all guidance being reviewed to ensure that it was appropriate to the whole service. Any policies or information that was expiring was being reviewed as a trust wide process.

Following the merger, staff reported that it had become increasingly difficult to access support teams and the necessary forms on the intranet. We were given examples of where human resource (HR) forms had been completed, and sent to previously used links, but then returned unopened. Staff reported that links to HR services had changed without their knowledge and this resulted in an increase in time to complete tasks, causing frustration.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There had been ongoing concerns around the engagement of staff across this trust. Staff had been vocal about their concerns and we had previously found teams to be disengaged with the service. During this insepction, we found that staff were largely positive about their roles and jobs, however, felt frustrated with increased activity, and were 'rethinking their long term commitments' to the service.

Senior leaders told us that there had been a change in the engagement of the team over the few months preceding the inspection and this linked to discussions about the additional reconfiguration of services. Midwives told us that this had caused significant unrest amongst the midwifery team who felt unable to support additional workloads. On reflection, leads felt that the communication about the clarity of the impact of reconfiguration had not been clear and had possible contributed to the change in engagement.

The service had a closed social media group which was used to share information. Staff reported that this was a good way of catching up with any changes or with seeking support or cover. The service also used newsletters to keep staff informed.

Despite the challenges, the team reported that they were very proud of the service and their achievements. Midwifes were proud of the care being provided and their colleagues for managing the workload under pressure. Matron's were particularly positive about how ward managers had 'stepped up' to take on additional roles to develop themselves and help move the service forward.

Some staff felt that all staff should rotate through each department to promote a deeper understanding of each clinical area.

Maternity

The service had two safety champions who were non-executive directors with a particular interest in maternity services. They visited the units regularly, liaising with the team and collecting key information for consideration. Their role also included the assurance that maternity services were considered at all board meetings as well as regular meetings with the senior leadership team. Midwives were aware of the safety champions and reported escalating concerns to them. The safety champions considered themselves as the critical friend who provided challenge and support.

We spoke with the maternity voice partnership (MVPs) who told us that they engaged with the service regularly and worked collaboratively with the local maternity system to develop services. The trust gave the MVPs clear areas where work was required. For example, there were a number of projects around engaging women, equality and diversity inclusion and infant feeding. MVPs were looking at different ways of engaging with women, including the introduction of a designated email address to enable direct contact.

MVPs had started to meet with service leads to discuss women's feedback.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Plans to develop the service had been delayed due to pressures on staffing. For example, the implementation of a dedicated transitional care bay was postponed, as was the introduction of a standardised triage system. Despite delays, staff were very keen to commence the projects as soon as possible, and could demonstrate awareness on the impact the changes would have on the quality of the service.

Continuity of carer was an expanding service, with two established team and a plan to introduce an additional five teams by the end of the year. This was planned to be completed once the recruited staff had started and teams were able to return to their 'day jobs' without supplementing inpatient clinical areas.

The service had started to develop local leaders and had completed a trust wide matron away day. This was to ensure that matrons were aware of their roles and responsibilities, and to start the standardisation of the service. Matrons were able to meet and discuss projects and plans of work, promoting a Mid and South Essex NHS Trust way of working. Matrons reported that the day had been beneficial to the team to enhance teamwork and communications. They also started to map out services across the organisation.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff, however not everyone completed it.

Not all staff received and kept up-to-date with their mandatory training. Data provided demonstrated that not all core mandatory training was up to date against the trusts target of 85%. Across the staffing groups the following areas were not compliant; Paediatric Basic Life Support Level 2 (73.12%), Adult basic life support level 2 (71.24%), Conflict Resolution Training (45.56%), Moving and Handling Level 2 (51.32%), Information Governance and Security Management (77.95%) and Fire Safety Training (78.30%).

Whilst the mandatory training offered was comprehensive and met the needs of patients and staff, due to low compliance there was a risk that staff were not trained to provide care and treatment which was safe and protected people from avoidable harm.

The trust had an action plan in place for the recovery of staff completing mandatory training to the trust target of 85%. The trust planned for mandatory training completion rates to meet the trust target by the end of January 2022, following the disruption caused by the COVID-19 pandemic.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse, although not all staff were up to date with training.

Nursing staff received training specific for their role on how to recognise and report abuse. Training records provided demonstrated that staff had received training applicable to their role which included, Safeguarding Adults Level one and Level two and Safeguarding Children Levels one and two. Those staff who required level three Safeguarding training for children were not meeting the trust target (85%) with only 79.78% of staff having received this.

Medical staff received training specific for their role on how to recognise and report abuse. Training records provided demonstrated that of staff had received training applicable to their role which included, Safeguarding Adults Level one and Level two and Safeguarding Children Levels one and two. Those staff who required level three Safeguarding training for children were meeting the trust target with 84.62% of staff having received this.

Additional Clinical Services and Administrative and Clerical staff received training specific for their role on how to recognise and report abuse. Training records provided demonstrated that staff had received training applicable to their role which included, Safeguarding Adults Level one and Level two and Safeguarding Children Levels one and two. Those staff who required level three Safeguarding training for children were not meeting the trust target (85%) with only 79.78% of staff having received this.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service utilised their internal systems to identify people at risk or suffering abuse. The records relating to these patients included red flags. Staff were aware of looking for signs of domestic violence and abuse and had good understanding of other circumstances such as emotional and mental abuse which would trigger a concern. The service demonstrated they worked with other agencies such as local authority and the police where safeguarding concerns were raised.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There were two local authorities which provided escalation routes of safeguarding concerns from within the hospital (depending on where the patient lives). Staff had access to both reporting systems and provided details of this on the day of inspection. There was a safeguarding policy in place which was comprehensive and contained relevant and up to date guidance. Staff from within the Emergency Department also had access to a trust wide safeguarding lead who they could contact for advice and guidance.

Staff followed safe procedures for children visiting the ward. Two records reviewed demonstrated that safeguarding issues had been considered for the children attending the emergency department on the day of our inspection. Staff within the department had good understanding and knowledge of what to do should they have a safeguarding concern including escalating internally and to the local safeguarding authority.

Cleanliness, infection control and hygiene

Staff did not always use equipment and control measures to protect patients, themselves and others from infection. Although, they kept equipment and the premises visibly clean.

All areas were visibly clean and had suitable furnishings which were well-maintained. Dedicated domestic staff maintained cleaning schedules.

However, the service did not perform consistently in infection control and prevention/ cleaning audits. We reviewed the infection prevention and control audits which demonstrated a variable completion of cleaning and infection prevention and control measures from April to June 2021. The trust target for cleaning and infection prevention and control did not meet the trust's 90% target for April 2021. We saw that there were gaps in nurses cleaning schedules in April 2021 and June 2021, and the department had not met the trust target of 90% for hand hygiene audits from October 2020 to December 2020 and scored 85% for this period. This had improved to meet the trust target of 90% from April 2021 to June 2021.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Staff were seen wearing masks and aprons throughout the inspection. All staff observed were seen to be bare below the elbows. We witnessed effective handwashing between patient contacts and appropriate waste procedures were in place including sharps bins and clinical waste bins. However, clinical audits for the department showed that clinical staff were not always observed using personal protective equipment such as aprons and gloves appropriately from April to June 2021.

The department had been redesigned to adhere to requirements in relation to the COVID-19 pandemic. Patients were being temperature checked prior to arriving in the department and a specific COVID-19 pathway had been put in place which included the utilisation of isolation bays to minimise the risk of spreading infection.

Hand sanitizers were readily available for use, the department provided face masks to patients and the service had processes in place to ensure social distancing.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Most of the equipment we saw had been labelled to show when it was last cleaned. All of the pieces of equipment we looked at appeared clean.

Environment and equipment

The trust did not always maintain critical equipment within the premises infrastructure well to keep people safe. Although staff managed clinical waste well.

Patients could not reach call bells. We observed ten patients within the department who did not have access to their call bells. We called a bell and whilst a member of staff responded quickly, they were unable to reset the system. We raised this concern following our inspection and the trust reported that call bell function and cleaning was completed during the cleaning process of each cubical. Staff had a checklist to complete for this process. However, we were not provided with any information about how the department was assured that patient had access to a call bell.

The design of the environment followed national guidance although there was chipped paint work in all areas and some ceiling tiles missing. We had received some concerns from patients who had concerns over the environment.

Staff we spoke with raised concerns about the lift not working within the department and informed us that another lift within the vicinity of the emergency department was under refurbishment. We were told that the lift being out of order was leading to long transfer times for patients between departments. In addition, we were told that critical care patients were transferred via alternative routes to intensive care from the emergency department leading to them having to be wheeled around the hospital. This did not support the dignity or safety of patients should a deterioration occur in transit to the intensive care, or other unit/ward. This issue was not being monitored by the service.

Waiting areas were well managed and staff had continuous oversight of these. Areas were kept secure with key-coded locks.

During our last inspection, we noted that access to the paediatric waiting area of emergency department was not being monitored. This had improved, the paediatric team now had sufficient oversight of the area.

The department had designed the area to be dementia friendly and a mock bus stop had been installed. All patient bays were clearly visible in the rapid assessment and treatment (RATs), major's unit and resus.

Staff carried out daily safety checks of specialist equipment. All the defibrillators within the department had been checked on the day of inspection and we checked five resuscitation trolleys within the department. These were generally checked daily, except for the paediatric resus trolley within the main ED (Emergency Department) resus unit where we found checks had not been undertaken, in some instances, for two to three days.

The service had enough suitable equipment to help them to safely care for patients. Equipment stocks were checked during the inspection. This including syringes, tracheal tubes, needles, PPE and anaesthetic masks. There was ample supply, and all pieces were in date. All equipment we looked at was single use.

The trust kept a portable appliance register and used an external company to complete portable appliance safety testing. Records we reviewed demonstrated that this testing was completed for portable appliances in January 2021.

Staff disposed of clinical waste safely. Appropriate clinical waste bins were in place. Sharps bins were in place which were correctly dated and labelled. The provider may however like to note that the storage of clinical waste outside of the department was located directly outside an area where staff took rest breaks and bad odours made their way into the building when the windows were open. This did not create a pleasant working environment for the staff utilising this part of the building.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly to remove or minimise risk to patients. Staff did not always identify and act quickly upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients but did not record outcomes appropriately. National early warning scores (NEWS2) were being managed via two different systems; paper and electronic. This made the notes unclear and confusing. We were therefore not assured that this system promoted the safety and welfare of people attending the service. There was a risk that information may be missed or confused across the two systems leading to patient harm. The leadership team were asked about these concerns and accepted there was a risk in the current NEWS2 scoring process. We were told that action would be taken to address this and minimise risk.

Staff were not always keeping accurate records of national early warning scores (NEWS2) in patient records or completing charts in line with NEWS2 guidance issued by the “Royal College of Physicians”. Seven NEWS2 charts had not been completed in the patient’s paper records.

We were told by staff that there were some inconsistencies amongst nursing staff completing their roles. For example, staff found that no care rounds, observations, or pain scores had been taken for 13 patients on the shift prior to theirs.

The department completed NEWS2 audits for assurance. We reviewed the audits undertaken June and July 2021. The audits were displayed differently and only reflected if hourly observations were completed and if staff escalated any concerns. The audits provided looked at seven patients in June 2021 and ten patients in July 2021 which was a small sample when the department had approximately 8,000 attendances a month. This meant that audits were not always driving improvements.

Staff did not always complete risk assessments for each patient on arrival to the department. Six out of 14 records had no completed body map or pressure ulcer risk assessment despite one of these patients being frail and having limited mobility. Three sets of records were illegible and the plan of care for the patients was unclear meaning that should the record need to be reviewed by other medical staff they may not be able to get a thorough understanding of the patient’s condition. Five patients had not received a falls risk assessment. This meant that those patients were at risk because timely assessment was not taking place to ensure the appropriate plans of care could be put in place.

The trust had a venous thromboembolism (VTE) policy in place which had a review date of December 2023. The policy referenced national guidance and stipulated that all patients should be assessed for VTE within 24 hours of admission.

VTE assessments formed part of admission clerking process. Data we reviewed demonstrated that the longest average decision to admit to clerking was four hours and 18 minutes from April to July 2021. Out of the 14 records we reviewed only two patients had an admission decision, one patient had received VTE prophylaxis medication and one patient was waiting for medical clerking.

Staff knew about and dealt with any specific risk issues. There were specific pathways in place for patients identified at risk from specific conditions such as sepsis and diabetes. A COVID-19 pathway was in place and staff we spoke with were aware of these pathways and when to implement them, for example the sepsis pathway would be initiated where a patient scored five or higher on their NEWS2 score. This pathway was documented and provided to us. Other pathways identified as good practice included a renal colic pathway, back/stomach pain pathway and hernia and abscess pathways.

Staff shared key information to keep patients safe when handing over their care to others. Speciality meetings were held with other departments across the trust to talk about patients being handed over to different departments within the hospital. Paper records were completed in the form of a SBAR (Situation, Background, Assessment, Recommendation) to provide relevant information to other departments taking over care however, these were not always fully completed as described above.

Shift changes and handovers included all necessary key information to keep patients safe. Regular meetings were held through the day to ensure that all staff were kept up to date with the running of the department, the status of patients and performance across the trust with regards to bed availability. These meetings had been identified as good practice by the wider trust and plans were in place to expand the format of these meetings to other emergency departments within the trusts group of hospitals.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Whilst the service did have vacancies in most staffing groups these were being manged with the use of bank and agency to ensure safe staff levels were being maintained. Most of staff, we spoke with confirmed that they felt the department was being staffed safely.

Patients we spoke with felt there were adequate numbers of staff to keep them well cared for and provided with information about their care and treatment. Data provided by the trust showed that any deficits in staffing were covered where possible. For April to June 2021, there were regular gaps in staffing which were requested for cover by interim staff such as bank, agency or locums. Data showed that healthcare assistant vacancies were usually covered, nursing and medical staff cover was usually covered to around 70%, which meant there were regular shortages in staffing. Gaps in paramedic staff were not usually filled. We saw that data showed that cover had improved over May and June 2021.

The urgent and emergency department had low numbers of nursing vacancies. The department had two whole time equivalent vacancies for nursing staff, a vacancy rate of 2%. However, there were vacancies for consultants and other senior staff. This was being managed by booking long term locum staff. Locum staff were orientated to the department and given a full induction.

Consultants provided daily cover, including weekends with registrar and junior doctors supporting in and out of hours. The urgent and emergency department had ten whole time equivalent vacancies for medical staff, a vacancy rate of 7.4%. Service leads were actively recruiting to vacancies.

The urgent and emergency department had a sickness absence rate of 9.42% for nursing staff. Managers were able to adjust staffing levels and gain additional support from bank or agency staff when short notice absence occurred. Where possible, staff familiar with the service were used, and all temporary staff were inducted to the service.

The urgent and emergency department had a low sickness absence rate of 0.9% for medical staff.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not clear or up-to-date, or stored securely and easily available to all staff providing care.

Patient notes were not comprehensive or completed accurately. Some notes reviewed were illegible making it difficult to understand what the plan of care for the patient was. National early warning score (NEWS2) charts were not always being completed within the patient record. The service operated both a paper record and electronic record which meant that information was not easily accessible in one location meaning that there was a risk important medical information could be missed. This contrasted with the twos sets of notes reviewed in the paediatric department which were fully completed, legible, with clear plans of care.

The service completed monthly records audits of ten patient records. The records audit did not include NEWS2 charts. The audits undertaken from March to May 2021 showed that records met the trust's requirements for documentation by staff with the exception of pain scores which were not consistently completed for all patients.

Records were not always stored securely. Patient information was often left open on computer screens which could be seen by people within the department and on one occasion we found medical records relating to a patient in the records of a different patient. This meant the department was not adhering to data protection legislation and guidance.

Medicines

The service was not always managing medicines safely.

During our last inspection we found that medicine fridge temperatures were not being monitored and we told the service it must make improvements. During this inspection, we looked the records relating to five medication fridges, two of these fridges had temperature records which demonstrated daily recording had not taken place. Three of the fridges we reviewed had blank records demonstrating no checks of temperature has taken place and one fridge we inspected did not have a temperature monitoring device attached to it.

The controlled drugs audits from March to July 2021 showed inconsistencies across different areas of the urgent and emergency department. Audits demonstrated that reconciliation record books were not always completed with the correct information or had omissions of information such as patient information and stock control checks.

The storage of medicines was audited by the pharmacy staff. Although minor actions were required for an improved audit score no major concerns about the storage of medicines was seen from the audits conducted in March 2021.

Urgent and emergency services

Is the service effective?

Inspected but not rated

We did not rate this service for effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies and saw that they were largely in date and all followed national guidance. Those policies and guidelines which were not in date were in process of being reviewed as part of the merger to Mid and South Essex NHS Foundation trust (MSE). All policies were planned to be amended to be an MSE version to facilitate standardisation across the hospital sites.

Staff told us that they could easily access policies and guideline which were held centrally and available via the intranet. Policies referring to emergency admissions were also available in paper format to ensure easy access. Staff told us these were replaced any time there was an updated version.

There was an audit programme to confirm staff compliance with policies. For example, we saw that infection prevention and control, national early warning scores (NEWS2) and patient records audits were completed monthly alongside local audits such as hand hygiene audits. Although we found the sample size of the patient records and NEWS2 audits was a low sample size compared with the number of ED attendances. The department audited ten patient records per month compared to an average of 8000 attendances per month.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain.

In four sets of records out of 14 we reviewed pain scores were not recorded. This meant we could not be assured pain was being appropriately assessed and that analgesia was being offered in timely way, where this was appropriate. We reviewed three audits from March 2021 to May 2021 which also demonstrated pain scores were not always being recorded in patient notes.

Competent staff

Managers did not always appraise staff's work performance and did not hold supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. Bank and agency staff received an induction prior to starting their shifts in the department.

Managers did not support staff to develop through yearly, constructive appraisals of their work. Staff we spoke with stated that they had not received a recent appraisal, and this was confirmed by the trust's data which stated that only 72.6% of staff within the department had received an appraisal. Nursing staff had the lowest appraisal completion rate of 63.5%. The trust was however aware of this, and action plans supplied confirmed that improvements were planned to address this. The trust had a planned recovery for appraisals to meet the trust target of 90% by the end of March 2022.

Managers did not support nursing staff to develop through regular, constructive clinical supervision of their work. Staff we spoke with confirmed that they were not receiving any clinical supervision relevant to their role. Data we reviewed showed that staff with safeguarding roles within the department had regular supervision, however, we did not see a wider provision of clinical supervision for nursing staff.

Staff did not always have the opportunity to discuss training needs with their line manager and were not supported to develop their skills and knowledge. Staff we spoke with confirmed that there were no formal one to one meeting occurring within the department. We asked to review team meeting minutes for the department narrative from the trust was that many of the team meetings had been suspended due to the COVID-19 pandemic.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Each training grade doctor was allocated to a consultant team within the department. Teams protected time to complete clinical supervision and learning required for their role.

Managers did not make sure staff attended team meetings or had access to full notes when they could not attend. Regular team meetings had not been being held within the department for all staff groups meaning there was limited opportunities for staff talk through the running of the department, to raise concerns or be kept up to date with changes occurring within the service.

Managers did not identify any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us there was limited opportunities provided to help them develop within the department.

Is the service responsive?

Insufficient evidence to rate

We did not rate this service for responsive.

Access and flow

People could not always access the service when they needed it to receive the right care promptly. Waiting times were not always in line with national standards.

The hospital had seen an increase of patients accessing the service. On average 320 attendances were being recorded daily in comparison to 292 in 2019/20 and 278 in 2020/2021. There had also been a 7.3% increase in ambulance attendances to the service, compared to the previous year's data (2019/2020).

Urgent and emergency services

Southend hospital was not performing as well as other trusts in the region for over 30 minute delays offloading patients from ambulances.

Data from the trust's board papers showed that the department was not meeting the A&E four hour standard of 95%. However, the data showed that service performed better or about the same as the national average and other trusts in the East of England, from June 2020 to May 2021. For example, in March to May 2021 the trust achieved 86.2 to 89.4% compliance with the four hour target against a regional and national average of 83.5 to 85.7%. For the same period (March to May 2021), the service reported 856, 1234 and 1377 four hour breaches and no 12 hour breaches.

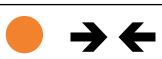
From June 2020 to May 2021, data showed that patients were consistently reviewed within 15 minutes of arrival to the department. There were two months where this was not achieved, September 2020 and May 2021(16 minute and 17 minute average).

The trust had been in line with the region for the last four months for time to treatment. Although Southend hospital had a larger percentage of patients seen within 60 minutes and was performing above the rest of the region (East of England).

Data received from the trust showed that the average time from decision to admit to admission clerking was 169 minutes (2 hours, 49 minutes) from April to July 2021. The longest waiting time from decision to admit to clerking was five hours. Although patients sometimes remained within the urgent and emergency department after clerking, they had been reviewed by a speciality team. At the time of our inspection seven patients had been in the department between 10 and 14 hours waiting for a bed in other areas of the hospital.

Data showed that the service admitted between 30 to 32% of patients attending the department, which was slightly higher than the other two hospitals in the group (Basildon 21 to 30% and 28 to 32% at Broomfield).

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders did not demonstrate that they understood or managed the priorities and issues the service faced. They were not always visible and approachable in the service for staff. Staff did not feel supported.

Since the hospital merged with Broomfield and Basildon hospitals there was one executive team responsible for the three hospitals. Local leadership team included the Associate Director of Nursing, the Deputy Director of Nursing for Emergency Services and Clinical Director for Southend ED. Prior to inspection we had received four whistleblowing concerns relating to the leadership of the service and how staff felt unsupported and not encouraged to develop.

Urgent and emergency services

During inspection, we found that there were issues around staff satisfaction with leadership. Nursing staff had mixed views about their immediate line managers and their ability to identify and illuminate poor behaviour in some groups of staff. Junior nursing staff we spoke with told us told us that there was not a strong team ethos with groups not supporting each other. Some junior members of staff told us they did not find the matrons approachable or supportive in order to escalate their concerns.

Whilst work had been undertaken to enhance staff wellbeing during the pandemic there was a disconnect between staff groups working within the department. For example, there was a lack of respect for managers with staff reporting a lack of visibility of senior staff within the department. Staff reported this impacted on supervision and support and that they did not have sufficient time or support to complete management duties, such as appraisals. Band 7 nursing staff and matrons we spoke with did not always feel supported by the senior leadership team.

Junior doctors we spoke with felt supported by consultant teams within the department. Junior doctors had allocated consultants for training oversight and the escalation of any concerns,

Staff also felt that issues were not always addressed by leads. For example, support staff told us that they continually raised concerns about the number of lifts that were out of order. They told us they felt their concerns were not taken seriously and although no harm had happened as a result up to the inspection, they felt the number of lifts that were out of service was becoming dangerous. This was raised with the trust at the time of inspection and action taken to manage the issues identified.

Culture

Staff did not feel respected, supported or valued. The service did not have an open culture where staff could raise concerns without fear.

COVID-19 had been extremely challenging for the department and wider hospital teams, this had clearly impacted wellbeing and morale during this period. Staff remained focused on meeting patient needs.

Prior to our inspection we received four whistleblowing concerns, alleging poor culture within the service and we found this to be accurate during our inspection. Staff felt undervalued with one staff describing working in the department as “thankless”. The majority of staff spoken with felt that they were not listened to or respected. Staff felt unable to speak up and when they did raise issues or concerns, felt these were not being escalated or responded to. Staff felt fearful to raise concerns. Executive leads were aware of the concerns within the department and had commissioned an external review of the culture within the department.

There was positive team working between the ambulance service and staff with a Hospital Ambulance Liaison Officer (HALO) on site. They worked collaboratively to ensure that patients were cared for and prioritised according to their clinical presentation and to ensure patient safety.

Departmental sickness absence data for the trust showed sickness absence for nursing staff (9.42%) was significantly higher than for medical staff (0.9%).

Governance

Staff did not always have regular opportunities to meet, discuss and learn from the performance of the service. Although, staff at all levels were clear about their roles and accountabilities.

Urgent and emergency services

The trust was in the process of adopting a new governance structure following the recent merger of the three hospital trusts. The new ways of working were not fully embedded.

The service had a clear governance structure in place and all staff we spoke with knew the process to escalate concerns. Staff had clear roles and responsibilities within the department. The divisional board reported quality and safety information to the trust board. This ensured that the board had oversight of the services performance. We were told that service leads were held to account for their actions and the service.

The department had a reporting structure from the staff to the divisional board through governance meetings. We reviewed minutes from the divisional board, emergency department governance and band 7 meetings from April to August 2021. Minutes showed that meetings were well attended and followed set agenda. Although, we were not assured that key messages and learning was shared effectively with staff. We saw that staff team meetings had been suspended as a result of the COVID-19 pandemic and had not restarted, although plans were in place for team meetings to recommence later in 2021.

There were action plans in place from our previous inspections to address concerns identified, however, some issues had not been resolved, for example, patients did not always have access to call bells.

Management of risk, issues and performance

The service did not identify or escalate relevant risks and issues or identify actions to reduce their impact. Leaders and teams did not use systems to manage performance effectively.

The service had a risk register in place however, it did not contain all relevant risks related to the department. For example, an assessment of risk for the out of order lift had not been completed or added to the register, the risks relating to changing to electronic records were not documented and there were no risks relating to the COVID- 19 pandemic. The risk register was also not comprehensive, it did not detail any mitigating actions the service was taking to reduce or eradicate the risks that had been identified. We can therefore not be assured that risk within the department was being appropriately managed.

Although the ED was undertaking local audits for hand hygiene, infection prevention and control and record keeping, we were not assured that the service had full oversight of the quality and safety of the care provided to patients. We requested information about the audit programme for the department including the last three months pain management and records audits, however, June and July audits were not provided. The March to May 2021 audits were not dated so we could not be assured that they related to the timeframes. This raised concerns regarding the quality of data being collected and used to inform decisions.

Patient record audits, including National early warning score (NEWS2) and pain audits, did not look at a large enough sample to provide assurance to the team that records were being completed appropriately. The service audited 10 records a month out of on average 8000 attendances. The NEWS2 audits did not contain relevant points such as whether scoring was correct. It was also not clear whether audits were completed in line with timeframes or used to drive improvements within the service. For example, a handover quality audit was due to commence in January 2021 but had not yet been initiated and results from pain audits showed recurrent gaps. It was therefore not clear if audits clearly reflected the service.

Urgent and emergency services

Performance was reviewed and managed through divisional board and emergency department (ED) governance meetings. The key information such as risk, staffing and patient experience was disseminated within the managers meetings and through the ED newsletter to staff. However, staff meetings had been suspended due to the COVID-19 pandemic.

Information management

The service collected data and analysed it. Staff could find the data they needed, to make decisions. The information systems were integrated and secure.

The service used a mix of paper and electronic patient record systems. Electronic systems were secured with passwords accessible by staff. However, we did witness occasions where staff had not logged out before leaving the computer which increased the risk of unauthorised people being able to access patient records.

The service used a mixture of paper based clinical observation records and electronic clinical observation records. We observed that paper records and electronic records were not always reflective of care provided, with gaps in each record where information had not been transcribed. The leadership had limited assurance that they had oversight of missed clinical observations. The patient records audits were a very small sample in comparison with the number of attendances to department and provided limited assurance of completed clinical observations and escalation of any concerns.

Engagement

Leaders did not always engage with staff actively and openly.

Although senior staff attended meeting on a monthly basis team meeting were suspended due to the COVID-19 pandemic. Staff told us that they did not always know what was happening or share learning. We found staff morale low and a disconnect between teams and the senior leadership team.

The services had staff notice boards with posters which provided information about performance. The posters were not easy to understand with lots of images and information, they were not in an easy to read format for staff members with visual stress.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had effective patient pathways in place which followed national guidance and were tailored to the hospital. We saw that patient pathways were displayed on the walls of the rapid assessment and treatment area to prompt staff as they worked.

The service was in the process of transition to a fully electronic clinical observation monitoring system (Nerve Centre). Although the department had some further developments to implement to ensure risks of missed clinical observations were resolved, the system should provide central oversight of deteriorating patients.

Surgery

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and monitored whether everyone completed it.

Staff received mandatory training. Data provided by the trust following our inspection showed that mandatory training compliance was 73%. This was below the trust target of 85%. Staff we spoke with told us that it had been challenging to complete all mandatory training as face-to-face training was cancelled or run with reduced numbers due to COVID-19. At the time of our inspection the trust was in the process of merging all training to one training programme and this had presented challenges of access to courses and compliance monitoring data. There was a program in place to address the deficit in mandatory training.

The mandatory training available was comprehensive and met the needs of patients and staff. It was delivered by a combination of on-line and face to face training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Local managers told us there was an action plan in place for statutory and mandatory training recovery to ensure that the service met the trust target. Training priorities had been identified. In main theatres managers used a staff notice board to alert staff to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Data provided by the trust showed that safeguarding training compliance was 85% for safeguarding adults level one and 96% for safeguarding adults level 2 above the trust target of 95%. Data showed that completion rate for safeguarding adults' level 3 was 0%. Following inspection, we were told that safeguarding adults level 3 training had recently been introduced and was planned to be delivered to staff with compliance of 95% expected by August 2023.

Leaders told us that systems used to record training across the sites had been unified and there had been problems accessing the data accurately. This was being addressed but they were unable at the time of inspection to produce figures to provide assurance relating to this training compliance. There was a program in place to address the deficit in mandatory safeguarding training.

Surgery

Training compliance levels for children's safeguarding was 90% for level 1 and 2. We did not see evidence that staff in surgery had completed level 3 children's safeguarding training. Following inspection, we were told that Level 3 training was in progress for appropriate staff with 95% compliance expected by August 2023.

Leaders told us that systems used to record training across the sites had been unified and there had been problems accessing the data accurately. This was being addressed but they were unable at the time of inspection to produce figures to provide assurance relating to this training compliance.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with could identify the safeguarding leads and knew how to contact them for support when required.

Cleanliness, infection control and hygiene

The service controlled infection risk well in the areas that we visited. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean in one area that we visited.

Ward areas we visited were visibly clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness. Infection prevention and control (IPC) audits showed that staff had knowledge of IPC and used PPE appropriately. The service conducted monthly hand hygiene audits. Results from the three months prior to our inspection showed that staff demonstrated good knowledge in relating to hand hygiene with knowledge showing at 98%. and observational audit of practice showed 88% compliance. Leaders had actions in place to improve compliance.

Staff used records to identify how well the service prevented infections. A monthly performance management report was produced, and this demonstrated the service performance around MRSA, CDIF, ECOLI and MSSA infections. Evidence provided by the trust showed that there had not been any infections in the past six months

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was available in all areas. However, on the surgical assessment unit PPE was kept outside of each bay. This meant that staff had to remove PPE and leave the area in order to put on new PPE before attending to another patient.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff using I am clean stickers on equipment and domestic staff followed daily work sheets to complete cleaning activities.

The trust told us that there was no current data on surgical site infections. Surgical site infections surveillance was paused nationally due to the pandemic and is expected to recommence later in 2021 / 2022.

Environment and equipment

The design, maintenance and use of facilities did not keep patients safe, we had concerns about the environment in the newly opened surgical assessment unit. Equipment was not always maintained in all areas we visited. Staff were trained to use equipment. Staff managed clinical waste well.

Surgery

The design of the environment did not always follow national guidance. On the surgical assessment unit (SAU) we found fire doors were propped open with door wedges, electrical equipment and piped oxygen connector valves had not been serviced in line with their service dates which showed a review date of October 2020. Staff demonstrated how difficult it would be to manoeuvre a patient bed in an emergency due to the size and layout of the ward environment. We escalated our concerns regarding these risks to the local fire authority. Information was provided by the local fire safety officer that principals regarding the doors and compartmentation are as expected. However, this did not mitigate the risk of fire when these doors were propped open. Following our inspection, we asked the trust to provide the fire risk assessment for the SAU and saw that this had been completed with a rating of low risk.

Staff told us this was so they could safely monitor patients as they could not view the bays from the nurse's station. Nursing staff stood outside the bays with works stations on wheels and had been instructed by the nurse in charge not to leave the bays unsupervised.

Patient bathrooms on the SAU were not fitted with handrails, shower pipe work was exposed and there were no mirrors for patients to use in their day to day hygiene. The ward manager told us they had escalated the uncompleted works but there was a dispute as to who had responsibility for completing this work causing delays in providing facilities for patients.

Staff we spoke with on the SAU told us they regularly supported patients who had self-harmed or inserted objects into their body. We were concerned that the SAU environment had a number of ligature points and areas where patients could not be easily observed. A ligature point is anything that can be used to tie a cord, rope or other material for the purpose of hanging. The trust had a ligature minimisation policy in place to ensure environments were free as reasonably possible of ligature and anchor points. There was a risk assessment in place which addressed the risks.

Staff carried out daily safety checks of specialist equipment. Anaesthetic machines were checked daily and this was recorded on the equipment. However, there was no logbook for machine documentation in line with AAGBI (2019) recommendations.

The service had enough suitable equipment to help them to safely care for patients. However not all equipment was within service date. We found equipment including wall oxygen valves and wall suction with due service date of October 2020 in the SAU and the day surgery unit. Not all equipment was compliant with electrical safety checks. We escalated this at the time of the inspection to the ward manager who told us that they would ensure that all checks were completed.

Patients could reach call bells and patients we spoke with told us that staff were responsive when they called for support.

Staff disposed of clinical waste safely. We saw that waste was separated appropriately and sharps bins were assembled correctly and not overfilled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Surgery

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used NEWS2 to identify deteriorating patients. Patient observations were recoded electronically and escalated when triggered.

Staff used a sepsis care bundle for the management of patients with presumed/confirmed sepsis.

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool. Staff did not always update risk assessments for patients. For example, Venous thromboembolism (VTE) assessments were inconsistent throughout the service. We reviewed evidence that showed this issue was being monitored by the trust and there was an action plan in place to improve compliance.

Staff completed risk based pre-operative assessments in line with pre-operative assessment guidance.

The service ensured compliance with the World Health Organisation (WHO) five steps to safer surgery surgical checklist including marking of the surgical site. We observed three WHO checks and saw they were completed appropriately. The service monitored compliance through a record and observational audit. Data provided by the trust following or inspection showed 100% compliance with the WHO checklist.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). There was a rapid, assessment, interface and discharge (RAID) team based at the trust that staff could access for support.

Staff shared key information to keep patients safe when handing over their care to others. We observed staff handovers between shifts on the ward. Shift changes and handovers included all necessary key information to keep patients safe.

Consultants completed harm reviews for patients on waiting lists in each clinical specialty. This process was to minimise the risk to patients waiting for surgery and ensure that patients were treated in line with their clinical risk.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff. However, this risk was mitigated to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers had access to a safe staffing tool but did not always use it. For example, staff told us the acuity of patients on Shopland ward had increased meaning that the number of staff per shift needed to increase to meet the needs of the patients. The matron confirmed that the planned staff numbers had increased but a safer staffing tool had not been used to determine this. This meant that there was no assurance that the new staffing numbers met the safe staffing level.

The number of nurses and healthcare assistants did not always match the planned numbers in the areas we visited.

Surgery

The ward manager could adjust staffing levels daily according to the needs of patients. There were regular staffing review meetings held throughout the day where staffing numbers were reviewed, and staff allocated to support areas that were short staffed to best meet patient need and mitigate areas where patients were at most risk to patients. However, due to staff shortfalls across the hospital this did not always prevent a shortfall in the planned numbers of staff.

The number of nurses, operating department practitioners (ODPs) and theatres assistants did not always match the planned numbers in the theatres we visited.

There was two daily theatre staffing meeting held across the three trust sites. Staffing numbers were reviewed and planned elective theatre list were reviewed to ensure that staffing levels were safe to carry out planned surgery lists. Where necessary lists were merged and, in some cases, patient's surgery was cancelled.

The vacancy rate was 14% above the trust target of 11.5% but there were actions in place to address this and the vacancy rate was reducing. Managers told us that there had always been a challenge to recruit staff to Southend and so there were a number of "grow your own" initiatives including apprenticeships, nursing associate training, student nurses and ODP training.

Managers used bank and agency staff and requested staff familiar with the service. Managers told us that it was a challenge filling bank shifts.

Managers told us that all bank and agency staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience. However, this risk was mitigated to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff and the medical staff did not always match the planned number. There were a number of vacancies across surgical specialities and an active recruitment programme in place. Doctors completed daily ward rounds and planned patient care and treatment accordingly. At weekends, consultants saw those patients referred to them by their peers to ensure ongoing reviews.

Data provided by the trust showed the vacancy rate for medical staff was 11% below the trust target of 11.5%. The turnover rate was 13% in surgery at Southend Hospital.

Data provided by the trust showed that sickness rate for medical staff was 0%. However, this did not reflect what doctors told us during inspection.

The service used locum staff. Managers could access locums when they needed additional medical staff. Managers told us that there was a focus within the trust to recruit more substantive medical staff to reduce locum use.

Managers told us that they made sure locums had a full induction to the service before they started work.

The service had a consultant on call during evenings and weekends.

Surgery

Records

Staff kept records of patients' care and treatment. However, records were not always clear, up to date, or stored securely. They were easily available to all staff providing care but the notes we reviewed were difficult to navigate.

Patient notes were a mix of electronic and paper records. Pre-admission notes were recorded electronically, theatre and recovery notes were paper-based, and the ward used a mixture of paper and electronic notes. All paper-based notes were scanned and were accessible on the electronic notes system.

People's individual care records, including clinical data, were not consistently written and managed in a way that kept people safe. We found there was no set order for the paper-based notes and patient care records were difficult to locate. Notes were recorded inconsistently, were not always legible and signed appropriately by the clinician. In two sets of notes we found information containing patient information not secured meaning these could easily be lost and breach information governance.

When patients transferred to a new team, there were no delays in staff accessing their records.

Electronic records were stored securely. Paper based notes were stored in trolleys that could be locked. However, during our inspection we saw that these were not always secured and left unattended.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. However, in day theatre, we saw medications that had been left out on a worktop which were left unattended by staff. The medications were for a number of patients on the afternoon theatre list. This is not in line with best practice. This posed a safety risk as no one was supervising or accountable for the medicines to ensure they were not accessed by people who were unauthorised to access them. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicine fridges and storeroom temperatures were monitored in line with trust policy and there was a clear escalation process in place if the temperatures were outside of tolerable range.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. These were shared at staff huddles and staff meetings. The information was also shared with staff by email.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The trust used an electronic reporting system.

Surgery

Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had nine never events in surgery across the trust in the 12 months prior to our inspection. Two never events occurred at Southend. Managers shared learning about never events with staff and across the trust. The trust produced a governance newsletter to share info about never events and serious incidents (SI's) with staff. Staff used a social media group established during COVID-19 to share immediate information and learning from Never Events and serious incidents. Learning was also shared via staff briefings, staff meetings, via email and in the trust's governance newsletter.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff we asked were aware of duty of candour. We reviewed two serious incident reports and noted that duty of candour was applied appropriately.

Staff met to discuss the feedback and look at improvements to patient care. For example, following a wrong site nerve block never event staff told us there had been learning around "stop before you block" and this was reiterated at team meetings and compliance was audited. We saw that stop before you block notices were in theatres, however in some area these were only A5 size and were not always clearly visible.

There was evidence that changes had been made as a result of feedback. However, in ophthalmology staff we asked could not tell us what actions had been taken following a never event as they were still awaiting the outcome of the route cause analysis investigation. They could not tell us of any immediate actions that had been put in place. This meant that we were assured that actions had been put in place to prevent a similar incident happening again.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and delivered high quality care according to best practice and national guidance. The trust was in the process of standardising policies, guidance and documents across the trust. Although the merger was in April 2020, the standardisation process was delayed due to the COVID-19 pandemic, meaning that some guidance was past their review date. There was a target to complete this standardisation by December 2021.

The service updated guidance and policies in line with NICE guidance. For example, we saw that pathways followed NG180 (perioperative care in adults). The service had National safety standards for invasive procedures guidance in place (NatSSIPs) and adapted these for local practice (LocSIPs).

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. For example, on Shopland ward we saw staff sharing information about the psychological needs of a patient in their care.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients confirmed they were given a choice of food

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition Staff fully and accurately completed patients' fluid and nutrition charts where needed. Southend University Hospital Nutritional screening assessments were fully completed and updated across all wards visited. Fluid balance charts were in place to monitor patients' hydration.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients waiting for surgery were kept "nil by mouth" in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a nationally recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it. However, staff in main recovery told us there was sometimes a delay in administering pain relief if the online Venous thromboembolism (VTE) assessment had not been completed meaning they could not administer the medication until this was completed. An action plan was in place to improve the completion of VTE compliance.

Staff prescribed, administered and recorded pain relief accurately. Medicines incidents were reported, and action taken when required. A pain assessment tool was in use to assess the level of pain a patient was experienced, and pain medication was administered as required. Medicine managements audits were completed, and action taken to address non-compliance.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Surgery

The service participated in relevant national clinical audits and produced action plans from the results. We reviewed national audit results and the trust action plans. For the National Joint Registry, Southend hospital performed as expected in line with the national ratio.

Managers and staff used the results to improve patients' outcomes and improvement is checked and monitored. For example, actions were put in place to increase staff awareness to improve the input of patients to the National Emergency Laparotomy Audit.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an ongoing local audit programme with action plans. Although during the COVID-19 pandemic, some local audit programmes were suspended as staff were pulled into clinical roles. At the time of the inspection senior leaders told us that local audit programme was in progress and we saw evidence of this.

Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. Audit results were shared via email and discussed at monthly meetings.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. We saw evidence that inductions were completed and that staff competencies were assessed and signed off.

Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisal completion rate for nursing staff was 73% against a target of 90%. Managers told us that the ability to complete appraisals had been impacted during the pandemic with staff redeployed throughout the hospital. There was an action plan in place to ensure that staff appraisals were completed.

The trust's clinical educators supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Information was shared on notice boards in staff rooms and via email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, health care assistants in the eye unit had received additional training to enable them to administer eye drops.

Managers made sure staff received any specialist training for their role. Training was provided either internally or externally. For example, we were told how some staff had commenced post as a healthcare assistant and been supported to complete nurse training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. We were told that MDT meetings occurred frequently according to the specialty. Meetings were inclusive of all staff including specialist nurses. MDT meetings included reviews of all patients awaiting procedures and the timelines of their treatments.

Patients had their care pathways reviewed by the relevant consultants. Consultants provided an on-call system which meant that there was a senior decision maker available.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, community services, such as home carers and community nursing services responded to inpatient referrals for community support packages.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, ward staff told us they sometimes found it challenging to contact the medical team if they had a concern about a medical patient on the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to tell us what actions they would take to assess whether a patient had capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood their responsibilities and the procedures in place to obtain consent from patients before undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and signed forms for treatment and exploratory investigation during the inspection.

Surgery

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records that we reviewed.

Staff we knew how to access policy and get advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We witnessed several episodes of care and saw that staff were kind, respectful and maintained patient dignity.

Patients said staff treated them well and with kindness. All patients we spoke with told us they were well looked after. One patient told us that "nothing was too much trouble for the staff". Another said they couldn't fault the care they received.

Staff followed policy to keep patient care and treatment confidential. Curtains were drawn around patients when sharing information or giving care.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. However, on the surgical assessment ward three patients in one bay told us they were cold due to the air conditioning. They had escalated this to staff, but it had not been resolved.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff offer emotional support to patients that were distressed. One patient who was living with dementia and was very confused and disorientated having been admitted to hospital. Staff were patient and kind whilst trying to reassure them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff demonstrated empathy for the patient and family experience and the increased emotional and social impact of the COVID-19 19 pandemic.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We witnessed staff supporting a relative who had become distressed about the length of time their relative had been in the hospital. Staff were supportive, talked kindly to the relative and helped them understand the need for their relative to remain in hospital.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff told us that this had been more challenging during the pandemic due to limited access for relatives. They told us of an example where they had risk assessed and authorised a patient's daughter to visit outside of visiting hours to support their relative who was very unsettled and distressed.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and relatives were encouraged to complete the friends and family test. The result showed that for the three months prior to our inspection the majority of those who responded felt that their experience was good or excellent.

Patients gave positive feedback about the service. Friends and family tests showed that the percentage of patients that rated the service positively was consistently at 95%.

Is the service responsive?

Requires Improvement  

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service was divided into specialties and the senior management team of each specialty had oversight of the entire patient pathway.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust told us that there had been no mixed sex breaches in the three months prior to our inspection.

Surgery

Facilities and premises were appropriate for the services being delivered. Patients who required a higher level of care were referred to the high dependency or intensive therapy units. If the need for additional care was known prior to the patient operation, a bed was booked in advance, and staff worked collaboratively with the critical care team to ensure that patients were cared for in the most appropriate location according to the patient's condition.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, the manager in pre assessment told us that patients with a learning difficulty who were coming in for surgery would be supported by the learning disability nurse specialist who would meet them during pre-assessment and plan support they may need throughout their stay in hospital.

The service relieved pressure on other departments when they could treat patients in a day. We were told that where possible the service ensured that patients were admitted as day surgery cases. Elective day surgery had a strict green COVID-19 pathway and patients were tested and required to self-isolate prior to their admission.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs. The service used an electronic database which captured any specific needs for each patient. This enabled services along the patient pathway to facilitate additional time for appointments, pre-admission visits or ensure that patients had the support in place they required.

Wards were designed to meet the needs of patients living with dementia. For example, we saw on Windsor ward that a "Bus stop" located near the patients which provided a quiet and safe place to help prevent them becoming unsettled or anxious.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was telephone translation service available for patients whose first language was not English as well as interpreters.

Staff made us aware that on Shopland and Castlepoint ward night staff were administering morning medication to relieve the pressure on the day shift. They told us they would commence this at 6am. This does not meet patient's individual needs as this practice meant waking patients to administer their medication. Following the inspection, we asked for as risk assessment and policy to support this practice. The trust told us that they did not have a risk assessment or standard operating procedure in place for this practice They told us that they monitored all medication incidents and had reviewed incident data for the previous six months and there have been no medication administration incidents relating to this practice during this time. However, this did not mitigate the impact of patients being woken to administer medication as a response to staff shortages and patient acuity.

Access and flow

Surgery

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients varied.

Managers monitored waiting times and made sure patients could access services when needed and monitored whether they received treatment within agreed timeframes and national targets. There was a robust process for monitoring patients awaiting surgical procedures. Each division had a waiting list and each patient on that waiting list was discussed weekly to identify what was needed to admit the patient for their planned procedure. The service reported waiting times and plans to reduce them to the trust board.

The trust did not meet any of the national standards for cancer waits in May 2021. The trust performed second worst in the east of England region for treatment within 30 days (87.6% compared to 96%) and for 62 days they achieved 61% against a target of 85%. 86.7% of patients were seen within two weeks against a national target of 93%. The trust completed harm reviews for all patients waiting for procedures greater than 52 weeks. Harm reviews were also completed for all patients within specific specialities, to ensure there was oversight of risk and harm. Patients identified as requiring urgent treatment were prioritised.

Trust board papers for September 2021 stated that the trust performance for two week waits (2WW) for cancer was 84.3% in June 2021 against a trust target of 90.3%. This was better than the 79.8% regional average and similar to the national average of 84.9%. There were 801 breaches in the 2WW which was gradually increasing month on month this year.

The 62 day urgent GP referral data was slightly below the trust target of 65.1% at 60.3% for June 202. This was lower than the regional and national averages (72.3% and 73.3% respectively). There were 380, 62 day wait patients and 75, 104 day waiting patients. These figures were similar to the preceding months.

The 18 weeks wait referral to treatment times for June 2021were better than the regional (67.1%) and National (68.8%) at 69.9%.

There was a robust process for monitoring patients awaiting surgical procedures and staff reviewed waiting lists regularly, monitored waiting times and reported these to the trust board. Each division had a waiting list and each patient on that waiting list was discussed weekly to identify what was needed to admit the patient for their planned procedure. The service reported waiting times and plans to reduce them to the trust board.

We were told that bed capacity and workforce challenges greatly impacted on the services ability to meet demands.

Managers worked to keep the number of cancelled operations to a minimum. During our inspection staff worked collaboratively to ensure theatre optimisation across the three sites. Staff reported that at theatre planning meetings they reviewed the schedule for elective patients and where necessary cancelled patients in advance to avoid on the day cancellations.

When patients had their operations cancelled at the last minute, managers monitored and attempted to rearrange as soon as possible and within national targets and guidance. Data provided by the trust showed that in June 2021 26% of patients whose operation was cancelled were not operated on within 28 days. This rate had increased from 20% in April and 25% in May.

Surgery

There was a number of non -surgical patients on surgical wards, for example, on Shopland ward there were ten medical patients. Processes were in place to ensure these patients were reviewed but the acuity of the patients impacted on the ability to provide staff to meet the patient's needs.

Managers and staff worked to make sure they started discharge planning as early as possible to avoid delays at discharge.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients asked told us they knew how to complain or raise concerns but had had no cause to do so.

We did not see information about how to raise a concern clearly displayed in all patient areas that we visited although staff told us that patient information leaflets had been removed due to infection risks. Information about how to make a complaint was available on the trust website.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff told us knew how to acknowledge complaints and patients received feedback from managers.

We saw that there had been 16 complaints regarding surgical services for the six months preceding the inspection. The majority of those were regarding ophthalmology and complaints about treatments.

The trust reported 409 complaints from August 2020 to July 2021, across all services. The response rate was recorded as between 40 to 61% within the trusts timeline.

Is the service well-led?

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff.

Surgery

Since the hospital merged with Broomfield and Basildon hospitals there was one executive team responsible for the three hospitals. There was also a leadership team on each site, which consisted of a managing director, medical director, operational director and director of nursing. Some staff we spoke with said that since the merger, executive leaders were less visible, and this was because they could be based across the other hospital sites. The leadership structure was not embedded following the recent changes. This meant that there was still work to do to ensure that all sites were aligned.

The trust managed all services through care groups and divisions within each care group. Surgical services were split across two care groups with each care group being led by clinical leads. Each division had a leadership team which included a clinical director, general manager and head of nursing. The leadership team was supported by speciality leads, ward managers and matrons who provided local leadership at ward/ department level.

Ward managers, supported by matrons, provided local leadership on each ward. Most staff we spoke with knew who their local leaders were and felt supported. Staff told us that local leaders were approachable and were responsive to their concerns. However, it was apparent that staff felt there were ongoing challenges that were not within the gift of the local management team to resolve such as the shortfall in staff numbers.

Staff described matrons and the ward managers as approachable and supportive. Staff told us that during the COVID -19 pandemic their managers had been available to listen to them and offer support.

Local managers had a good understanding of the challenges in their areas and had introduced plans to improve delivery. Leaders understood the challenges in the service and told us the actions in place to address them. For example, senior nurses attended three times daily meetings to discuss nurse staffing numbers to address staffing shortages and ensure that staffing numbers were safe in all areas. This ensured there was oversight of staffing issues, which were reviewed and mitigated daily.

Daily theatre meetings were held where staffing, lists and potential cancellations were discussed. Theatre managers from the three locations at the trust met monthly.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

There was a trust strategy with objectives to achieve their ambition: "to improve health and wellbeing through excellent, financially sustainable services, provided by staff supported to develop, innovate and build rewarding careers". Senior leaders told us that following the merger of the trust, the overall aim of the surgical services was to come together as one service delivered from three sites.

The service strategy was part of the clinical reconfiguration model which was aligned to the Mid and south Essex Health and Care Partnership five-year strategy and delivery plan. The clinical reconfiguration of services started in 2019/ 20 and the changes were phased over three years.

The service's quality goals, and targets had been developed to ensure they met the trust's clinical strategy which aimed to create specialist centres of excellence and sustain excellent, reliable local care.

Culture

Surgery

Staff felt supported. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt challenged due to ongoing staffing issues and the impact of the previous 18 months working through the pandemic. A number of surgical areas had been suspended during the pandemic and staff redeployed to support workloads in other areas. Staff were tired and morale was low. Seven members of staff on the surgical wards raised their concerns with us around staffing numbers, patient acuity and support from management. Staff told us that the frequent moving of staff to cover empty shifts in other areas and the short staffing numbers on shifts was having an impact on staff morale.

Staff we spoke with were very proud of the service they delivered and described their colleagues as supportive. All staff we asked told us they had good working relationships with their colleagues. During redeployment in response to the pandemic a member of staff told us that coping with the impact of the pandemic at work was made harder as they were not working with their familiar colleagues to offer them support.

Another challenge to the culture was the return to normal areas of work for some staff. The experience of COVID-19 had been different for members of the team and although colleagues and managers were supportive of each other different experiences some staff found it difficult to settle back into the team.

Staff were patient focused, and the culture was focused on the needs and experiences of people who used the services. Several members of staff told us they were proud of the care they gave to patients and told us they felt the service was patient centred. However, they were concerned that low levels of staffing was impacting on patient care in some areas.

Staff told us there was good teamwork within the teams and we observed this during our inspection. Staff worked together to resolve issues and worked flexibly to accommodate service needs. They told us the whole team worked together to provide the best care for patients.

There were processes in place to provide staff with career development opportunities although this had been challenging during COVID-19. Staff had not received regular appraisals although they said they had received regular well-being checks. Staff told us that the trust was supportive of training and they felt encouraged to undertake additional training when funding and scheduling allowed.

Leaders told us they were proud of the hard work of staff and their commitment to improve care to patients. They said they could not overstate the dedication of the staff and their drive and commitment to provide care to patients throughout the pandemic and the post pandemic recovery.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, governance processes were not embedded.

Surgery

Governance systems were in place to support the functions of services across the three locations of the trust in surgery, but these were yet to be fully embedded across all divisions. As the governance structure was very new, further work was required to embed the processes within the service. Monthly meetings were conducted to allow oversight of the service which fed into divisional governance meetings. Governance meetings had a set agenda and meeting minutes showed that this was followed.

There was an effective process to share governance outcomes and updates with staff. Monthly staff meetings were held. Meeting minutes showed they had a formal agenda and governance was included.

There was an audit programme supported the hospital to ensure patient safety. This had been suspended during the pandemic and only commenced again in July 2021. We saw that wards completed these audits around areas such as hand hygiene and cleanliness.

Senior managers told us that incidents, near misses and complaints were monitored for trend and improvements with action plans put in place to drive and monitor improvement. Staff we spoke with were aware of serious incidents and complaints across the clinical areas Across the hospital and the trust.

Staff of all grades were clear about their roles and what they were accountable for and to whom.

Leaders told us that governance was a regular agenda item at monthly team meetings where governance outcomes were shared and escalated. However, during the pandemic, these meetings were not regularly held. In the minutes we reviewed, governance processes such as incidents, complaints and mandatory training were standard agenda items.

The surgical service had Multi-Disciplinary Meetings (MDT) with an established governance structure with a clinical governance lead.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

Surgery had a risk register in place. Each risk was rated and had a named manager responsible for overseeing the risk and there were details of the actions taken to mitigate the risk and updates provided as the risks were reviewed. The risk register was reviewed and updated at the clinical governance meetings. Service risks sat within the division responsible for the service. The top risk identified by leaders were staffing and there were actions in place to address this.

There had been three never events at the hospital all within ophthalmology services. The service had reviewed the incidents and shared learning across the service where it could make changes. However, we were not assured that learning had been shared across sites.

There were effective processes in place to monitor patients waiting for surgery and performance against the post COVID-19 recovery plan. A patient tracking list was in place and this was reviewed at weekly meetings. Clinical urgency was reviewed by clinical specialists to ensure that patients were prioritised in line with clinical need. Capacity issues were highlighted. Senior leaders told us that capacity issues were addressed by effectively utilising independent health providers and the vanguard theatres across all three sites.

There were processes in place to give leaders oversight of patients waiting for appointments and RTT performance and these were used to plan access for patients. The service reported waiting times and plans to reduce them to the trust board.

The service had effective systems for monitoring and managing performance. The service used a quality assurance dashboard report to monitor performance information including waiting time to referral, theatre utilisation, length of stay (LOS) and unexpected returns to theatre. The dashboard allowed the service managers to monitor performance against targets and implement actions to improve where required.

Each surgical specialty held regular mortality and morbidity meetings to share outcomes of mortality reviews. We reviewed a selection of mortality and morbidity meeting records from April to June 2021. The meeting records identified learning and actions to share across the service.

Information Management

The service collected data and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements. However, staff felt that there was a lack in consistency between electronic and paper records.

Staff received training on information governance as part of their mandatory training.

Information stored electronically was secure. Computer access was password protected and we observed staff logging out of computer systems or hand-held devices they had completed tasks. Staff had access to a trust intranet system which provided a range of internal and external resource material to assist staff in their daily tasks

Staff used multiple systems for recording patient care, including paper and electronic records. Staff told us they were frustrated with the lack of consistency in records.

The trust had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements.

Engagement

Local leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers engaged with staff at regular team meetings in all the areas that we visited. Meeting minutes showed discussion of incidents, complaints and staffing.

Surgical specialties used the friends and family test (FFT), which gathered data on whether patients or their families or carers would recommend the service to their friends or family. The monthly quality assurance report for surgery included feedback from patients in the form of complaints and compliments These were discussed at the meetings.

Staff in most areas we visited told us that local leaders were visible and offered opportunities to listen and feedback to staff. However, they told us that senior leaders were less visible and did not feel assured they were aware of the challenges faced by staff. However local leaders told us they felt very supported by the senior leadership team and were involved in decisions about their service.

Surgery

Cross-site working was limited. Staff told us they were aware of plans but there had been no consultation with them yet. Senior leaders told us that this had been delayed due the pandemic. Senior leaders told us that work was under way to improve staff engagement across the three trust hospital sites Senior leaders were attending local team meetings and a consultation process was planned to explore cross site working.

The trust carried out an annual staff survey to gain staff feedback.

Basildon University Hospital

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Description of this hospital

Basildon University Hospital is operated by Mid and South Essex NHS Foundation trust. There are 25 inpatient wards and 637 inpatient beds at the main Basildon University Hospital site located in Basildon. The hospital serves a local population of 450,000 living in and around the south west Essex area.

We inspected maternity service due to ongoing concerns relating to performance. In June 2020, we issued the trust with a Section 29A warning notice and rated it as inadequate. This was because we identified a number of issues particularly around the staffing and safety of the service. We carried out a further focused inspection on 18 September 2020 to follow up on the concerns raised during engagement with the trust for monitoring their compliance to the warning notice. This focused inspection did not include all of our key lines of enquiry (KLOEs).

On 7 October 2020, we issued an urgent notice of decision, under Section 31 of the Health and Social Care Act 2008, to impose conditions on the trust's registration as a service provider in respect of the regulated activity: maternity and midwifery services. The conditions set out specific actions to enable the improvement of safety within the service.

This inspection was completed as part of our routine regulatory action and to follow up on the safety of maternity services across the trust. We inspected Medical care and Surgery due to concerns around the management of risks and patient safety.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities. Medical Care and Surgery had not been inspected since the merger to become the Mid and South Essex NHS Foundation Trust, and therefore there were no previous ratings. Maternity services had been rated as Inadequate at the October 2020 inspection.

During this inspection, we visited a number of wards and departments, including, Marjorie Warren ward, Pasteur Ward, Florence Nightingale Ward, Lionel Cosin Ward, Orsett Ward, William Harvey ward, Elizabeth Fry Ward and the Acute Medical Unit (AMU) West within medicine. We also inspected the Endoscopy Unit and Discharge lounge.

Within surgery we inspected the Same Day Emergency care, Pre-operative assessment unit, Day surgical unit, Day surgery theatres and main theatres, Recovery area, Surgical referral unit, and Bulphan, Chelmer (CTC), Horndon, Laindon and Linford.

Within Maternity services, we inspected two dedicated maternity theatres, Cedar Ward, and the Mulberry Suite.

We spoke with 113 members of staff including, nurses, doctors, 19 patients and reviewed 43 patients notes.

Our findings

At this inspection, we rated Medicine, as requires improvement for safe and well led, and good for effective, caring and responsive. Surgery was rated, requires improvement for safe, responsive and well led and good for effective and caring. We rated Maternity services as requires improvement for safe, effective and well led, good for responsive and we did not inspect caring. The overall rating was Requires Improvement because:

Medicine:

- Staff did not always complete and update risk assessments for each patient and removed or minimised risks.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up to date, stored securely and easily available to all staff providing care.
- Staff appraisals were not always completed annually.
- Leaders did not always have oversight of risks in the service for example, bed rail risk assessment and record keeping.

Surgery:

- Compliance with mandatory training was not in line with trust target.
- Not all staff had completed training specific for their role on how to recognise and report abuse.
- Equipment was not always maintained in all areas we visited.
- Staff did not always complete and update risk assessments for each patient and removed or minimised risks.
- The service did not have enough nursing and support staff with the right qualifications, skills, training and experience.
- The service did not have enough medical staff with the right qualifications, skills, training and experience.
- Medicines were not always stored in line with policies and procedures.
- Not all staff had received an appraisal in the last 12 months.
- Mental capacity assessments were not always clearly identified in patients notes.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.
- Governance processes were not fully embedded.
- There were repeated never events within the service with similar themes.
- Staff felt that there was a lack in consistency between electronic and paper records.

Maternity:

- Compliance with mandatory training was below the trust target for most topics.
- Some compliance with safeguarding training was below the trust target.
- Some staff did not follow the trust uniform policy.
- Annual equipment checks were not always completed.
- Triage was not always completed by a designated midwife.
- The service did not have enough maternity staff with the right qualifications, skills, training and experience.

Our findings

- Not all staff had completed speciality specific training or had an appraisal within the last year.
- The trust wide governance structure was under review and not embedded.
- Staff did not always feel respected, supported or valued.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service generally controlled infection risk well. Staff mainly used equipment and control measures to protect patients, themselves and others from infection. They generally kept equipment and the premises visibly clean. COVID-19 precautions were in place.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected reliable data and analysed it. Staff mainly could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were secure. but were not fully integrated.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Our findings

- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Surgery

Requires Improvement

Is the service safe?

Requires Improvement

Following the merger of the trust in April 2020 Basildon University Hospital surgical service did not have a previous rating. At this inspection we rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, compliance was not in line with the trust target.

The mandatory training was comprehensive and met the needs of patients and staff. It was delivered through a combination of online and face to face training.

With the impact of the COVID-19 pandemic since March 2020, mandatory training had been postponed. However, at the time of our inspection, staff told us the trust's annual commitment to mandatory and statutory training had restarted but accessing face to face training including life support training was difficult as demand was high.

Data provided by the trust dated August 2021, showed the service had not met the trust target of 85% for any of the mandatory training modules. The highest compliance rate was 75% for Preventing Radicalisation and the lowest compliance rate was for Adult Basic Life Support (BLS) which was only 42%. We raised this concern with the senior leadership team who told us that there was a plan in place for all staff to be compliant with their mandatory training by January 2022. The trust told us they were on plan to meet trajectory for mandatory training.

The leadership team met regularly to review mandatory training compliance and identify areas of concern, of which BLS and moving and handling had been identified. Staff were encouraged to use any spare time available to complete their online training. Ward staff told us that at the end of monthly ward meetings practice development nurses provided training and support.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training, but they did not have access to the overall compliance figures. A new system had been introduced whereby emails were sent to staff directly and their managers. Ward managers were made aware of who had not completed a module but did not know their overall compliance rate for the ward. A further issue was that the new system did not reflect training completed by staff at home. Therefore, we were not assured that individual ward managers had oversight of staff mandatory training compliance.

As part of the governance processes, the service reported to the trust board monthly on mandatory training compliance.

Safeguarding

Surgery

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had completed training specific for their role on how to recognise and report abuse.

Staff received training specific for their role on how to recognise and report abuse.

Data provided by the trust showed that safeguarding adults training compliance for level 1 was 82.3% and for level 2 was 85.3%. Data for level 3 training was not provided. Following inspection, we were told that safeguarding adults level 3 training had recently been introduced and was planned to be delivered to staff with compliance of 95% expected by August 2023.

Data provided by the trust showed that safeguarding children training compliance for level 1 was 78.2% and for level 2 was 80.8%. Data for level 3 training was not provided. Level 3 training was in progress for appropriate staff with 95% compliance expected by August 2023.

Leaders told us that the training systems across the sites had been unified and there had been problems accessing the data accurately. This was being addressed but they were unable at the time of inspection to produce figures to provide assurance relating to this training compliance.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Risk assessments were completed, and any concerns were escalated appropriately.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were given examples of when referrals had been made and actions that had been taken in response to concerns or feedback. We saw records of a safeguarding concern relating to a patient with a mental health condition detailing actions taken, including referrals and discussions with safeguarding leads.

The service had safeguarding leads who supported staff with any concerns. There were clear safeguarding policies which described escalation and reporting processes.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Ward cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There were dedicated cleaning staff who completed checklists and confirmed that cleaning schedules were completed. All bed space curtains we looked at had a date for when they should be changed, and all were within the date range.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE such as disposable gloves and aprons were readily available in all clinical areas and staff used them correctly. We observed staff complying with the trust's policy of 'bare below the elbow'.

Surgery

During the Covid19 pandemic the monthly audits for hand hygiene were suspended. Managers told us the audit programme was reinstated in July 2021. Staff told us during the pandemic there were visual spot audits undertaken in clinical areas with immediate staff feedback being given for any areas of concern. Trust data showed that for the month of July hand hygiene audits for all surgical wards were 100% compliant.

COVID-19 precautions were effective in all areas we visited. Hand sanitiser and masks were freely available, and, at the hospital's entrances, staff ensured visitors complied with the precautions.

Patient pathways had been streamlined. The trust had a COVID-19 free green pathway for patients undergoing elective surgery. Patients on a green ward were required to have a negative COVID-19 swab test and self-isolate for 72-hours prior to surgery. Staff in the Basildon Day Unit and the green wards were asked to sign in, complete a COVID-19 questionnaire and have their temperature taken.

Face masks were worn by staff in line with COVID-19 guidance. However, we observed that during handover on Bulphan ward, three nurses had to be asked by the nurse in charge to put their face masks on properly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean' stickers were appropriately used on equipment throughout the service.

There were signs on doors stating the number of people who could be in a room at one time to comply with social distancing precautions. Appropriate isolation facilities were available for patients with a suspected infectious disease.

Staff worked effectively to prevent, identify and treat surgical site infections. Surgical site infections surveillance was paused nationally due to the pandemic and was expected to recommence later in the year.

All staff completed Infection Prevention and Control training. Data provided by the trust showed that the overall compliance rate was 80%. For nursing staff, the compliance rate was 90%.

Environment and equipment

The design, maintenance and use of facilities, and premises kept people safe. Staff were trained to use equipment, but equipment was not always maintained in all areas we visited. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed that call bells were within easy reach for patients and those we spoke with confirmed that staff arrived quickly when needed.

The design of the environment followed national guidance.

Wards we visited had enough space around the bed space for staff and equipment. Wards were well-maintained and in a good state of repair. There were single side rooms available on most wards, with priority given to patients who were at the end of their lives or needed to be isolated because of infection.

The environment had been planned to accommodate patients who entered the green pathway to avoid going through other parts of the hospital where there were potential COVID-19 risks. For example, Horndon Ward was an 'ultra-green' elective orthopaedic ward. It had its own lifts and direct access from the carpark. The Basildon Day unit (BDU), had a separate entrance and day surgery patients were asked to phone when they were in the parking bay to come in for a temperature check and to complete a COVID-19 questionnaire.

Horndon Ward had a room where a portable X-ray machine was used. A risk assessment had been completed detailing requirements. However, when we visited this ward, we noted the warning signage that detailed risks and specified it was a controlled area was not displayed. We escalated our concerns; this was rectified, and assurances provided.

Staff carried out daily safety checks of specialist equipment.

Resuscitation equipment was readily available in all surgical areas and theatres. A difficult airway trolley was also available in theatres and Chelmer Ward. The resuscitation trolleys were safely secured with tamper proof seals and records showed that staff conducted daily checks in line with the trust policy. In all wards we visited we observed that resuscitation trolleys had been checked again after being used.

Most equipment had been tested annually as per safety test recommendations. However, on Laindon Ward, out of five pieces of equipment checked, one (suction) was due August 2020 and in Basildon Day Unit (BDU) out of three pieces of equipment checked, one (ECG) was due February 2020.

We checked 18 other pieces of equipment and all had been appropriately tested and were within their service date.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Appropriate facilities were in place for storage and disposal of household and clinical waste, including 'sharps'. A 'sharps' bin is a container that can be filled with used medical needles and all categories of 'sharps' waste, before being disposed of safely. 'Sharps' bins we observed were appropriately labelled and stored correctly.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and removed or minimised risks.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff used the national early warning score system (NEWS2). An early warning score is a guide used by staff to quickly determine the severity of illness of a patient. We reviewed 13 sets of patient records and found NEWS2 was recorded appropriately in all of the records. Audits had been suspended during the pandemic but re-started in July 2021. There was 100% compliance for NEWS2 scoring, however there were areas of non-compliance with the timeliness of observations, actions had been identified to address this.

There was process in place to escalate and manage the care of deteriorating patients. The critical care outreach team provided services to patients outside the critical care unit supported by the trust wide deteriorating patient policy. The critical care outreach team visited patients who had recently been discharged from the critical care area and surgical patients on wards to help with interventions to stabilise them and prevent them becoming more ill.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Surgery

Nursing staff recorded the levels of risk during pre-assessment and on admission the risks for surgery were recorded by the anaesthetist. Medical and nursing staff completed risk assessments when patients were admitted for surgery. The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient's level of risk whilst undergoing surgery. For example, ASA 1 was low risk. Nursing staff recorded the levels of risk during pre-assessment and on admission the risks for surgery were recorded by the anaesthetist.

Nursing staff used nationally recognised tools to assess patient's risk of developing for example, pressure ulcers, nutritional risks, falls as well as risks associated with moving and handling. However, on Bulphan Ward, two patients had bed rails up, but their falls risk assessments stated that bed rails were not to be used. We also found that two patients on the Cardio Thoracic Centre (Chelmer ward) had bed rails up, but there were no risk assessments completed.

Following our inspection, a trust-wide audit was undertaken to review gaps in risk assessments, including bed rails over five days. The results showed non-compliance with risk assessments for bed rails for three days on Bulphan Ward, two days on Laindon, Linford and Katherine Monk Wards and one day on surgical referral unit (SRU). Remedial actions were put in place, daily checks were also instigated to ensure that appropriate risk assessments were undertaken.

Staff knew about and dealt with any specific risk issues.

NICE guidance (NG89) Venous thromboembolism in over 16s: reducing the risk of hospital acquired deep vein thrombosis or pulmonary embolism March 2018 states that all surgical and trauma patients should be assessed to identify the risk of venous thromboembolism (VTE) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. Reassessments for VTE and bleeding should be at the point of consultant review or if their clinical condition changes. In 11 of the 13 records we reviewed, VTE risk assessment had been completed appropriately however two patients' VTE assessment was incomplete.

The service audited the patients having a VTE assessment and reported on them in the monthly quality performance dashboard. We reviewed the data from February 2021 to June 2021 and found that the target of 95% was not being met in division 4, trauma and orthopaedics where compliance for February, March and April was below 90% and for May it was 73%. In division 5, general surgery, compliance was not being met consistently with only May meeting the target.

Staff used a deteriorating care bundle for the management of patients with presumed/confirmed sepsis and acute kidney injury.

The service ensured compliance with the five steps to safer surgery, World Health Organisation (WHO) surgical checklist including marking of the surgical site. We observed WHO checks and found they were completed appropriately. The service monitored compliance through a record and observational audit. For main theatres, quarter one 2021/22, there were two areas of non-compliance where staff were not ensuring the agreed sample size of 15 procedures to be audited and the anaesthetic sign off had not been verbalised as per WHO processes. In Cardiothoracic theatres the audit for the same period showed target compliance.

Theatres had a register for traceability and audit trail for patient implants which included breasts, hips and vascular. We observed theatre processes and saw robust processes in place.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

A member of the mental health team would come to complete an assessment of a patient when required and were available over the phone for support. However, it was not always possible to have a mental health nurse on the ward to provide one to one care if a patient needed it.

Staff shared key information to keep patients safe when handing over their care to others and

shift changes and handovers included all necessary key information to keep patients safe.

We observed staff handovers on Bulphan Ward and Linford Ward. Situation, background, assessment, recommendation (SBAR) tool was used. The night nurse responsible for each bay gave a summary of each patient, this included all necessary key information to keep patients safe, highlighting any concerns such as incidents or new admissions overnight.

Harm reviews of patients on waiting lists were completed in each clinical specialty by consultants. This process aimed to minimise the risk to patients waiting for procedures and to ensure that patients were treated in line with clinical risk.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience. However, this risk was mitigated to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough nursing and support staff to keep patients safe.

The ward manager could adjust staffing levels daily according to the needs of patients.

A staffing acuity tool was in use and nurse controllers could move staff across clinical areas if staffing was highlighted as at risk.

There were regular staffing review meetings held throughout the day where staffing numbers were reviewed, and staff were allocated to support areas that were short staffed to best meet patient need and mitigate risk to patients. Staffing issues were escalated daily but on Linford Ward staff told us they did not always get help and the ward manager had been working on the ward. If patients required one to one care, this was initially provided by staff who were included in the existing staff numbers. This was also the case on the Surgical Referral Unit (SRU) where they often had more than one patient who required one to one care. The SRU came under surgery previously and would help other wards or receive support from them if needed. They had recently changed to come under the emergency department. Staff told us that this had improved flow but meant they could no longer get staff from surgical teams to cover staff shortage.

The number of nurses and support staff did not always match the planned numbers.

Most of the wards we visited during our inspection did not have enough staff to maintain patient safety and support. Data provided by the trust for April, May and June 2021 showed that all wards, apart from Katherine Monk Ward, were short staffed. However, the figures were improving across all wards apart from Laindon Ward.

Staffing was also a challenge in theatres. Operating Department Practitioners numbers in particular were worse since the pandemic. Agency staff were being used as substantive staff were allocated to the Vanguard theatre. Recruitment was discussed at weekly theatre meetings. There were two daily theatre staffing meeting held across the three trust sites. Staffing numbers were reviewed, and elective theatre list were reviewed to ensure that staffing levels were safe to carry out planned surgery lists. Where necessary lists were merged and in some cases patients' surgery was cancelled.

The staff vacancy rate was 21.70% for qualified nursing staff in surgery. This was above the trust target of 11.5%. However, the trust was taking actions to address the high rate of vacancy through various initiatives including apprenticeships, nursing associate training, student nurses, recruiting from grass roots in the local community and schools. The turnover rate for the previous 12 months was 9.35% for qualified nursing staff in surgery, which was under the trust target of 12%.

The sickness rates were 1.03% for qualified nursing staff in surgery against the trust target of 3.5%.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

On Linford Ward agency staff were used to mitigate the shortfall of staff, however, these were staff known to the trust and were familiar with the ward. Staff rotated between the Basildon day unit (BDU) and pre-assessment unit. If they were short staffed in pre-assessment, staff from the ward would be moved to cover and bank staff would be sent to the ward areas. Recruitment was in progress with a number of wards and theatres expecting new starters in August and September.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience. However, the risk was mitigated to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had consultants available 24 hours per day with and on call service at night and weekends. Patients admitted would be seen within 12 hours by a consultant and prioritised according to clinical presentation. The service did not have enough medical staff. However, the risk was mitigated to keep patients safe with the use of long-term locum staff where possible.

The vacancy rates were 6.6% for medical staff in surgery which was below the target of 11.5%

The turnover rates for the previous 12 months were 8.5% for medical staff in surgery.

Sickness rates were reported as 0% for medical staff in surgery. However, this did not reflect what we were told by doctors during inspection.

The service used locum staff. Managers could access locums when they needed additional medical staff. Managers told us that there was a focus within the trust to recruit more substantive medical staff to reduce locum use.

Managers told us that locum staff received full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Surgery

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

Patient notes were a mix of electronic and paper records. Pre-admission, theatre and recovery notes were paper based, and the ward used a mixture of paper and electronic notes. Once a patient has been discharged home all paper records were scanned and made accessible on the electronic records system. We reviewed 13 sets of nursing and medical records. They included details of a patient's admission, risk assessments, pre-assessment forms and treatment plans.

Electronic records were stored securely. Paper records were kept in lockable trolleys next to the nurses' station. There was password protected electronic tablets where patients' risk assessments and NEWS2 scores were stored.

During our inspection we found some inconsistencies with access to electronic records. For example, staff could not always find risk assessments on the electronic system in a timely way.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not always stored in line with policies and procedures.

Staff followed systems and processes when safely prescribing, administering and recording medicines.

Medicine storage rooms had suitable preparation facilities for all types of medicines such as controlled drugs and antibiotics. Controlled drugs are prescribed medicines used to treat severe pain, induce anaesthesia, in end of life care or treat drug dependence. However, some people abuse them by taking them when there is no clinical reason to do so or divert them for other purposes. For these reasons, there are legislative controls around their use. Our review of documentation and observations confirmed that controlled drugs were stored in line with legislation and national guidance. This included daily checks by two registered nurses.

Checks completed showed all medicines were within the expiry date.

Staff stored and managed medicines and prescribing documents in line with the provider's policy in most of the areas we visited. At the time of our inspection the medicine cupboards in Bulphan Ward treatment room had locks that were broken. Managers told us that this was reported and waiting to be fixed. The treatment room door was secure with access only to authorised staff.

On most wards we inspected, the temperature checks for the medicine fridges were undertaken by the ward teams and were found to be within the expected range. However, on Bulphan ward we saw that some fridge temperature records were missing for 1 to 4 May, 10 May, 9 to 22 June and 25 to 26 June 2021. Staff had recorded that the thermometer was not working in June however there was no record of what action had been taken. We escalated this to the matron.

We reviewed a total of six medicine administration records and found them to be complete with relevant information and up to date. For example, any known allergies or sensitivities to medicines were recorded on all medicine charts seen.

Surgery

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The trust used an electronic reporting system which had recently been standardised across all three sites.

Staff raised concerns and reported incidents and near misses in line with trust policy.

The trust had nine never events across the three sites and five of these were at the Basildon site between September and November 2020. Three were wrong site surgery in dermatology, two were retained foreign objects; one in the cardiothoracic centre (CTC) and one in orthopaedic surgery. We reviewed the investigation reports into these never events and the actions taken. The action plan had actions assigned to individual staff members and was reviewed regularly to ensure the actions have been implemented.

Managers shared learning about never events and serious incidents with their staff and across the trust in line with trust policy.

There was a governance newsletter to share information about never events and serious incidents with staff. messaging app group established during COVID-19 was used to share immediate information and learning from never events and serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Some staff we asked were aware of duty of candour. We saw evidence that duty of candour was applied appropriately to the serious incidents we reviewed.

Staff received feedback from investigation of incidents, both internal and external to the service.

To ensure lessons were learnt from incidents, staff received incident investigation feedback by email, including those that had occurred in other areas. They were also discussed at team meetings, but these were not held as often during the pandemic. Incidents were mentioned at handovers and on Linford Ward we were told information would be put on the staff noticeboard to ensure bank and agency staff were aware.

All staff we spoke with in theatres were aware of the never events that had occurred and the actions that had been implemented. For example, the world health organisation (WHO) checklist and policy were to be standardised across the trust.

Staff met to discuss the feedback and look at improvements to patient care. A learning event around ‘stop before you block’ had been held following the most recent never events at another site.

Surgery

There was evidence that changes had been made as a result of feedback. Following an incident where there had been a delay in a specimen being sent for histology, due to the surgeon completing relevant paperwork, there had been a review and update of the policy.

"Topic of the Month" was brought in following an incident at Southend site to highlight learnings from incidents across the trust. This was shared with staff through various means, including emails, handovers, staff noticeboards and team meetings.

Is the service effective?

Good

Following the merger of the trust in April 2020 Basildon University Hospital surgical service did not have a previous rating. At this inspection we rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance.

The service was in the process of standardising all polices, guidance and procedures across the trust in line with the merger in April 2020. The standardisation process was delayed due to the pandemic and senior leaders told us there was some guidance past their review date. For example, all pre-assessment guidance was due for review in 2019. The trust had a target to complete all standardisation work by December 2021.

The service updated guidance and policies in line with NICE guidance. For example, we saw that pathways followed NG180 (perioperative care in adults). The service had National safety standards for invasive procedures guidance in place (NatSSIPs) and adapted these for local practice (LocSIPs).

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients confirmed this and told us the choice and quality of the food had been very good.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All patient records we reviewed had nutritional status assessed within 24 hours of admission using the malnutrition universal screening tool (MUST). Staff assessed patient's nutrition and hydration needs using the MUST tool. This was in line with NICE guidance QS15 Statement 10: "Physical and psychological needs" 2012.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. MUST assessments were fully completed and updated in the records we looked at across all wards visited.

Specialist support from staff such as dietitians and speech and language therapists (SALT) was available for patients who needed it. Staff on the cardiothoracic centre (CTC) told us that SALT would visit daily when referred.

If a patient required support with eating and drinking this was communicated at handover. Domestic staff were informed if there was anything they needed to know about the patients and there was also information above the bed if, for example, a patient was at risk of choking.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients waiting for surgery were kept "nil by mouth" in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Staff followed guidance from the Royal College of Anaesthesia, raising the standards (2012), and offered specially formulated drinks to patients up to two hours before surgery to ensure optimisation of energy (calories) and fluid before surgery.

We attended the elective surgical pre-assessment clinic and staff confirmed they gave patients clear instructions about fasting before admission. Information was given to patients both verbally and in writing. For example, patients were told not to eat for six to eight hours before a general anaesthetic and were encouraged to drink sips of water up to two hours before a surgical procedure. Staff confirmed patients would be encouraged to drink when ready, providing there were no contraindications.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a nationally recognised tool and gave pain relief in line with individual needs and best practice. Staff had access to tools to help assess the level of pain in patients who were non-verbal, living with dementia or who had complex communication needs.

Patients received pain relief soon after requesting it. Patients told us that staff tended to offer pain relief without them having to ask. There was a dedicated pain team to support patients who were cared for on the surgical wards. In addition, an anaesthetist was accessible for pain management advice out of hours.

Staff prescribed, administered and recorded pain relief accurately. Staff chose appropriate pain relief using the 'pain hierarchy' (starting with common medicines and moving to more powerful medicines some of which were controlled medicines). Commonly used painkillers were prescribed routinely but if these were not effective, they could ask the pain team for advice and additional medicines to be prescribed to ensure patients were pain free and comfortable.

Patient outcomes

Surgery

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits and produced action plans from the results. We reviewed national audit results and the trust action plans. For the National Prostate Cancer Audit 2020, the trust performed better compared to the 2019 report for men with complete information to determine disease status. The trust had a percentage of 92.7% in 2020 compared to 88.7% in 2019. This was better than the England average of 91.5% however, was below the national standard for the metric.

The National Hip Fracture Database 2020 showed that Basildon University Hospital was in the bottom 25% of hospitals for two metrics: case ascertainment and crude proportion of patients having surgery on the day or day after admission. The hospital was in the middle 50% for the three other metrics and was worse than expected for risk-adjusted 30-day mortality rate with 9% compared to the England average of 6.1%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an ongoing local audit programme with action plans. Although during the Covid-19 pandemic, some local audit programmes were suspended as staff were pulled into clinical roles. At the time of the inspection senior leaders told us that local audit programme was in progress, and we saw evidence of this.

Managers shared and made sure staff understood information from the audits. Audit results were shared by email and discussed at monthly meetings.

Competent staff

The service made sure staff were competent for their roles. However, not all staff had received an appraisal in the last 12 months.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

New starters process included the trust induction. New staff were given a competency booklet, assigned a mentor, and worked supernumerary. Inductions were completed and staff competencies were assessed and signed off.

Managers did not always support staff to develop through yearly, constructive appraisals of their work.

The appraisal completion rate was 61.7% against a target of 90%. Managers told us the ability to complete appraisals had been affected by the pandemic with staff redeployed throughout the hospital. There was an action plan in place to ensure staff appraisals were completed.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Data provided by the trust showed that all medical staff that required revalidation were up to date.

The clinical educators supported the learning and development needs of staff. They attended staff meetings to provide face to face training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Team meetings were held in some wards, but had been less frequent during the pandemic, partly because staff had been moved to work in other areas. When meetings were held, they were minuted. Agendas included a "hot topic" from the management team. Staff were able to bring their own agenda items. Other items included learning from complaints and incidents.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, a study day had been held in the cardiothoracic centre (CTC) where recovery was set up as an operating theatre with a mannequin, instruments, and fake blood. Managers told us that this was well attended.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, the trust funded apprenticeships for operating department practitioners (ODPs). In the CTC a band 7 had been funded to complete a top up degree course.

Managers made sure staff received any specialist training for their role. However, during the pandemic, patients from different specialties were being treated on wards and staff did not always feel they had the relevant competencies. However, staff on the ward also told us that they would be supported by specialist teams for example staff from the gynaecology emergency unit.

The trust had link nurses for various specialties on each surgical ward. However, during the Covid-19 pandemic, the link nurses had not been able to have their regular meetings. Managers told us that this was an area that would be reviewed. There were some links nurses in some areas we visited. For example, in pre-assessment there were leads for health and safety and infection prevention and control (IPC). In the surgical referral unit (SRU) there was a safeguarding champion and a falls link nurse.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary team meetings to discuss patients and improve their care.

Meetings we observed were well attended and were focused on a multidisciplinary team approach to meeting patients' needs. They included input from physiotherapists, occupational therapists and the discharge co-ordinator. Horndon ward had physiotherapists based there. The physiotherapists prioritised patients immediately post-surgery and then those who were ready for discharge.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Discussion during handover and ward rounds included patient requirements prior to discharge such as care packages, referrals to district nurses or other community services. On Horndon Ward they had a Community Orthopaedic Mobility Basildon and Thurrock (COMBAT) team, who visited patients in the community for two weeks after discharge. If the patient needed longer, they would be referred on to the community orthopaedic team.

CTC had a huddle every morning with the other intensive treatment units (ITUs) across the trust to discuss capacity and escalate issues to gold command.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Surgery

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway, this included surgical outlier patients.

Acute and emergency services were available seven days a week. The surgical services provided consultant cover on site seven days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Input was available from the Speech and Language Therapy (SALT) team, pharmacy, physiotherapy, occupational therapy, specialist palliative care team as well as other specialities such as tissue viability or diabetes nurses. There was support from these services at weekends and on call out of hours.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Health promotion information and materials was available on the wards. Examples included eating a healthy diet, moderating your alcohol intake, increasing your physical activity, and smoking cessation.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The pre-assessment clinic provided patients with information on how they could promote their fitness before their procedure. Staff reminded patients of the importance of eating a balanced diet and quitting smoking.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty; however, mental capacity assessments were not always clearly identified in patients notes.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, the Mental Health Act 1983, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were not included as part of mandatory training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance Staff understood their responsibilities and the procedures in place to obtain consent from patients before undertaking surgical procedures. This was in line with the consent for examination and treatment policy which gave clear guidance for staff. We saw completed and signed forms for treatment and exploratory investigation during the inspection.

Surgery

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Medical and nursing staff we spoke with explained the consent procedures and what to do if a person lacked capacity to consent to care and treatment. They could outline the principles of the MCA and the implications for their practice

We reviewed the record of a patient who had a best interest decision made and found the relevant Mental Capacity Assessment (MCA) documented included discussion with the patient's next of kin. A Deprivation of Liberty Safeguarding (DOLS) application had been made and was in date.

In another case, we found a patient wearing mittens. Mittens were used to stop patients from pulling out any lines or tubes used to give medicine, fluid or nutrition. Staff had been advised at handover from ITU that the process had been completed prior to the patient arriving on their ward. However, we could not find any documentation to evidence the completion of MCA.

Staff clearly recorded consent in the patients' records. In all the records we reviewed, consent forms had been signed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Following the merger of the trust in April 2020 Basildon University Hospital surgical service did not have a previous rating. At this inspection we rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Patients we spoke with described staff as kind and friendly. One told us they were "really pleased with care given" and another said staff were "very helpful, polite and comforting. Can always go to them, day or night".

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Surgery

On Linford Ward, staff told us how they supported a patient to keep in touch with their partner who was on another ward. They couldn't visit each other as one was on an amber ward and the other was on a green ward. Staff organised regular phone calls for the patient on Linford Ward to speak to their partner.

Patients were allowed one continuous visitor, unless they were at the end of their life in which case, they would be cared for in a side room and were allowed more visitors. The Dandelion symbol was displayed when someone nearby was receiving end of life care, to remind visitors to be respectful and mindful of noise.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients said that staff were approachable and provided support when required. Patients were able to receive support to help them cope emotionally with their care and treatment. One patient told us they were very upset, having been rushed into the hospital and found the staff comforting.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

We observed staff caring for a patient with vascular dementia. The staff supported them to maintain their dignity when they got undressed in the corridor and encouraged them to go back to their room.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Additional support was given to patients if they had their procedure cancelled, having been cancelled before. On Horndon Ward, they tried to prioritise one patient who had arranged care for her husband for the procedure.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

All patients we spoke with told us they could ask questions and that staff were happy to keep explaining if they were unsure.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients could provide feedback to the service using the Friends and family test (FFT). Patients were encouraged to give feedback through a QR code which was displayed on wards.

Data from July FFT showed a mixed response with four surgical wards scoring above 90% for overall positive comments. Two wards, Katherine Monk and the Surgical Referral Unit scored 71% and 81% respectively. Linford Ward scored 67%.

Patients gave positive feedback about the service.

Surgery

All patients we spoke with gave positive feedback of their experience. We saw numerous thank you cards on the Linford Ward with comments including: “Thank you for all your help in getting me back on my feet” and “Thank you for taking care of me”.

Is the service responsive?

Requires Improvement

Following the merger of the trust in April 2020 Basildon University Hospital surgical service did not have a previous rating. At this inspection we rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service was arranged into specialties and the senior management team of each specialty had oversight of the entire patient pathway. The trust was undergoing a clinical reconfiguration programme which was planned as part of the integrated care system to provide services in specialist centres.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. During the reporting period no mixed sex breaches were reported.

Facilities and premises were appropriate for the services being delivered. Patients who required a higher level of care were referred to the high dependency or intensive therapy units. If the need for additional care was known prior to the patient operation, a bed was booked in advance, and staff worked collaboratively with the critical care team to ensure that patients were cared for in the most appropriate location according to the patient's condition.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, in the Basildon Day Unit (BDU) magnetic symbols were used on the white board to indicate to staff patients who might require specific support. This included patients living with dementia, at risk of falls and those living with other disabilities.

The service relieved pressure on other departments when they could treat patients in a day.

Managers told that where possible the service ensured that patients were admitted as day surgery cases.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Surgery

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs.

Double appointments were made for pre-assessment for patients living with dementia, learning disability or other complex needs. Patients living with a learning disability would also be accompanied by a learning disability nurse from the trust.

Wards were designed to meet the needs of patients living with dementia. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. On the ward's patient passports were used to support and encourage patient tailored reasonable adjustments when patients with learning disabilities attended the hospital. Electronic patient records flagged up alerts for staff to identify when reasonable adjustments were required. On the surgical referral unit (SRU) and other wards we visited they had a trolley with activities to be used by patients living with dementia. This included therapy dolls and robotic therapy pets.

There were dementia specialists across the trust who could provide support if required. On the SRU, healthcare assistant (HCA) staff would provide one to one care on a two-hourly rota basis.

Clinical nurse specialists, such as stoma care nurses, breast care nurses, urology nurses, palliative care team, vascular care nurses, nurses and diabetes nurses were available to provide additional support to patients in times of need.

To reduce the risk of potential exposure to COVID-19 for elective orthopaedic patients, on Horndon Ward a side room was assessed and agreed to be a dedicated space for portable imaging. This avoided transferring patients to the main imaging department.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Translation requirements were identified at pre-assessment. Double appointments were made to allow time for this. Staff on wards had access to booking interpreters when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff recorded patient's food needs and preferences on patient menus and on patient whiteboards at the bedside.

Patients told us that a choice of meals was available.

Access and flow

People could mostly access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times. However, patients could not always access services when needed or receive treatment within agreed timeframes and national targets.

The referral to treatment times (RTT) had been affected by the COVID-19 pandemic. Data from May 2021 showed there were 32,552 new referrals across the trust.

The percentage of patients treated within 18 weeks at the trust had been relatively stable at around 80% since January 2021.

Surgery

The percentage of patients treated in 52+ weeks had been gradually increasing since February 2021 (5.3% in May 2021). As a result, the percentage of people waiting over 52 weeks as a proportion of all waits decreased further in May 2021 after peaking at 9.2% in February 2021.

The trust was performing better than the regional and national averages for percentage of patients treated in 18 weeks (East of England 74.9% and England 74.3%).

Managers and staff worked to make sure patients did not stay longer than they needed to.

The trust had been outsourcing to the independent sector for Ear, Nose and Throat (ENT) and General Surgery. There was a recovery plan in the timeliness of treatment for most specialties.

52-week waits had declined for all specialties aligned to the surgical core service except for the Cardiothoracic Service. The percentage of 52+ week waits had increased substantially in January 2021 as more than 20 people were waiting 52 weeks (previously it had been below six weeks). As of May 2021, there were 31 patients waiting 52+ weeks.

For trauma and orthopaedics, the percentage of patients treated within 18 weeks was 75.7%. For urology it was 76.6%.

The trust had not been meeting their targets for 62 day waits. The backlog total was 269 patients as at 27th June 2021 against a trajectory of 216. The backlog for the Basildon site was 56 patients. The Trust had set a target to reduce the backlog to 163 by September 2021.

In June 2021, backlog by tumour site stated that there were more people waiting over 104 days for Urology than any other service (19 patients) at the trust.

The trust did not meet any of the national standards for cancer waits in May 2021. The trust performed second worst in the east of England region for treatment within 30 days (87.6% compared to 96%) and for 62 days they achieved 61% against a target of 85%. 86.7% of patients were seen within two weeks against a national target of 93%.

Managers worked to keep the number of cancelled appointments/ treatments/ operations to a minimum. Staff worked collaboratively to ensure theatre optimisation across the three sites. Staff reported that at theatre planning meetings they reviewed the schedule for elective patients and where necessary cancelled patients in advance to avoid on the day cancellations.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient had not been treated within 28 days of a last-minute cancellation, then this was recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Data from April to June 2021 showed the number of cancelled operations had increased from 28 in April to 89 in June. The percentage of operations that were not rescheduled within 28 days had also increased from 17.9% in April to 32.6% in June.

Surgery

At the time of inspection, two elective theatre lists had been cancelled when patients who were on the amber COVID-19 pathway were inappropriately placed on Horndon Ward, which was an ultra-green ward. This meant the ward could not be at full capacity until the amber patients had been discharged or relocated to appropriate beds.

Staff told us the high acuity of patients admitted through the emergency pathway led to the increase number of last-minute cancellations.

The service moved patients only when there was a clear medical reason or in their best interest. Moves were made due to patient's COVID-19 status. Staff told us they tried to minimise the number of moves, however the time requirement to receive the test result had an impact on the number of moves. For example, the average length of stay on the surgical referral unit (SRU) was 72 hours. During our inspection, there was one patient who had been there for two weeks as a result of being exposed to COVID-19 on the ward and needing to isolate.

Managers and staff worked to make sure that they started discharge planning as early as possible. The discharge planning process started on admission on most wards, patients were given an estimated date of discharge. All the surgical wards undertook daily multi-disciplinary board rounds, when updates to patient's medical conditions and plans for discharge were communicated

Senior staff met daily to discuss complex patients awaiting discharge. Each patient was reviewed, and a plan agreed for the next steps to move the patient towards discharge. There were processes in place to manage complex discharges. Patients on admission were informed by staff of their expected date of discharge. Ward staff discussed at their daily board meeting, handover and safety huddles what assistance they had identified to overcome any possible delays that prevented the patient discharge plan. Senior staff worked to ensure there were no avoidable treatment or discharge delays, for example waiting for x -rays or packages of care.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Staff understood the policy on complaints and knew how to handle them. Staff told us that they would tell their manager if a patient wanted to make a complaint and/or refer them to Patient Advice Liaison Service (PALS).

Managers investigated complaints and identified themes. Complaints were a regular agenda item on clinical governance and ward meetings. The service received 48 complaints from August 2020 to March 2021. The majority of concerns were around treatment and care, although there were some concerns around delays in treatment, staff attitude and communication.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us they would contact the patient to explain if a complaint was received.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared by email and discussed at handovers and ward meetings.

The trust reported 409 complaints from August 2020 to July 2021, across all services. The response rate was recorded as between 40 to 61% within the trusts timeline.

Surgery

Is the service well-led?

Requires Improvement

Following the merger of the trust in April 2020 Basildon University Hospital surgical service did not have a previous rating. At this inspection we rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff.

Since the hospital merged with Southend and Broomfield hospitals there was one executive team responsible for the three hospitals. There was also a leadership team on each site, which consisted of a managing director, medical director, operational director and director of nursing. Some staff we spoke with said that since the merger, executive leaders were less visible, and this was because they could be based across the other hospital sites.

The trust managed services through care groups. Surgical services were managed through two care groups; care group one, which included critical care, cardio thoracic centre (CTC), vascular and cardiology and care group two which included trauma and orthopaedics, general surgery, theatres and anaesthetics. Each care group was led by clinical leads. The leads were supported by teams of divisional and operational managers, matrons, ward and theatre managers.

Ward managers, supported by matrons, provided local leadership on each ward. Staff described matrons and the ward managers as visible, approachable and supportive. Ward managers told us they felt supported by the matrons. Staff, in most cases, were able to tell us who the senior management team were and could describe instances when they had visited wards/department.

Leaders understood the challenges to quality and sustainability and could identify the actions being taken to address them. Staff told us, and we saw during our inspection, that matrons and the surgery associate director of nursing were visible on the wards. Matrons attended trust wide bed occupancy and staff briefings three times daily to discuss nurse staffing to ensure safe numbers of staff for the acuity of patients. There was daily oversight of staffing issues, which were reviewed and mostly mitigated.

Daily theatre meetings were held where they discussed staffing, lists and potential cancellations. There was a weekly theatre oversight group that looked back at theatre lists. Theatre managers across the trust met monthly.

Leaders regularly met across the three sites to identify and discuss concerns and issues such as mandatory training for prioritisation.

Medical and nursing staff understood management reporting structures and told us they were supported by their managers.

Vision and Strategy

Surgery

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress.

There was a trust strategy with objectives to achieve their ambition: "to improve health and wellbeing through excellent, financially sustainable services, provided by staff supported to develop, innovate and build rewarding careers". Senior leaders told us that following the merger of the trust, the overall aim of the surgical services was to come together as one service delivered from three sites.

The service strategy was part of the clinical reconfiguration model which was aligned to the Mid and south Essex Health and Care Partnership five-year strategy and delivery plan. The clinical reconfiguration of services started in 2019/20 and the changes were phased over three years.

The service's quality goals and targets had been developed to ensure they met the trust's clinical strategy which aimed to create specialist centres of excellence and sustain excellent, reliable local care, to improve patient's outcomes, reduce harm, improve patient's pathways and make a better working environment for staff. The goals and domains were incorporated into the performance dashboard, which tracked activity from ward to board.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers and ward staff told us that it had been a challenging 18 months due to the pandemic and staffing levels. Several surgical areas had been suspended during the pandemic and staff redeployed to support workloads in other areas. This had affected morale among staff.

Staff described a positive relationship described between ward staff and theatres. Teams in all areas told us they worked well together. Staff had supported those struggling with the impact of COVID-19.

The trust had arrangements in place to support staff's mental and physical health. Senior leaders recognised the strain on staff wellbeing during the pandemic and put a number of initiatives including health and wellbeing hubs in all sites which were designed as spaces for staff on the frontline to take a break. The trust also provided staff with counselling support and a number of resources for lifestyle support to improve health and wellbeing of staff.

Staff told us there was good teamwork within the teams and we observed this during our inspection. Staff worked together to resolve issues and worked flexibly to accommodate service needs. Staff told us and we saw that the whole team worked together to provide the best care for patients.

Staff were empowered to challenge behaviour and performance that was inconsistent with the vison and values. Actions had been taken to address behaviour that was inconsistent with the vision and values and staff told us that more work was being done to support the team.

There were processes in place to provide staff with career development opportunities although this had been challenging during COVID-19. Staff had not received regular appraisals or one to one meeting with their managers but told us they felt they could approach their managers at any time if they needed to. Staff told us they felt supported to report incidents and raise any concerns to their line managers.

Each ward area had the 'Freedom to Speak up Guardian' contact details and staff were aware how and when to contact them. The role of the Freedom to Speak up guardian is to ensure that staff have the capability to speak up effectively and are supported appropriately.

Senior leaders highly praised staff and recognised the challenges staff faced especially during the covid-19 pandemic.

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, governance processes were not fully embedded.

Governance systems were in place to support the functions of services across the three locations of the trust in surgery, but these were yet to be fully embedded across all divisions. Monthly meetings were conducted to allow oversight of the service which fed into divisional governance meetings. Clinical governance meetings had a set agenda and meeting minutes showed that this was followed.

There was an effective process to escalate outcomes to the trust board through the appropriate committees.

Leaders told us there was a process to share governance outcomes and updates with staff at monthly staff meetings. However, during the pandemic, these meetings were not regularly held. In the minutes that we reviewed, governance processes such as incidents, complaints and mandatory training were standard agenda items.

There was an audit programme to support the hospital to ensure patient safety. This had been suspended during the pandemic but had recommenced again in July 2021. We saw that wards completed these audits around areas such as hand hygiene and cleanliness.

Senior managers told us that incidents, near misses and complaints were monitored for trends and improvements via action plans. Staff we spoke with were aware of serious incidents and complaints in their clinical areas.

Staff of all grades were clear about their roles and what they were accountable for and to whom.

The surgical service had Multi-Disciplinary Team Meetings (MDTs) with an established governance structure and a clinical governance lead. The trust provided us with information demonstrating how they had implemented recommendations from a review by the Royal College of Surgeons to strengthen their MDT meetings and Mortality and Morbidity (MM) meetings by ensuring the terms of references and membership reflected best practice. We saw evidence of the newly structured MDT and M&M agenda and minutes which showed they were all well attended.

The service had a process for monitoring patients who were waiting for surgical procedures. Each division had a waiting list and every patient on the list was discussed weekly to identify any requirements to admit the patient for the planned procedure. The service reported waiting times and plans to reduce them to the trust board. Patients that met the criteria to be referred to the independent health service pathway were reviewed at the MDT meetings. There were appropriate arrangements with partners and third-party providers under service level agreements to govern and manage interaction and promote coordinated, person-centred care.

Surgery

The service used the Get It Right First Time (GIRFT) process to monitor actions to improve the service. The service had a GIRFT action plan which detailed areas for improvement identified with red, amber, green ratings for progress against target date.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, there were repeated never events within the service with similar themes.

There had been nine never events within surgical services, which had similar themes. Five of which had occurred at Basildon Hospital. We were concerned that despite action plans and learning, there were repeated failures to prevent never events from occurring. The survey we conducted as part of this inspection showed that there were a number of staff concerned about the sharing of learning from incidents across sites.

Surgery had a risk register. Each risk was rated, included details of the actions taken to mitigate it and a review date. The risk register was reviewed and updated at the clinical governance meetings. Service risks sat within the division responsible for the service. The top risk identified by leaders was staffing. They were working with local universities and the community to recruit students to the trust. Other risks identified by the leadership team were capacity and ageing equipment in some areas of the services.

The service had a quality assurance dashboard report which included the top risks by division. The senior management team were aware of the procedure to escalate any of the risk to the trust risk register so that the trust board were aware of this and the mitigations they had.

The service had effective systems for monitoring and managing performance. The surgical services used a comprehensive quality assurance dashboard report to monitor performance information such as waiting time to referral, theatre utilisation, length of stay (LOS) and unexpected returns to theatre. The dashboard allowed the service managers to compare performance over time and against targets and seek ways in which to improve.

There were effective processes in place to monitor patients waiting for surgery and performance against the post COVID-19 recovery plan. A patient tracking list was in place, and this was reviewed at weekly meetings. Clinical urgency was reviewed by clinical specialists to ensure that patients were prioritised in line with clinical need. Senior leaders told us that capacity issues were addressed by effectively utilising independent health providers and the vanguard theatres across all three sites.

There were processes in place to give leaders oversight of patients waiting for appointments and RTT performance and these were used to plan access for patients.

Each surgical specialty held regular mortality and morbidity meetings to share outcomes of mortality reviews. We reviewed a selection of mortality and morbidity meeting records for cardiothoracic centre and general surgery from April to June 2021. The meeting records identified learning and actions to share across the service.

Information Management

Surgery

The service mostly collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. However, staff felt that there was a lack in consistency between electronic and paper records.

The monthly quality assurance report for surgery included feedback from patients in the form of complaints and compliments These were discussed at the meetings.

Staff received training on information governance as part of their mandatory training.

Information was shared with staff. There were handovers throughout the day on the wards and theatre department.

Information stored electronically was secure. Computer access was password protected and we observed staff logging out of computer systems or hand-held devices they had completed tasks. Staff used multiple systems for recording patient care, including paper and electronic records. Staff told us they were frustrated with the lack of consistency in records.

There were arrangements to submit relevant data to national audit programmes. The trust had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements.

Staff had access to a trust intranet system which provided a range of internal and external resource material to assist staff in their daily tasks. All referrals and diagnostic requests were made electronically and staff within the department told us that they had access to the information that was needed for them to undertake their roles.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Senior managers had regular walk arounds and drop-in sessions where staff could speak to them. Managers engaged with staff using different methods, including team meetings, newsletters, email and a group messaging service app. Staff in the areas we visited told us that local leaders were visible and offered opportunities to listen and feedback to staff.

The service gathered patients' feedback and views through the friends and family test (FFT), which gathered data on whether patients or their families or carers would recommend the service to their friends or family. However, response rates were low, and managers told us that they were promoting various alternatives such as QR codes.

Cross-site working was limited. Staff told us that they were aware of plans but there had been no consultation with them yet. Senior leaders told us that this had been delayed due the pandemic, but work was under way to start staff engagement by senior leaders attending local team meetings.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Surgery

The cardiothoracic centre had been nominated for the Healthcare Services Journal 2021 staff engagement award. This was for the work they had done during the pandemic surge where the whole cardiothoracic team worked together to care for patients and for each other. As rates reduced locally the surgical team pulled together to rapidly redesign the clinical pathway and restart the surgical programme.

Surgeons in the cardiothoracic centre (CTC) developed a minimally invasive uniportal procedure to be used on patients with lung cancer. The technique meant patients had a shorter recovery time before being able to receive further chemotherapy and be fully mobile soon after the procedure. In addition, the average length of stay in hospital for this kind of treatment would be greatly reduced.

On Horndon Ward, which is an elective orthopaedic ward, there was a dedicated team (COMBAT) who could visit patients in the community post-surgery for two weeks. This reduced the inpatient stay and maintained continuity of care. If further care was needed the patient was referred to the community orthopaedic team.

The cardiothoracic centre had a dedicated hospital transfer team who managed patients on the pathway from booking through to the discharge process. This meant that patients had a dedicated point of contact throughout their treatment

Maternity

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, compliance with mandatory training was below the trust target for most topics.

Nursing and midwifery staff received and kept up-to-date with their mandatory training where possible. The trust target for mandatory training was 85%. At the trust board meeting in May 2021, it was reported that trust wide mandatory training compliance (76.6%) was and had been below the trust target for the preceding six months.

The mandatory training was comprehensive and met the needs of women and staff. Most training was completed via online training courses, however, some topics required in person training. The ability to complete training had been impacted by the need to reduce class numbers in response to social distancing for COVID-19, but also by the staffing shortages within the service.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training records were held electronically, and managers prompted staff when training was about to expire. They also allocated training sessions in person as able.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. The team worked collaboratively with the mental health team to support women.

Some staff told us that they were asked to complete mandatory training in their own time and claim time back, however, they felt that this was not acceptable, and placed additional pressures on them.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, some compliance with safeguarding training was below the trust target.

Nursing, midwifery and medical staff received training specific for their role on how to recognise and report abuse. Training compliance for safeguarding adults training level 1, was reported as being 96.13% for nursing and midwifery staffing which was above the trust target of 85%. Medical staff compliance with safeguarding adults training was also above trust target at 96.67%. Safeguarding adults' level 2 training compliance was also above the trust target at 93.58 for midwifery staff and 93.92% for medical staff.

Safeguarding children training was completed at different levels depending on the staff members roles and responsibilities. Trust data showed that staff compliance with safeguarding children level one was 92.3% for nursing and midwifery staff and 93.3% for medical staff. Safeguarding children level two compliance was 92.3% for nursing and midwifery staff and 90% for medical staff. Safeguarding children level three training was reported as being 89% for nursing and midwifery staff and 47% for medical staff.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We saw that any concerns relating to a woman or babies safeguarding were escalated appropriately.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were given examples of when referrals had been made and actions that had been taken in response to concerns or feedback. We saw clear records within women's notes detailing any safeguarding actions taken, including referrals and discussions with safeguarding leads.

Staff followed the baby abduction policy and undertook baby abduction drills, although staff could not recall the date of the most recent drill.

The service had safeguarding midwives who supported staff with any concerns. We saw that there were clear safeguarding policies which described escalation and reporting processes. Safeguarding midwives reported that they regularly met with peers from across the trust and that they discussed cases. The types of concerns were reported as being similar across the patch. The safeguarding midwife was also covering paediatric safeguarding and reported joint working with the trust safeguarding and local authority leads. Analysis of common themes included domestic abuse, teenage pregnancy, social deprivation and high vulnerability for women with regards to female genital mutilation. Themes were discussed and shared and used as learning.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean. However, some staff did not follow the trust uniform policy.

Ward areas appeared clean and had suitable furnishings which were well-maintained. The service had completed a refurbishment of the inpatient ward with staff moving back to Cedar ward in June 2021. Facilities were seen to be appropriate for their use. Although staff reported that some changes were required, and that they had not had sufficient time, since their move to identify areas for all their equipment.

The service generally performed well for cleanliness. There was a cleaning schedule in place and designated cleaning staff who ensured the schedule was followed. Cleanliness was audited regularly, and managers reviewed outcomes and challenged poor performance/ compliance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that staff were responsible for cleaning any clinical equipment and we saw that staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used I am clean stickers to confirm that they were ready for use.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that PPE was available throughout clinical areas and staff ensured they wore it when attending patients. Staff were observed to largely follow safe infection control and prevention, although we saw two doctors wearing wrist watches and gold chains, and some midwives wearing multiple earrings.

Hand sanitiser was available at the entrance and throughout clinical areas. We saw that staff prompted visitors to use hand sanitiser. Hand hygiene audits were completed regularly, and we saw that compliance was from 87.5% to 95% in the delivery suite, 82.5% to 87.5% in Mulberry assessment unit and 85% to 95% in Cedar ward from May to July 2021. Data showed that six monthly hand hygiene training had lapsed in response to staffing challenges, and there were plans to reinstate this.

We saw that staff used a COVID-19 proforma, which was placed into every set of notes to prompt staff to undertake the day one, three and five swabs for COVID testing. There was also a section for women to complete confirming that they had completed a lateral flow test and their results.

The service reported no cases of hospital acquired bloodstream MRSA infections of C. Difficile in the six months preceding the inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, annual equipment checks were not always completed.

The service had suitable facilities to meet the needs of women and their families. The maternity department was located in a dedicated area, which enabled all services to be co-located. All departments were secure with pass access. There was a central stairwell which enabled staff to easily move between departments.

The design of the environment followed national guidance. We saw that there had been a refurbishment programme across the service. Rooms were sufficiently sized to enable multiple staff attendees.

There was easy access to additional clinical areas, such as theatres and the neonate unit, which enabled access in an emergency. There were two maternity theatres, which were used for elective and emergency cases.

The service had enough suitable equipment to help them to safely care for women and babies. Staff carried out daily safety checks of specialist equipment and we saw that resuscitation equipment was checked daily and following any usage. However, we saw that annual equipment maintenance checks were not always completed. There were a number of pieces of equipment across all departments which were not in date including suction machines and blood pressure monitoring devices. The trust told us that this was in response to issues with accessing equipment during COVID-19 and there were plans in place to ensure equipment was checked.

Staff told us that COVID-19 had impacted on the number of beds within the neonatal unit, which placed additional pressures on the service. The number of cots had reduced from 21 to 13 which meant that staff had to consider transferring babies to other units when there was increased activity.

Women could reach call bells and staff responded quickly when called.

Staff disposed of clinical waste safely.

Maternity

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, triage was not always completed by a designated midwife.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. We reviewed eight women's records and saw that risk assessments were completed for each woman on admission or arrival to the unit, using a recognised tool. Risk assessments were completed and detailed clinical findings, however there was not always clear evidence of what action was taken in response to these findings.

Staff knew about and dealt with any specific risk issues. We saw that venous thromboembolism (VTE) assessments were completed for all inpatients and consideration was taken for risks such as sepsis, depending on the woman's clinical presentation.

We saw that carbon monoxide (CO) monitoring was not always recorded within women's records. This was flagged as an issue at our last inspection. Risks associated with smoking were planned to be recorded at the initial assessment, and at 36 weeks. The service audited staffs recording of CO, which showed an increase from 0% to 50% for CO measurements at initial assessment and 0% to 30% measurements at 36 weeks. There was an action plan in place to improve monitoring which included training and spot checks.

Staff completed modified early obstetric warning score (MEOWS) as necessary to monitor women's conditions. We saw that these were calculated and escalated appropriately, and audits completed to ensure compliance. Audits completed showed that there was good compliance with MEOWS completion.

The service had access to mental health liaison and specialist mental health support. Staff reported that since our last inspection in November 2020, there had been an improvement in the visibility of the mental health team, who now attended handovers regularly which sped up the process of referral and seeing women.

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. We saw the morning handover which detailed women in attendance and what needed to be done to facilitate their care or treatment. This was an improvement since our last inspection.

We saw the multidisciplinary team (MDT) handover which was well attended and followed a systematic approach. The meeting was safety focused and included aspects such as housekeeping, COVID-19 updates, feedback from risks, any capacity or staffing concerns and then a review of patients. The team interacted positively and were respectful of each other.

Staff completed safety huddles in addition to handovers to update coordinator and the team on changes in activity.

Telephone triage was completed by any midwife available, using a standardised template for questions to determine and record what actions were taken. The lack of consistent midwife for triage increased the risks of miscommunication and identification of ongoing issues. All telephone triage cards were scanned into women's records to ensure the calls were recorded.

Maternity

Women attending the department were seen initially by the midwife and then the designated doctor who worked from 9am to 5pm. Staff reported that this sometimes created a delay in treatment after 5pm, when the doctor left, and the ward doctors covered activity. The team reported that they were planning the implementation of the Birmingham Symptom-specific Obstetric Triage System (BSOTS) and training was taking place.

There was a process to Red, Amber and Green (RAG) rate women attending with obstetric presentations. The RAG rated assessment card was completed on arrival and is filed in the handheld notes. The triage process was audited in 2020, and results showed that on average 90% of women were seen within 15 minutes if rated as red (urgent review).

The coordinator had oversight of activity across all clinical areas and assisted with the management of patient flow. During inspection, we saw that the coordinator on Cedar ward was included in numbers and had a clinical workload. Staff told us that due to staffing shortages this happened frequently and impacted on their ability to have complete oversight or complete care in a timely manner.

Out of hours, teams were supported by the on call medical team and consultant and a midwifery manager, matron or head of midwifery. This enabled staff to access clinical support 24 hours per day.

The service used the World Health Organisation (WHO); five steps to safer surgery checklist for all theatre procedures. We saw that the steps were followed and audited monthly to confirm ongoing compliance. Audits observed showed most questions achieved 100% compliance with the checklist.

Fresh eyes were routinely completed and clearly recorded in women's notes. This is a buddy system for reviewing continuous cardiotocography (CTG) records, to ensure appropriate escalation.

There were processes in place to protect babies and prevent abduction and staff told us that there had been learning from a drill which included the installation of swipe access and inclusion of reception staff to ensure knowledge of any risks or safeguarding concerns.

Nurse staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. Staffing risks were mitigated to reduce the risks of potential harm.

There had been ongoing concerns regarding the staffing levels across maternity services. Trust data showed that there were 24.84 whole time equivalent (WTE) midwife shortages at Basildon Hospital. Staff reported that they regularly worked with reduced numbers of staff and that this impacted negatively on women's care and treatment. We were given examples of when midwives had been unable to provide the level of care, they wanted, and how some women had poor experiences as a result of reduced staffing.

Staffing shortages were acknowledged by the senior leadership team and service leads. There had been recruitment events and development opportunities, which had resulted in some increases in staffing, however, this did not meet the demands of the service. The latest recruitment had resulted in an additional 20 midwives, who were planned to join the team in September, however, these staff would need ongoing development and support to make the transition from student midwives to competent practitioners. There were an additional five maternity support workers and experienced midwives planned to join the team in the following few months.

Staff reported ongoing concerns about the movement of staff from other clinical areas to ensure safe staffing numbers. We were given examples of when midwives were moved from other units and this increased staff's frustration, however, there was no evidence of this impacting patient safety.

In addition to trying to increase midwifery numbers the trust was in the process of reviewing services to identify what actions could be done to reduce pressure on the site. For example, the movement of some elective caesarean sections to Southend University Hospital. The movement of elective patients would reduce the capacity of women attending the site and therefore reduce staffing requirements. The plans had not been fully accepted by the clinical team, and their concerns had delayed the transfer of care. This is further explored in the well led section of this report.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and health support workers needed for each shift in accordance with national guidance. Trust data shows that there had been an uplift in staffing numbers for midwives in November 2020. This was equal to around 10% of the previous establishment.

The service did not always have enough nursing and midwifery staff to keep women and babies safe although the number of midwives and midwifery support workers did not match the planned numbers. On the day of inspection, we saw that staffing numbers were reduced by one midwife and two midwifery support workers. Staffing was supplemented by staff from other clinical areas; however, this caused some anxiety to the staff moved, due to lack of familiarity in the service. Staff told us they regularly worked with reduced numbers and that coordinators were not always supernumerary. Despite staffing shortfalls, we did not see a negative impact on women and babies care.

Although ward manager could adjust staffing levels daily according to the needs of women, midwives reported that there had been a decrease in uptake of bank and agency shifts in recent weeks. Staff felt this was in response to staff being tired and the ability for people to travel following an extended lockdown.

The service had introduced the safer staffing tool which calculated the impact of staffing deficits. We saw that data for April to June 2021, which highlighted that staffing met acuity for 61.7% of the time, with a shortfall of two midwives 13% of the occasions recorded which was 75.1% of total shifts. The impact of staffing shortages was noted as being delays in accepting transfers, and delays in medication, such as antibiotics and pain relief. There was no evidence of significant harm as a result of the staffing shortages.

The service had a higher vacancy rate than the national standard of 17%. Trust data showed that as of June 2021, there were 24.84 whole time equivalent (WTE) band 5 midwifery vacancies. There had been an upward trajectory for the six months preceding inspection.

Trust wide the service had a slightly lower turnover rate than the national standard of 12%. The turnover rate of midwives was reported as 11.7% in May 2021. This was similar to the five months preceding the inspection. However, there had been a gradual increase in the turnover of staff since December 2019.

The service had a sickness rate of 8.19% for nursing and midwifery staff (excluding COVID-19). Staff reported that sickness had also increased due to staff needing to self-isolate in response to COVID-19.

The service had low and/or reducing rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Maternity

The staff birth to midwife ration was reported as in line with targets for March to May 2021. Trust data showed that the ratio was 1.22 in March, 1.25 in April and 1.26 in May 2021. This was in line with the trust target of below 1.3. The service monitored one to one care for women in labour. Audit data showed that with the exception of February 2021, from January to June 2021, 100% of women received one to one care. In March, the service achieved 99.6% compliance with one to one care.

Continuity of carer to women ratios were monitored by the service and we saw that trust data showed that the continuity of carer team had around 39 women to each midwife This was similar to services across the trust.

Stand-alone birthing unit ratios were slightly higher than continuity of carer services with the community site at Basildon reporting a ratio of one midwife to 84 women. This was similar to the ratios across the whole trust.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The medical staff matched the planned number. The service had enough medical staff to keep women and babies safe. The service had 14 consultants. There were sufficient numbers of registrars and training grades to ensure that there were doctors available in all clinical areas.

The service had a good skill mix of medical staff on each shift and managers reviewed this regularly. There were two doctors available 24 hours per day, including a registrar and training grade doctor. Trust data showed that consultants were present on the clinical delivery suite in line with recommendations for April to June 2021.

The service had minimal medical vacancies with 0.74 whole time equivalent (WTE) consultants, 1.28 WTE staff grade and 0.45 WTE trainee medical vacancies. Any uncovered shifts were covered by locum staff and managers could access locums when they needed too. Managers made sure locums had a full induction to the service before they started work. The locums were usually in post for extended periods which enabled them to become familiar with the service, processes and policies.

The service always had a consultant on call during evenings and weekends. Doctors reported that the on call provision was one in 11, and they were happy with this provision. We saw that all women were seen daily by a consultant and within 14 hours of admission. This included weekends. There were clear escalation processes for consultants to come into the hospital and doctors told us consultants were always responsive. Staff reported that consultant cover at night was much better than at our last inspection.

The turnover rate for medical staff was reported as 18.34% trust wide and 16% locally, in July 2021.

There was no reported medical staff sickness (excluding COVID-19) for the service.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily. We saw that records were complete and reflected regular assessments and reviews. Staff wrote clear descriptions of care given and planned. We reviewed 11 women's records and saw that risk assessments were generally completed, and records demonstrated interactions undertaken. Information recorded was clear. All records were stored securely, and all computers were locked when not in use preventing unauthorised access.

When women transferred to a new team, there were no delays in staff accessing their records.

The trust audited women's records to ensure that there were personalised care plans in place. Trust data shows that there were plans in place for 59% to 71% of all women's records reviewed in April to June 202, this was below the trust target of 95%.

We saw that bookings are undertaken directly on to the electronic system and ongoing visits were recorded in the handheld notes. Clinical observations were recorded electronically with the exception of in the triage unit, where a paper record was maintained.

Key information was shared electronically with women's GPs. The electronic system used, enabled staff to choose information being shared securely with GPs, including discharge summaries, delivery summaries or pregnancy records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw 11 prescription charts and saw that medicines were given in line with prescriptions with no omissions.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We saw that medicines were largely stored in locked cupboards in treatment rooms. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check women had the correct medicines. Women were asked to confirm their identity prior to any administration and where necessary two midwives checked and administered controlled drugs.

The service regularly completed audits of women's prescriptions. We saw that June and July 2021 audit showed that dates were recorded on prescription charts 67% to 75% and weights recorded on 60 to 78% of charts. Allergies were recorded 97 to 100%, and women's identification and corresponding wrist band information showed 100% compliance. The audit showed that prescribers signatures were not always clearly written (7% to 62%). In response the service had devised actions to be taken, including targeted training and sharing or results.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely.

Incidents

Maternity

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

There had been changes to the management of risks since our last inspection. The trust had recruited a new risk lead for the service and there were local staff who monitored risks and incidents daily. We saw that risks were reviewed as part of daily meetings with service leads to discuss and grade incidents. Incidents requiring escalation were managed appropriately. This was an improvement since our last inspection.

Staff knew what incidents to report and how to report them. Staff told us that they reported incident using the new electronic report tool. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. We saw that incidents from May to July 2021, largely related to clinical occurrences, such as transfers, shoulder dystocia, post-partum haemorrhages, however, we also saw 18 incidents relating to staffing shortages in midwifery or medical staff. There were also two incidents reporting that low risk women were unable to use the midwife led unit for their labour due to closure of the service due to staffing shortages elsewhere.

The service had no never events in the year preceding the inspection.

Staff reported serious incidents clearly and in line with trust policy. Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Where appropriate incidents were reported to the Healthcare Safety Investigation Branch (HSIB) and staff told us that they had been involved with HSIB investigations.

Managers debriefed and supported staff after any serious incident. Staff told us they were aware of and involved with any incidents. We were given examples of when staff had a difficult day and the senior team held debriefing support sessions for all involved.

Staff received feedback from serious incidents and their investigation, both internal and external to the service. However, staff reported that they did not always receive feedback about other incidents reported.

Trends in reporting were reviewed by the risk and management team, and the service reported an increase in the number of incidents reported for the same period the previous year. We saw that there had been 397 incidents reported from May to July 2021.

All serious incident investigations were reviewed by the non-executive director safety champions, this ensures oversight at board level of incidents, and their investigation outcomes.

Is the service effective?

Requires Improvement ↑

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Maternity

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies and saw that they were largely in date and all followed national guidance. Those policies and guidelines which were not in date were in process of being reviewed as part of the merger to Mid and South Essex NHS Foundation trust (MSE). All policies were planned to be amended to be an MSE version to facilitate standardisation across the hospital sites.

Staff told us that they could easily access policies and guideline which were held centrally and available via the intranet. Policies referring to emergency admissions were also available in paper format to ensure easy access. Staff told us these were replaced any time there was an updated version.

The trust had changed their approach to monitoring women and babies and had introduced the physiological based interpretation for the assessment of fetal wellbeing. This process enables timely detection of changes to babies enabling early interventions to reduce unnecessary interventions. Since introducing this method of monitoring, the trust had seen considerable changes in outcomes for babies, with no infant deaths.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We saw that staff considered any additional support needed by women and their families.

We saw that there was clear guidance available to staff which included the process of handing over women between departments and the use of the SBAR tool (Situation, Background, Actions and Recommendations).

There was an audit programme to confirm staff compliance with policies. For example, we saw that World Health Organisation: safer surgery checklist audits were completed monthly alongside local audits such as hand hygiene audits.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. This included the saving babies lives bundle which was reviewed at each governance meeting. Data showed that the services had varied outcomes against all elements. For example, in element one (smoking) the service achieved 100% for conversations with women about smoking, and referrals to smoking cessation support. However, did not always record carbon monoxide (CO) monitoring, with 10 to 30% in February to April 2021 audits.

Clinical leads reported that they achieved nine out of the ten Clinical Negligence Scheme for Trusts (CNST) safety actions. The exception was the implementation of transitional care which the teams were working towards.

Outcomes for women were positive, consistent and met expectations, such as national standards. We saw the key performance indicator report for the October to December 2020, showed that compliance was in line with targets. The only exception was antenatal screening which achieved 74% against a target of 75%. This was a recognised pressure and recorded on the service risk register. Managers and staff used the results to improve women's outcomes. We saw that audit data informed discussions at performance meetings giving leads areas to target work in response to findings.

Trust data showed that from January to July 2021, the service had 2.1 to 6.1% unexpected admissions to the neonate intensive care unit. This was potentially aligned to the inability to provide transitional care.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers shared and made sure staff understood information from the audits. Performance dashboard were displayed across clinical areas and staff openly discussed performance and compliance with targets.

Improvement is checked and monitored. Service leads met regularly to review performance and identify areas for further development. We were told of several improvement plans; however, these were hampered by the focus on staffing and ensuring safe cover.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, not all staff had completed speciality specific training or had an appraisal within the last year.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Although mandatory training compliance was below the trust target there was provision by the practice development midwives to ensure that staff had clinical skills necessary to perform their roles.

Managers gave all new staff a full induction tailored to their role before they started work. New staff were provided with a structured induction programme. Staff told us that their preceptorship programme enabled working across all areas of the service to develop under supervision.

Managers made sure staff received any specialist training for their role. For example, Practical Obstetric Multi-Professional Training (PROMPT) was completed regularly by all staff and training compliance was reported as being 100% for consultant and medical staff, 87.5% for anaesthetic consultants, 82% for anaesthetic trainees, 99% midwifery staff and 73% for theatre nurses.

We saw that in July 2021, cardiotocography (CTG) training had been completed by 95% of midwives and 100% of doctors, which was better than the trust target of 90%. Trust data showed that 28% of staff were trained in new-born screening.

Managers had an appraisal framework; however, compliance was not in line with trust targets. Staffing shortages had impacted on staff's ability to complete appraisal. The trust reported an appraisal rate of 68.7% for nursing and midwifery staff and 88% for medical staff as of July 2021. We saw that there was a planned trajectory of full compliance within the women's and children's care group for March 2022. We were told by service leads that the teams were in line with trajectory and compliance was noted as being 77.6% overall for the care group in June 2021. Appraisals had been postponed during COVID-19, and there were plans in place to ensure compliance. However, it was acknowledged by the service leads that staffing shortages and ongoing pressures on the service impeding the ability to complete appraisals in a timely manner.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Doctors reported being able to attend training sessions and felt supported. Some consultants took on additional lead roles in areas of clinical interest such as fatal medicine and maternal medicine. Part of this role included the clinical teaching of their chosen topic and the insurance that polices, and processes followed the latest guidance

Medical revalidation had been completed by 93% of consultants in July 2021, which was equivalent of 14 out of 15 consultants. Revalidation had been completed by 100% of other grade doctors as of July 2021.

Doctors told us they had protected time for training, which was supported by the consultants. We were given examples of speciality specific training session which included cardiotocography (CTG) and mandatory training.

The clinical educators supported the learning and development needs of staff. There were two practice development midwives who worked within the service, they were responsible for the ongoing training of staff and the preceptorship of new midwives. However, their role had been impacted by COVID-19 and the reduced staffing pressures.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge where possible. We were given examples of where additional support had been given to individuals to support their objectives however, training had been impacted by the pressures of safe staffing.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff reported and we saw that there was positive multidisciplinary team (MDT) working. Conversations were respectful and inclusive. We heard that doctors were very supportive of midwifery staff and acted accordingly when there were staffing pressures, taking on additional tasks.

Staff held regular and effective MDT meetings to discuss patients and plan their care. The handover was structured and well attended by the full team. There was a focus on women's safety and records were stored electronically. This was an improvement since our last inspection.

We saw the medical ward round which was multidisciplinary, and patients' midwives presented the case. We saw the daily trust wide meetings to identify areas of increased pressure and agree on actions to take in response to them.

Staff worked across health care disciplines and with other agencies when required to care for patients. We were given examples of when women had been referred to other agencies or teams for support.

The service completed Avoiding Term Admissions to Neonate Intensive Care Units (NICU) ((ATAIN)). We saw that ATAIN meetings were held monthly and involved the review of care and treatment of babies admitted to NICU. These were completed to identify if there were any lapses in care and to identify any areas for learning.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women are reviewed by consultants depending on the care pathway

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Maternity

Consent

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw that consent was clearly recorded in women's records. Staff made sure women consented to treatment based on all the information available.

Is the service responsive?

Good

We had not previously rated this service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service had been working collaboratively with their peers across the Mid and South Essex NHS Foundation Trust since their merger. There was an appreciation that service ran slightly differently and that there was a need to standardise some practices.

The trust executive team were in the process of redirecting some elective caesarean sections to Southend University Hospital in response to pressures on the service with regards to capacity and reduced staffing. We were told that there was also reduced capacity within obstetric ultrasound which was being managed by providing additional support at the site.

The service worked collaboratively with the peers across the Local Maternity and Neonatal Service (LMNS). Teams met regularly to discuss national guidance and share experiences.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for women in need of additional support or specialist intervention. Staff were able to refer to specialist such as infant feeding, community support and mental health services.

Staff reported that they worked collaboratively with the safeguarding and mental health midwives, sharing information about women and babies at risk or in need of support.

Meeting people's individual needs

Maternity

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Women using the service were able to make decisions about the type of birth they wanted. The service provided a midwife led birthing unit and home births for low risk women.

Service data showed that personalised care plans were in place for 59% to 71% of women using the service, this was below the trust target of over 95%.

The service had two established continuity of carer teams, who provided consistent midwifery support through the woman's three stages of the pregnancy (pregnancy, labour and post-natal care). Trust data showed that the service achieved continuity of carer for 16.4% to 19.7% of women from April to July 2021. This as lower than the trust target of 35% but recognised to be in response to staffing challenges with COVID-19 and the movement of staff to support inpatient areas.

The service reported a higher percentage of total caesarean sections (c-sections) with 45% in March, 40.4% in April, 42% in May, 38% in June and 42.7% in July 2021. This was higher than the trust target of 28.6%. The number of c- sections had been consistently higher than the trust target and we were told that the service was in the process of reviewing the cases to identify the rationale for the choice of delivery. The World Health Organisation (WHO) recommends a population c- section rate of 10 to 15% to ensure mortality rates are kept low for mothers and babies.

Women could access support when necessary. For example, women could access a breast feeding specialist nurse. Trust data showed that breast feeding initiation was completed from 75.4% to 78% for March to July 2021, which was higher than the trust target of 70%. Similarly, breast feeding at ten days was above the trust target of 75% for the same period, achieving 77% to 82%.

Staff told us that booked appointments were recorded on the electronic patient record, and that appointments were planned to coincide with any other appointments or needs. For example, morning appointments were arranged to include blood sampling slots, and later appointments were planned for scan reviews.

Doctors told us that there were sometimes delays in women being seen in response to the gynaecology assessment unit being closed. This meant that women with gynaecological conditions needed to attend the urgent and emergency care department, and the obstetric doctors were required to work between the two departments.

The service had bereavement midwives who worked across all clinical areas. They had introduced a checklist for compassionate inductions and a physiotherapy service. There was a dedicated bereavement suit which was sufficiently sized to enable extended family to attend.

There was an established antenatal screening service with a non-invasive prenatal test screening process which enabled women to have timely screening for genetic conditions such as Down syndrome.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Maternity

The service delivered around 300 to 350 babies each month. Trust data showed that there were 311 babies born in March, 324 in April and 343 in May 2021 at the hospital. Staff reported that there had been an increase in babies being delivered over the weeks preceding the inspection.

The service routinely monitored the types of delivery and recorded this on a dashboard. Trust data showed that 48% to 53% of all deliveries for April to July 2021 had been normal vaginal deliveries (NVDs). Elective and emergency caesarean sections were reported as being consistently around 40%. For April to July 2021, elective C- sections were 15.1%, 10.5%, 15.5% and 17.1%. The trust target was less than 12.6%. Emergency C-sections were reported as 25.3%, 31.5%, 22.5% and 25.6% for the same period.

Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Women attending the hospital were triaged and allocated to the correct pathway. Triage was routinely completed within 15 minutes of arrival to the department.

Managers and staff worked to make sure women did not stay longer than they needed to. Once women were deemed fit, they were encouraged to go home.

Managers worked to keep the number of cancelled appointments/treatments to a minimum. We were told that clinical pressures and emergencies sometimes impacted on elective cases which meant that women sometimes stayed in hospital slightly longer than planned. Staff told us that women may be moved to the following day for a procedure, although this was rare. We saw that there was one reported incident where there had been a delay in treatment from April to July 2021.

The service moved women only when there was a clear medical reason or in their best interest. Women were cared for in the most appropriate area for their clinical condition.

Staff supported women and babies when they were referred or transferred between services. We saw that there was a clear transition between services with staff accompanying women to the new area. When babies were transferred to neonate intensive care units, women were able to accompany them.

Managers monitored transfers and followed national standards. Staff reported all transfers of care through the incident reporting system, and these were escalated where necessary for investigation.

The service reported the need to divert services to other trusts on no occasions in April, six occasions in May, nine occasions in June and four in July 2021.

The service leads recognised that there was a higher percentage of deprivation in the locality in comparison to the other hospital sites. There was also a more diverse population and staff reported that community teams focused on women's health including diet and lifestyle. Translators were used where necessary to inform discussions.

There were no reported maternal deaths and for the period April to July 2021.

The service reported that there were 3.2% to 6.1% of babies admitted to the neonate intensive care unit from April to July 2021, against a target of less than 5%.

Service data showed that the service had diverted care to another provider on 19 occasions from April to July 2021.

Maternity

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Staff understood the policy on complaints and knew how to handle them. Where possible concerns were addressed at the time. Staff escalated to the midwife in charge or matron when issues arose, enabling concerns to be addressed immediately.

Managers investigated complaints and identified themes. Concerns were usually around treatment plans and communication.

Complaints were generally managed in line with the trust policy for response times of 20 days. Service information showed that there had been 11 complaints to the service from April to July 2021.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, the leadership structure was not fully embedded.

Local leadership consisted of a head of midwifery and a clinical lead. The team was well established, and staff told us they were accessible, and supportive. The teams were supported by four matrons and seven ward/ unit managers.

The service leads reported directly to the trusts senior leadership team (SLT) and there were clear escalation pathways and meetings for reviewing performance. Progress against national and local targets were monitored by the SLT with daily reporting on progress and activity. The service leads were held to account for performance.

The chief nurse was the designated board member lead for maternity services and staff told us that the SLT were visible and approachable. Service leads told us that they felt supported by the SLT.

Please see the Southend University Hospital report for further details of the trust wide leadership for this service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Maternity

Please see the Southend University Hospital report for further details of the trust wide vision and strategy for this service.

Culture

Staff were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff did not always feel respected, supported or valued.

There had been ongoing concerns around the culture of this service for some time. Prior to insepction, CQC had received ten whistleblowing concerns from members of staff, relating to poor staffing and the impact this had on women's care. We heard that staff were feeling pressured by the senior leadership team and service leads to work in particular ways. Staff felt unsupported and were generally unhappy in their work.

During inspection, we found that staff were frustrated by consistent issues with staffing levels, the turnover of staff and the impact this had on them being able to complete their jobs. Some staff felt overwhelmed with the activity, felt unsupported by managers and vulnerable to risk.

Staff told us that COVID-19 had placed additional pressures on the team and that staff had lost their good will, becoming less likely to work additional shifts.

Despite this, teams spoke positively of each other and there was clear compassion amongst the team to ensure that staff on duty were supported as much as possible. We saw colleagues from other departments attend the inpatient area to ensure staff had breaks and encouragement was given when staff became upset.

Staff told us that matrons were responsive to their concerns, often offered support and assisted clinically when able, however, staff did not feel that ward managers offered the same level of support. Staff had noticed that senior staff had started to work clinically in the weeks preceding the inspection.

Some midwives reported an improvement in the culture of the team with a focus on learning. We were given examples, where service leads had held debriefing sessions or meetings where the team identified what they could have done differently.

Matrons spoke positively about their teams and their achievements during a very stressful and difficult time. Senior leads reported that they were concerned about the pace of change and the impact this had on staff.

Matrons had started to work more closely with their peers across all sites. Matrons and heads of midwifery had daily morning calls to discuss any pressures and activity. They reported that this had been beneficial and enabled cross service developments. They had also commenced external coaching.

Student midwives told us that they had had positive experiences within the service, and all planned to start substantive roles in the next few weeks.

Staff used a closed social media account to share information.

We completed a staff survey which showed that staff strongly disagreed that they could raise concerns without fear of what would happen as a result, did not feel that action would be taken when concerns were raised, did not believe there

was effective communication between management and staff, and did not feel that changes were implemented well. 18% of staff felt that there was no feedback following incidents, 50% felt that there was cross site learning following incidents and 69% of staff felt there was unrealistic pressures on their time. Full details of survey results can be found in the Southend University Hospital report.

Governance

Leaders operated effective local governance processes, and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, the trust wide governance structure was under review and not embedded.

The service had compiled an action plan in response to the concerns flagged at our last inspection. We saw that this was reviewed at least weekly, as part of governance meetings and any changes clearly recorded. Staff were fully aware of the action plan and its content. There were named owners to each area for development.

The governance structure was under review following the merger, with an expectation for the Mid and South Essex governance structure and processes to be in place by the end of the year.

Local meeting minutes were detailed and showed good attendance across the multidisciplinary team. Agendas were standardised and minutes were shared across teams to keep staff informed.

We saw that the service reported to the trust board every quarter detail of any stillbirth or neonate deaths as part of the perinatal mortality review process. Reports shared, detailed cases, actions taken and involvement with families.

Leads told us that there was a monthly newsletter that shared information relating to audit results, feedback from complaints and women's feedback about the service.

Please see the Southend University Hospital report for further details of the trust wide governance of this service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, processes for monitoring risk were under review and not fully embedded.

Due to ongoing concerns with pressures on the service and the ability to manage care safely, the senior leadership team had decided to transfer some care to Southend Hospital as they did not have similar staffing concerns to Basildon. This was planned to assist with the reduction of numbers of women attending the unit placing reduced pressures on the service. The plans had been presented to board and at the time of inspection, the SLT were in the process of consulting the medical staff who would be required to transfer to Southend Hospital for approximately one or two days per month.

Additional actions being taken by the trust to manage activity was to review satellite unit provision, staffing and activity to identify whether staff or services could be moved to reduce pressures on the main hospital site.

Information about the services performance and development was displayed in the communal stairwell. We saw a selection of noticeboards which demonstrated completed projects or action taken to improve the service.

Leads told us that there was a monthly newsletter that shared information relating to audit results, feedback from complaints and women's feedback about the service.

Locally the service had two risk midwives who tracked risks and reviewed incidents, escalating any concerns to service leads. We saw how the team shared information and discussed incidents and risks on a daily basis.

Risks identified locally included clinical risks and non-clinical risks, such as staffing, environment and sharing information. All risks were reviewed regularly and discussed at risk meetings.

Please see the Southend University Hospital report for further details of the trust wide management of risk for this service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Midwives told us that handover meeting were recorded electronically, however the system did not enable staff to access historic data. This meant that staff could not check on previous information and needed to seek support from the information technology team.

Please see the Southend University Hospital report for further details of the trust wide information management for this service.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There had been ongoing concerns about the culture and staff engagement at this service for some time. Trust leads had been working towards improving services, but we heard that engagement of staff was varied. Changes to women's care pathways and revisions of services had not been fully accepted. Whilst there was an understanding of the pressures on the service, some staff were reluctant to accept changes. This directly impacted on the leaderships ability to address concerns and increased the time taken to implement changes, creating additional anxiety across teams.

There were multiple concerns within the midwifery cohort about the lack of support, lack of understanding from the senior leadership team and the lack of visibility of service leads. Some staff reported that they felt bullied if they did not agree with decisions being made and most felt that they could not do the job they wanted to.

The trust was completing regular engagement calls and visits with the team to improve communications across the service.

The service had a closed social media group which was used to share information. Staff reported that this was a good way of catching up with any changes or with seeking support or cover. The service also used newsletters to keep staff informed.

Midwives told us that external engagement varied but use trust patient experience lead to support engagement.

The service was supported by the NHS improvement team, and staff told us that this had benefitted the service and helped make significant changes.

We were also told that the service had completed 60 supportive steps to safety, which consisted of a walk around by the regional maternity quality lead and an obstetrician. The conclusion outlined the need to embed safety champions, the impact of staffing on the ability to complete projects and review incidents, and the need for a supernumerary coordinator.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service had developed an action plan to address concerns following our last insepction and the enforcement action taken.

We saw that there had been significant improvement within the service. Although the leadership team was not fully embedded, there were processes in place to improve the clinical oversight of the service. We saw that there were regular meetings to review performance, incidents, allocation of risk grading and investigations, with a focus on patient safety. Staff used performance data to benchmark against peers and inform decision making.

We saw effective multidisciplinary team meetings, which were well attended and focused on sharing accurate information and safety of women and staff.

COVID-19 had impacted negatively on the service, adding additional pressure in relation to staffing, coordinator supernumerary status and the ability to improve compliance with mandatory training. However, the senior leads had a clear plan in place to address staffing concerns and improve training compliance. Trust data showed that the services was in line with targets.

Staffing remained a significant risk, although this was mitigated where possible. Staff recognised that there was a national shortage of midwives and leads were looking at alternative staff to support teams. The service had introduced a safer staffing tools to inform decision making.

Additional development plans were around the implementation of a dedicated transitional care area and a dedicated elective caesarean section bay. Staff were familiar with these plans and recognised that they were dependent on improvements with staffing levels.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

This was the first time we inspected this service under this provider. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff but there was difficulty in the monitoring to ensure everyone completed it. Mandatory training had been impacted by the pressures of the COVID-19 pandemic.

Staff received mandatory training. Data provided by the trust showed that training compliance was at 68.96% against a trust target of 85%

All mandatory training was paused during the COVID-19 pandemic, however, there was an e- learning system in place, which had been updated in April 2021. Staff told us face to face training, for example in life support, had restarted however, demand was high. An automated system sent emails directly to staff to inform them of modules that were due for completion.

The mandatory training was comprehensive and met the needs of patients and staff. Since the trust merger the mandatory training content had been standardised across the sites.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The training on dementia awareness and learning disability awareness was not available however this was due to be included in the compliance reports from September 2021.

Ward Managers had difficulty monitoring mandatory training on the new system due to staff sitting in the wrong reporting line. Staff were in the process of being realigned in the system which would improve local oversight.

The new e-learning system alerted staff when they needed to update their training. Staff told us that they were aware of any outstanding training and time could be allocated to complete it. The trust had an action plan in place for statutory and mandatory training recovery to ensure that the service met the trust target. A review of the action plan showed the trust aimed to increase compliance by 2% per month with the 85% trust target achieved by January 2022.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Data provided by the trust showed safeguarding adult compliance at level one was 84.25%, at level two it was 85.07% however, there was no data available at level three. Following inspection, we were told that safeguarding adults level 3 training had recently been introduced and was planned to be delivered to staff with compliance of 95% expected by August 2023. The trust target was 85%. Safeguarding children compliance at level two was 80.15%, the trust target was 85%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated an effective awareness of the trust's safeguarding processes. At the time of the inspection, visitors to ward areas were restricted in accordance with the trust's COVID-19 pandemic response plans.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff mainly used equipment and control measures to protect patients, themselves and others from infection. They generally kept equipment and the premises visibly clean. COVID-19 precautions were in place.

Ward areas generally appeared clean and had suitable furnishings which appeared clean and well-maintained. Disposable bed curtains were used, and staff had marked them with the date of last change. However not all areas were clean, for example, we did notice that the shower in Elizabeth Fry ward that was housed in a storeroom showed signs of black mould.

The service generally performed well for cleanliness. The data provided by the trust showed good compliance with hand hygiene and staff personal protective equipment (PPE) management. The July 2021 observational audit demonstrated 100% compliance in high impact hand hygiene and 90% to 100% compliance in infection prevention and control (IPC) hand hygiene and PPE. Areas of non-compliance was managed by targeted training.

Staff mainly followed infection control principles including the use of personal protective equipment (PPE). Although we observed a member of non-nursing staff on Orsett ward enter a room, with an aerosol generating procedure (AGP) sign on the door, without the correct PPE. They did not change their PPE before entering the next room and this was escalated. The donning procedure prior to entering a room with AGP was completed outside the room however the doffing procedure was carried out in the room prior to exit. Donning is the correct sequence for putting on PPE and doffing is the correct sequence for removing PPE. The correct procedure minimises infection risk to both the patient and staff.

Staff working in medium or high-risk areas, for example endoscopy, required a higher level of protection from face masks. The face mask used had to be fit tested A fit test checks whether a mask properly fits the face of the person who wears it. The staff in endoscopy had been mask fit tested and had three members of staff trained to conduct fit testing.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The endoscopy service had a robust equipment cleaning and decontamination process. The endoscopy service had a clean and dirty scope rooms. The dirty scopes came into the cleaning room via hatches. They were then processed by the automated disinfection machine and exited the machine directly into the clean room. The scopes were all tracked to ensure they could identify which scope was uses in the event of contamination or infection risk.

Medical care (including older people's care)

All wards we visited had a visitors and staff sign in and sign out book for COVID-19 tracing. This was robustly enforced in some wards but not all. Staff were able to explain the COVID-19 precautions in their work areas and isolation facilities were available for patients with suspected infectious disease. The electronic bed board clearly showed if a patient had tested positive for COVID-19.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw 'I am clean' stickers in use. We observed high touch area cleaning taking place. High touch cleaning is the cleaning of any surface that is frequently touched by many hands, for example, door handles or handrails.

Gel hand sanitiser and PPE was freely available on all wards we visited.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed staff responding to patient call bells in a timely manner.

We noted on Orsett ward the emergency alarm system was linked to the non-invasive ventilation (NIV), when the NIV was disconnected, for example, when the patient was having lunch, the alarm sounded. Staff commented that they were de-sensitised to the alarm due to the frequency of the alarms sounding. This could result in a delayed response to genuine emergency alarm. We escalated our concerns during inspection and the buzzer tone was changed immediately.

The endoscopy department was well planned and included dedicated waiting areas, private consultation rooms, well equipped recovery area as well as clean and dirty scope rooms.

The design of the environment did not always follow national guidance. For example, on Elizabeth Fry ward, there was a shower room within a storeroom. This did not have a separate door and privacy was maintained using a shower curtain. The door to this area, did not have a functioning occupied/in use sign and unless the corridor door was locked there was no indication the shower was in use. Staff told us that this door was not routinely locked if a nurse was assisting the patient which did not protect the patient's privacy and dignity. We also observed a portable air conditioning unit in use on Elizabeth Fry ward. There were Perspex screens fitted across the entrance to the bays for infection control purposes, which made the areas very hot. The ward was undergoing a planned window replacement programme at the time of our inspection

Staff carried out daily safety checks of specialist equipment, including resuscitation equipment and we saw daily record checks on resuscitation trolleys. We saw evidence that maintenance checks had been carried out on equipment including hoists and weighing scales. However, we did find evidence of defibrillator electrical checks that were overdue, this included two in endoscopy and one on Pasteur ward. This was escalated to the staff.

The service had enough suitable equipment to help them to safely care for patients. We reviewed expiry dates on consumable products and found them to be stored correctly and were within date.

Staff disposed of clinical waste safely. We saw evidence of segregated waste and facilities were in place for the storage and disposal of household and clinical waste, including 'sharps. We saw 'sharps' bins were generally appropriately labelled and stored however, we observed two incorrectly labelled 'sharps' bins and one which was full. This was changed immediately on escalation.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff did not always complete risk assessments on admission using recognised assessment tools, and did not review these regularly, including after any incident. Patient risk assessments were completed on the electronic tablet system. This included the falls risk assessments and venous thromboembolism (VTE) assessments.

The falls risk assessment clearly indicated if bed rails were appropriate for the individual needs and requirements of a patient. We saw evidence of bed rails in use when the risk assessment stated they were not necessary and when the assessment had not been completed. Bed rails, also known as side rails or cot sides, are widely used to reduce the risk of falls. Although not suitable for everyone, they can be very effective when used with the right bed, in the right way, for the right person. However, bed rails sometimes do not prevent falls and can introduce other risks if used inappropriately. We reviewed 18 falls risk assessments, looking at the use of bed rails, across five wards and found that 13 assessments were not completed, were overdue or inappropriate. This was escalated to the trust and following our inspection, a trust wide audit was undertaken with daily checks on the bed rail assessments. The audit data provided by the trust showed good compliance in the completion of bed rail risk assessments in August 2021 post inspection.

We saw evidence of venous thromboembolism (VTE) risk assessments flagged red, meaning the review was overdue or had not been completed. VTE is a condition in which a blood clot (a thrombus) forms in a vein, most commonly in the deep veins of the legs or pelvis. This is known as deep vein thrombosis, or DVT. Medical patients should be considered as being at risk if they have significantly reduced mobility. We reviewed six records across three wards all were either overdue or not completed. Service leads were aware of poor compliance with VTE assessments and the action log from the July 2021 sub-divisional governance meeting stated a new strategy had been agreed for monitoring.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS 2) is used to identify acute deterioration, including sepsis. The nursing staff recorded the patient observations on an electronic iPad system. A demonstration of the system showed that there was a traffic light system to inform the nursing staff if observations were due. A green flag indicated they were not due, amber indicated they were due or were slightly late and red indicated they were overdue. The electronic system also plotted and recorded the results and flagged if the observations indicated a change in the patient condition.

Staff knew about and dealt with any specific risk issues. The staff we spoke to knew how to escalate if the electronic tablet showed a NEWS 2 alert. We saw evidence of escalation, in the patient nursing notes, after an increase in respiratory rate was recorded.

The staff we spoke with confirmed they received training on sepsis pathways and that the electronic tablet triggered the sepsis questions. We saw evidence of completed daily pressure area checks and daily Waterlow scores. The Waterlow score is a medical assessment tool used to assess the risk of a patient developing pressure sores (bedsores).

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and specialist mental health support.

Staff shared key information to keep patients safe when handing over their care to others. We observed a multidisciplinary team (MDT) meeting which included a consultant, doctors, ward sister, occupational therapist, physiotherapist, dietitian and speech and language therapy (SALT). We heard examples of discharge planning, goal setting, requesting input from the different professionals and discussion of individual patient requirements. The consultant knew the patients well and in detail. We observed health care assistant (HCA) to HCA handover of a patient who had a nil by mouth status.

Shift changes and handovers included all necessary key information to keep patients safe. We observed the morning handover of patients from the night staff to the day staff. The staff described the patient by name and bed number and included orientation status, mobility status, history, any overnight issues, NEWS2 score and plan. The nursing staff had printed handover sheets to write their notes on.

The wards we visited all had a large electronic information bed board. This was mainly sighted in open view in the ward corridor. This electronic board was used to conduct the board round. The board round we observed was consultant led. Board rounds are a summary discussion of the patient journey. They facilitate allocation of the daily tasks required for the journey to progress and identify and resolve any delays in the patient's hospital stay. This enhances patient experience and reduces the risk factors associated with a prolonged hospital stay.

Staffing

Nurse staffing

The service generally had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff an induction.

The service generally had enough nursing and support staff to keep patients safe when we visited, but staff reported long standing staffing pressures across most wards, exacerbated by the pressures of the COVID-19 pandemic, especially pronounced in the healthcare of older people wards. The number of nurses and healthcare assistants did not always match the planned numbers, but local leaders reviewed the staffing on each ward throughout the day and there were escalation and mitigation processes in place.

The number of nurses and healthcare assistants (HCA's) mainly matched the planned numbers. The wards we visited displayed daily the staffing requirement for both registered nurses and HCA's for both day and night shifts. Overall, there seemed to be sufficient staff within most areas visited at the time of the inspection, with mitigation in place for areas of shortfall such as agency staff, bank staff and re-deployment of staff to other wards.

At the beginning of the pandemic a nurse controller role was introduced with responsibility for safe nursing. The local matrons report staffing concerns to the nurse controller. This role had been extended across the three hospitals in the trust with meetings chaired by a senior nurse to assess the need for cross site working.

Medical care (including older people's care)

Managers accurately calculated and reviewed the number and grade of nurses, health care assistants and healthcare assistants needed for each shift in accordance with national guidance. There was close oversight of each area with matron of the day looking at the skill mix required. Consideration was given to the acuity of the patients and the number of patients in side rooms.

The ward manager could adjust staffing levels daily according to the needs of patients. There was an established escalation and mitigation procedure in place for the ward managers to raise staffing issues and concerns.

From data the trust sent us the service had a nursing vacancy rate of 13.19%, compared to a trust target of 11.5%

The service had reducing sickness rates and the ward managers monitored long term sickness. There has been a rise in mental health issues and there was a staff wellbeing 'here for you' service available. There was support available for all staff who had ongoing physical and mental health issues. The same day emergency care (SDEC) service had developed a self-referral pathway for staff who had post COVID-19 health issues.

Managers made sure all bank and agency staff had an induction and understood the service. The ward manager and staff we spoke to confirmed new bank and agency staff completed an induction. The bank and agency staff were allocated patients based on their experience and expertise. There had been a risk-based assessment of bank staff pay rates with enhanced rates available in areas of greatest need.

Medical staffing

The service generally had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service generally had enough medical staff to keep patients safe when we visited, but staff reported long standing staffing pressures across most wards. The COVID-19 pandemic had impacted on overseas recruitment.

The medical staff did not always match the planned number. For example, on Pasteur ward we were told there should be eight doctors but there were six, with the shortfall being covered by the consultants.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was a monthly medical staff rota, which included the junior doctors, senior doctors and consultants. This was reviewed on a Monday and Friday. Any shortfalls in medical staff was covered by locums and the service leads told us that they had reliable bank doctors available.

From data the trust sent us the service had a medical vacancy rate of 11.41%, compared to a trust target of 11.5%

Sickness rates for medical staff were reducing. There had been high levels of sickness among the junior doctors, but this situation was improving. Leaders said colleagues were supported on their return to work and there was support available for all staff with ongoing physical and mental health issues.

The service always had a consultant on call during evenings and weekends and had introduced a weekend medical controller, who was a senior clinician, to oversee staffing issues.

Records

Medical care (including older people's care)

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes consisted of paper and electronic records and most staff could access them easily, however, we observed different levels of competency in the use of the electronic tablet, which affected the ability to access records. The electronic tablet system could be slow and new members of staff needed to be issued with passwords before they could access the system. As a security and confidentiality safeguard the electronic tablet system had individual and not generic login passwords.

We reviewed 18 electronic records and saw that risk assessments were inconsistently completed, with gaps in initial or repeated assessments. We also reviewed 12 sets of patient paper records and found evidence of timely medical reviews, MDT working and pain relief however, we did not see evidence of communication with the family. It appeared that staff were using written notes contemporaneously but did not regularly update the electronic records.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. The paper notes were stored in notes trolleys. Trolleys were cited by the central nurse's station however, we observed on multiple wards the trolley was often left open. We also found patient notes in the incorrect patient folder. This was escalated and action taken.

Staff were able to demonstrate to us the electronic monitoring system and we were informed by one of the ward clerks that it was her role to ensure the most up to date DNACPR and admission mental assessment documentation was at the front of the notes to enable access.

Medicines

The service generally used systems and processes to safely prescribe, administer, record and store medicines.

Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed seven prescription charts, three had a recorded weight, one had an estimated weight and three had no weight recorded. A patient's weight is important information because it is often used to calculate the appropriate medicine dose. The dose of a prescribed medicine could be significantly different from what is appropriate if an inaccurate weight is used.

Staff mostly reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff followed current national practice to check patients had the correct medicines. We observed good practice on James McKenzie ward during the medicine round. The nurse was wearing the correct PPE, used the electronic tablet to cross reference to the paper chart, the medicine trolley was tidy and well stocked. The nurse confirmed the patient's identification and asked about pain.

Staff mainly stored and managed medicines and prescribing documents in line with the provider's policy. We found that medicines were not always stored securely. On one ward we found a medicine room unlocked, with the medicine drawers and fridge unlocked, this was escalated and actioned by the staff. On another ward we also found unlocked medicine cupboards in a keypad locked medicine room, this was also escalated and actioned.

Medical care (including older people's care)

We found multiple entries of fridge temperatures out of range with the action noted 'reset', however, no further record to note if the temperature returned to range. This meant that temperature sensitive medicines may not always be stored at correct temperatures.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. The hospital had introduced a new incident reporting system. The staff we spoke with knew how and what they needed to report and confirmed that they received feedback from reporting an incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. The minutes of staff meetings provided by the trust demonstrated incident feedback.

Managers shared learning with their staff about incidents, this was done in a variety of ways, at handover, staff meetings and via email. A review of the acute medical unit (AMU) staff meeting minutes the trust provided demonstrated incidents were a standing agenda item.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff mainly understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong, however we did speak to some staff who were not aware of duty of candour.

Is the service effective?

Good

This was the first time we inspected this service under this provider. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance, however due to the trust merger some of the policies we reviewed were to be updated to standardise practice across the trust. Staff were able to demonstrate to us how they could access policies online and we observed that paper copies were also available. The ward manager we spoke to confirmed that printed copies were re-issued if policies were updated.

. **Nutrition and hydration**

Medical care (including older people's care)

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients we spoke with were complimentary about the quality and choice of food available. We observed staff assisting patients at mealtimes

Staff completed patients' fluid and nutrition charts where needed. The data the trust provided of the matron's May 2021, June 2021 and July 2021 patient safety audit demonstrated 100% compliance with 'Documented/recorded evidence of review of nutritional assessment within last 24hrs.'

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients said they received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. A review of ten patient notes during inspection supported this.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes

The service participated in relevant national clinical audits, however, due to the COVID-19 pandemic many audits had been paused. The service was in the process of recommencing some audits. Service leads and staff used the audit results to improve patients' outcomes. Information the trust shared with us included action plans in response to completed audits, for example, the 'Audit of systemic anti-cancer treatment' action plan showed that there was an on-going action to reduce the time from decision to treat to starting treatment and a completed action on the accuracy of patient records.

Ward managers shared and made sure staff understood information from the audits. For example, the acute medical unit (AMU) staff meeting minutes and band 7 meeting minutes demonstrated audits were a standing agenda item.

Improvement was checked and monitored. Staff used the clinical audit and safety data to further improve services. The service leads had a 'maintaining high standards' topic of the week. This was shared with the staff.

The endoscopy service was accredited by Joint Advisory Group (JAG) on gastro-intestinal (GI) endoscopy. The aim of the JAG accreditation standards is to define a high-quality, safe and appropriate endoscopy service, delivered by a highly trained, highly supported and highly motivated workforce. The standards were written in consultation with endoscopy services and were underpinned by national policy.

Medical care (including older people's care)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, staff appraisals were not always completed annually.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff on a number of wards all said they had received local inductions, which had met their needs. All new medical staff completed mandatory training as part of their induction. We observed new medical staff handover and orientation.

Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisal system was being updated, the new system 'time to connect' went live June 2021. Appraisals for nursing staff were conducted at ward level.

The appraisal completion rate was 64.44% against a target of 90%. Managers told us that the ability to complete appraisals had been impacted during the pandemic with staff redeployed throughout the hospital. There was an action plan in place to ensure that staff appraisals were completed by March 2022.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role and clinical educators supported the learning and development needs of staff.

The impact of COVID-19 had affected traditional team meetings however, managers were creative with technology with virtual team meetings, social media messaging to inform of changes and a secure text messaging system developed for healthcare to ensure staff were kept informed.

The impact of the pandemic had paused most training however, managers usually identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We visited a ward based education centre where training sessions were held for medical staff on a weekly basis. Nursing staff were also supported if a specific training need was identified, for example we were told ECG training was provided for nursing staff who required it.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. We observed an MDT meeting, which included medical staff, ward sister, occupational therapy, physiotherapy, dietitian and speech and language therapy (SALT). The paper notes review we conducted also showed evidence of MDT working.

Staff worked across health care disciplines and with other agencies when required to care for patients. The same day emergency care unit had a close working relationship with the hospital at home service. Staff referred patients to outpatient services to continue their rehabilitation, for instance community physiotherapy.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Patients had their care pathway reviewed by relevant consultants. This was evidenced in our review of patient notes and the ward rounds and handovers we observed.

All staff spoke positively about how all the staff, not just the clinical staff, worked together as a single team.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and most other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There were services such as the speech and language therapy (SALT) team that were not available out of hours or at weekends and some services such as occupational therapy and physiotherapy had reduced weekend cover to concentrate on discharges and areas of patient need.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff knew how to signpost or refer patients to relevant services when required such as diabetic service, alcohol liaison and although there is no smoking cessation service, they could prescribe of nicotine patches for in patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. We observed the patient consent process in endoscopy. The patient was informed of the risks, given the information needed to make their decisions, was given time to consider the options and their understanding of the procedure and aftercare was confirmed prior to them signing the consent form.

Staff clearly recorded consent in the patients' records.

Staff we spoke with could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Medical care (including older people's care)

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We saw evidence of the correct process documented in patient notes.

Is the service caring?

Good

This was the first time we inspected this service under this provider. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. The staff we observed with the patients were engaging with patients in a positive personalised way. We saw staff engaged with their patients including when carrying out personal care, assisting with feeding and during drug rounds. Staff attitude was generally positive, and the atmosphere was warm and welcoming; however, there was clear evidence that staff were having to work very hard to meet service demands on some wards, notably the healthcare for older people wards.

Patients we spoke to said staff treated them well and with kindness, however we were told some night staff could be less responsive.

Staff focused on the needs and experience of people who used the services. however, we did observe unsuitable language between medical staff, used to describe patient outcomes and treatment on two different wards

Staff followed policy to keep patient care and treatment confidential and the inspectors presence at a board round was challenged, however the layout of most of the wards we visited with the large electronic bed board in a main corridor meant board rounds and handovers were conducted in a busy thoroughfare which meant it was difficult to maintain confidentiality

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff drew curtains around bed spaces to maintain privacy and dignity for the patient before carrying out any care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Medical care (including older people's care)

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed this during our visits to the wards.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We were given examples of how staff managed difficult situations well. For example, during COVID-19, as families were unable to be with a loved one when they passed, Florence Nightingale ward asked if they would like a keyring with a fingerprint or lock of hair.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff mainly made sure patients and those close to them understood their care and treatment. Patients we spoke with did understand their treatment plan and were able to ask staff questions. We saw a doctor take time to talk to a relative however, the relatives that we spoke with said communication was difficult, and it often took a long time to get information and when they did it was not accurate.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service. We saw evidence of thank you cards on staff notice boards in most ward areas.

Is the service responsive?

Good

This was the first time we inspected this service under this provider. We rated it as good.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. As a result of the COVID-19 pandemic, wards had physically changed location to ensure the ward design and format was the most appropriate for the medical condition of the patient. The review of the wards also enabled the service to continue to provide care for non COVID-19 patients on speciality wards for example stroke patients and those in palliative care areas.

Medical care (including older people's care)

Facilities and premises were mainly appropriate for the services being delivered. The endoscopy suite was well planned and carefully thought out however, storage was at a premium on most wards which made them feel cluttered and untidy.

The service mainly had suitable facilities to meet the needs of patients' families. Marjorie Warren ward was a palliative care ward and had chairs that converted into beds to allow families to stay over however it did not have a family room or day room. The lack of a dedicated day room meant that staff were unable to talk to the patients and their families in a private environment.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We saw evidence of single sex bays, toilets and shower facilities on all wards; however, we did observe a mixed sex shower on Elizabeth Fry ward which was accessed through a storeroom.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

On inspection we observed an MDT meeting where a patient from out of the area was discussed. This patient would have had on going rehabilitation needs post discharge and these needs had to be coordinated with the patient's local services. The patients GP was contacted to ensure the ongoing rehabilitation was facilitated with their local provider.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Elizabeth Fry ward staff told us the dementia nurse sent out the daily sparkle magazine, which they then share with dementia patients. The Daily Sparkle was a reminiscence newspaper which offered activities for older people and people living with dementia.

Staff on Florence Nightingale ward described how they try to keep patients occupied with colouring and other activities and how the use of pet therapy had a significant positive calming effect for one of their patients. On William Harvey ward we observed a dementia resource trolley which had colouring books and jigsaws. The service has had an activities co-ordinator who covered three wards and specifically focused on patients with dementia and communication with relatives. Pre COVID-19 they had activity rooms such as a café.

We observed staff supporting patients to go to the bathroom to wash and clean their teeth rather than do it at the bedside. This helped elderly patients to maintain their independence.

Managers made sure staff, and patients, loved ones and carers could get help from interpretation services when needed. The service had information posters available in languages spoken by the patients and local community. Staff told us they had access to translation services however they were unaware of any other communication aids to help patients become partners in their care and treatment.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. There was a trust wide learning disability nurse and staff knew how to contact them. There was a learning disability hospital passport on the hospital website which could be downloaded and completed prior to admission. A hospital passport provides important information about a patient with a learning disability, including personal details, the type of medication they are taking, and any pre-existing health conditions.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention.

We saw a multi-faith prayer room was available and there was a hospital chaplaincy service.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. For example, the stroke team held an emergency bleep, this enabled the emergency department to contact them when a patient was admitted with a stroke and treatment could be started in a timely manner.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. For example, we were informed in Endoscopy, that patients were able to have their appointments or follow up appointments within the expected timeframe.

The service moved patients only when there was a clear medical reason or in their best interest. The COVID-19 pandemic has impacted on the movement of patients as patients had to be moved to the ward most appropriate for their care.

Staff tried to minimise movement of patients between wards at night. However, data provided by the trust showed there were 165 out of hours bed moves in July compared to 177 in June 2021. Transfers between wards especially at night can cause a breakdown in continuity of care, inhibit recovery and cause distress.

When patients had their appointments cancelled, managers made sure they were rearranged as soon as possible. The endoscopy service re-started in February 2021 and had put in place additional lists to increase capacity and reduce the backlog of appointments.

Managers and staff worked to make sure patients did not stay longer than they needed to. We saw evidence of patients ready for discharge being prioritised at the board round. Managers and staff worked to make sure that they started discharge planning as early as possible. The service has a discharge lounge which was open from 8am to 8pm, the last admission was 6pm to ensure no overnight delays. On Pasteur ward we were informed the discharge facilitators work from 7.30 am to 8.00pm. Many of their palliative care patients had fast track discharge pathways in place.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. There was a frailty discharge facilitator and we were informed that occupational therapy and physiotherapy have a weekend rota to concentrate on discharges, they also referred patients to community physiotherapy.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on the hospital when they could treat patients in a day. The same day emergency care (SDEC) service had a positive impact on inpatient admissions and a pre COVID-19 audit showed a 31% reduction in patient admissions. The service had established pathways for 'fit to sit' patients. These were patients who were not

admitted to hospital, but needed follow up care and scans for example, patients with suspected deep vein Thrombosis (DVT). The service also established a COVID-19 pathway for suitable patients to be remotely monitored at home. The patients were shown how to use the equipment to monitor and record their observations. They were then checked on day two, five and seven by telemonitoring. Telemonitoring is the use of information technology to monitor patients at a distance. The service also worked with the hospital at home service and local GP's.

We met an admissions avoidance project contractor. This was an Essex wide initiative which they hoped to have in place by the autumn 2021. The aim of admission avoidance was to
to provide assessment of the care needs of patients, with the aim of preventing admission to hospital by supporting recovery at home.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. The acute medical unit (AMU) staff meeting minutes and Band 7 meeting minutes the trust provided demonstrated audits were a standing agenda item.

Managers investigated complaints and identified themes. The ward manager on Florence Nightingale ward reviewed complaints with the patient advice and liaison service (PALS) which maintained a consistent approach to complaints and responses. PALS provide impartial advice and assistance in answering questions and resolving concerns that patients, their relatives, friends and carers might have.

Is the service well-led?

Requires Improvement

This was the first time we inspected this service under this provider. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Medical care (including older people's care)

The trust managed services through care groups. Medical services were managed through care group one. Each care group was led by clinical leads. The Medical director was supported by the director of operations and director of nursing. The local site leadership teams which included divisional and operational managers, matrons, ward and theatre managers reported to the care group clinical leads.

Ward managers, supported by matrons, provided local leadership on each ward. Staff described matrons and the ward managers as visible, approachable, supportive and responsive to their concerns. Ward managers told us they felt supported by the matrons. Staff, in most cases, were able to tell us who the service leads, and senior management team were and could describe instances when they had visited wards. However, staff told us that service leads were less visible and there was a feeling of disconnect with the senior leadership

Leaders understood the challenges to quality and sustainability and could identify the actions being taken to address them. Local managers had a good understanding of the challenges in their areas and had introduced plans to improve delivery. The matron we spoke with described positive work across the trust to standardise practice and paperwork.

Staff told us that matrons were visible on the wards. Matrons attended trust wide bed occupancy and staff briefings daily to discuss nurse staffing to ensure safe numbers of staff for the acuity of patients. There was daily oversight of staffing issues, which were reviewed and mostly mitigated.

Leaders regularly met across the three sites to identify and discuss concerns and issues such as mandatory training for prioritisation.

Medical and nursing staff understood management reporting structures and told us they were supported by their managers.

The local leads were supportive of staff development for example we spoke to a recently appointed ward manager who informed us that their matron was encouraging and helpful and the senior management were accessible.

ision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a trust strategy with objectives to achieve their ambition: “to improve health and wellbeing through excellent, financially sustainable services, provided by staff supported to develop, innovate and build rewarding careers”. Senior leaders told us that following the merger of the trust, the overall aim of the medical services was to come together as one service delivered from three sites.

The service strategy was part of the clinical reconfiguration model which was aligned to the Mid and South Essex Health and Care Partnership five-year strategy and delivery plan.

The service’s quality goals, and targets had been developed to ensure they met the trust’s clinical strategy, the service leads told us the vision focused on the safety of the patient receiving quality compassionate care, right patient, right place, right person.

Medical care (including older people's care)

Staff we spoke with understood the service vision and the service leaders informed us they held online surveys with the staff to include them in the development.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

All staff at all grades, were always friendly and welcoming and we had open and honest conversations with a wide variety of staff across the service.

Staff felt challenged due to ongoing staffing issues and the impact of the previous 18 months working in the pandemic. Some medical services such as endoscopy had been suspended during the pandemic and the staff redeployed to support other areas. Staff were tired and morale was low on the general medical wards however, staff in the specialist services that had re-opened were more positive.

Staff raised their concerns with us around staffing numbers and patient acuity. Staff told us that the frequent moving of staff to cover empty shifts in other wards was having an impact on staff morale. During redeployment in response to the pandemic, a member of staff told us that coping with the impact of the pandemic at work was difficult as they were not working in their familiar environment, with their usual colleagues and they often only found out on the day which ward they were allocated to.

Despite staffing concerns, staff we spoke with were very proud of the service they delivered and described their colleagues as supportive. They told us that they had good working relationships.

Staff were patient focused, and the culture was focused on the needs and experience of people who used the services.

Staff told us there was good teamwork within the teams and we observed this during our inspection, however, we did observe occasional irritability between staff when asking for assistance, for example, we observed impatience with a student nurse when assistance with a patient was requested. Staff worked together to resolve issues and worked flexibly to accommodate service needs. They told us that the whole team worked together to provide the best care for patients.

There were processes in place to provide staff with career development opportunities although this had been challenging during COVID-19. Staff had not received regular appraisals although they said that they had received regular wellbeing checks. Staff told us that the trust was supportive of training and they felt encouraged to undertake additional training when funding and scheduling allowed.

Leaders told us that they were proud of the hard work of their staff and their commitment to improve care to patients.

Staff were able to access information on equality and diversity online and were able to demonstrate the navigation to the relevant pages to us.

Freedom to speak up guardians were a new concept for the site and was not embedded in all areas. The senior leadership were aware of this.

Staff told us of a trust award scheme where staff can volunteer each other and teams for recognition. Staff also told us of a gift voucher that they received from the senior management at Christmas.

Medical care (including older people's care)

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance systems were in place to support the functions of services across the trust, but these were yet to be fully embedded. Monthly meetings were conducted to allow oversight of the service which fed into divisional governance meetings. Governance meetings had a set agenda and meeting minutes showed that this was followed. We reviewed the March 2021 and April 2021 specialist divisional governance meeting minutes provided by the trust. The minutes demonstrated escalation, actions and improvement plans.

There was an effective process to share governance outcomes and updates with staff. Staff meetings were held however, due to the pandemic some meetings had been suspended and technology was used to enable virtual meetings. Staff meeting minutes showed that they had a formal agenda and governance was included. Leaders informed us that they plan to re-start the two at the top meetings for staff. Two at the top meetings were ward meetings led by the lead consultant and the nurse in charge and had a structured formal agenda and minutes taken. All staff were encouraged to attend.

There was an audit programme supported by the service leads to ensure patient safety. We saw that wards completed regular audits around areas such as hand hygiene and cleanliness. The electronic tablet patient record downloaded into a patient track system which allowed the local and senior leaders to conduct patient data audits, generate reports and look for compliance, such as patient risk assessments.

Senior managers told us that incidents, near misses and complaints were monitored for trend and improvements actioned via action plans.

Staff of all grades appeared clear about their roles and what they were accountable for and to whom.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The trust had introduced a new incident and risk management platform and were in the process of transferring all the risks onto this platform. As a result, medicine had two risk registers in place. There was an internal deadline of 31 August 2021 for the completion of this transfer.

Each risk was rated, and status updates provided as the risks were reviewed. The risk register was reviewed and updated at the clinical governance meetings. Service risks sat within the division responsible for the service. The top risks identified by leaders were staffing and capacity. The risks were mitigated where possible, for example, areas of staffing shortfall were managed using agency staff, bank staff and re-deployment of staff from other wards

It was not clear that service leads had oversight of all risks, for example, bed rail assessment audit had not been completed at the time of inspection. Following escalation of concerns around gaps in risk assessments the trust provided us with a post inspection audit of bed rail assessments. This showed largely positive compliance over a five-day period. However, the trust did not provide us with evidence of audits being completed prior to this being raised as a concern.

Information Management

The service collected reliable data and analysed it. Staff mainly could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were secure. but were not fully integrated.

The service was in transition between electronic and paper systems. The service leaders were aware of the challenges caused by having two systems and they were on track to have all the patient assessments on the electronic tablet system. This electronic patient track system allowed for real time monitoring and data audit.

The service was due to upgrade to electronic prescribing of medication from the paper based charts.

Staff were able to demonstrate to us both the paper and electronic systems. The electronic tablet system has a personal login to maintain security. Staff did tell us they found the electronic tablet slow especially when changing between patients.

An integrated acute care portal across all three trust sites was part of the wider information technology (IT) strategy.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Managers engaged with staff at regular team meetings in all the areas that we visited. Meeting minutes showed discussion of incidents, complaints and staffing.

Staff in most areas we visited told us that local leaders were visible and offered opportunities to listen and feedback to staff. Staff told us that service leads were less visible, and they were less able to engage with them, they did not feel assured that they were aware of the challenges faced by staff. However local leaders told us that they felt very supported by the service leads team and were involved in decisions about their service.

The trust carried out an annual staff survey to gain staff feedback. The trust board papers from May 2021 identified five key areas to prioritise for action, health and wellbeing, immediate managers, morale, staff engagement and teamwork.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Medical care (including older people's care)

The service had trialled and implemented changes to the service including the same day emergency care (SDEC) COVID-19 admission avoidance programme, which had been recognised and published. This care pathway was developed so that suitable patients with COVID-19 could be safely monitored in their home environment and reduced patient admissions. Staff informed us that they were encouraged and supported in developing this new patient pathway.

The service leaders told us of standardisation of patient pathways, this ensured consistency and continuity of care. They had also implemented an email based referral process for specialist input into patient care, this streamlined and sped up referrals. A dedicated, health care, smart phone based system was introduced to assist in the monitoring of patients.

Broomfield Hospital

Court Road
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CM1 7ET
Tel: 01245362000

Description of this hospital

Broomfield Hospital is part of the Mid and South Essex NHS Hospitals Foundation Trust which was formed in April 2020. The hospital is in Broomfield and provides a variety of services for the local population of Essex. There are 566 inpatient beds at the main hospital site.

Although we rated Broomfield Hospital on 6 March 2020 the ratings did not carry over as the hospital was acquired into Mid and South Essex Trust. This was the hospitals first inspection as part of the trust.

This inspection was completed as part of our routine regulatory action and to follow up on the safety of maternity services following regulatory action being taken at the Basildon University Hospital site. We inspected Surgery due to concerns around the management of risks and patient safety.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities.

At this inspection, we rated Surgery as requires improvement for safe, responsive and well led and good for effective and caring. This inspection followed our comprehensive methodology.

We rated Maternity services as requires improvement for safe, effective and well led. We rated responsive as good and did not inspect caring as we followed our focused methodology.

The overall rating was Requires Improvement because:

Surgery:

- The service provided mandatory training in key skills to all staff but could not evidence that everyone had completed it.
- Not all staff completed safeguarding training on how to recognise and report abuse.
- Infection prevention and control audits were not routinely completed.
- Safety checklists and assessments were inconsistently completed.
- The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience.
- The service did not have enough medical staff with the right qualifications, skills and training.

Our findings

- Paper records were not always clear, and not stored securely.
- The service did not always ensure the safe use of medicines.
- Not all staff received an appraisal in the last 12 months.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.
- Patients did not always have new appointments for procedures booked within 28 days of being cancelled.
- Not all leaders were visible and approachable in the service for patients and staff.
- Not all staff were aware of the trust vision.
- The governance processes were not embedded, and the surgical team were not always represented at all governance meetings.
- Staff felt that there was a lack in consistency between electronic and paper records.

Maternity:

- Mandatory training compliance was not in line with trust target.
- The handover between teams was not always structured.
- Triage times and processes were not always recorded or robust.
- The service did not always have enough maternity staff with the right qualifications, skills, training and experience.
- Compliance with some specialist training and appraisals was not always in line with trust target.
- The leadership structure was not fully embedded.
- Staff did not always feel respected, supported and valued.
- Governance processes were not embedded.
- Processes for monitoring risk were under review and not fully embedded.
- Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

However:

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Our findings

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Maternity

Requires Improvement

Is the service safe?

Requires Improvement

This was the services first inspection. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff however, training compliance was not in line with trust target.

Midwifery staff received mandatory training in line with their role. Training was provided either in person or via online training, depending on the topic. For example, basic life support and manual handling training was completed in person whilst equality and diversity was completed online.

We saw that the trust clearly allocated training according to roles and responsibilities, for example, staff who were nonclinical were required to complete a different level of manual handling to those who were clinical. As part of the merger into the Mid and South Essex NHS Foundation trust, mandatory training had been reviewed to produce a standardised level of training for each role. This was in the process of being implemented when we inspected.

Compliance for midwives mandatory training was below the trust target of 85%. Overall trust mandatory training compliance was reported as 69.8% in May 2021 in the trusts board papers.

Staff reported that training had been difficult to complete due to restrictions on face to face training in response to COVID-19, and due to reduced staffing numbers. There had also been restrictions on training in response to staffing levels and period when training had been ceased. There was a trajectory for compliance which was reported to the trust board monthly as part of the governance meetings. Full compliance was expected by March 2022.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. The team worked collaboratively with the mental health team to support women.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training needs were recorded centrally, and managers prompted staff to completed training or booked sessions for them when staffing allowed.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Midwifery and medical staff received training specific for their role on how to recognise and report abuse. Training compliance for safeguarding adults' level 1 and 2 training was reported as being 96.07% and 94.5% for nursing and midwifery staffing which was above the trust target of 85%. Medical staff compliance with safeguarding adults training was also above the trust target at 92.9% and 95%.

Safeguarding children training was completed at different levels depending on the staff members roles and responsibilities. Trust data showed that staff compliance with safeguarding children level one was 96% for nursing and midwifery staff and 86% for medical staff. Safeguarding children level two compliance was 96% for nursing and midwifery staff and 86% for medical staff. Safeguarding children level three training was reported as being 94.3% for nursing and midwifery staff and 86.3% for medical staff.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Risk assessments were completed, and any concerns were escalated appropriately.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We were given examples of when referrals had been made and actions that had been taken in response to concerns or feedback. We saw clear records within women's notes detailing any safeguarding actions taken, including referrals and discussions with safeguarding leads.

The service had safeguarding midwives who supported staff with any concerns. We saw that there were clear safeguarding policies which described escalation and reporting processes. Safeguarding midwives reported that they regularly met with peers from across the trust and that they discussed cases. The types of concerns were reported as being similar across the patch.

Staff followed the baby abduction policy although staff reported that they had not recently completed a baby abduction drill to test the efficiency of the process.

Staff had access to the mental health midwives who were able to support then with managing patients.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas appeared clean and had suitable furnishings which were well-maintained.

Cleaning audits were completed and reviewed by service leads to ensure standards were maintained. Cleaning audits showed that compliance was above 90%.

We saw that staff infection control and prevention audits showed good compliance. Trust data showed that from January to July 2021, hand hygiene compliance was monitored monthly across all clinical areas and results 96 to 100% compliance across all areas.

Ward cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw that there were dedicated cleaning staff who completed checklists and confirmed that cleaning schedules were completed. Cleaning scores were displayed on ward notice boards.

Equipment and clinical areas were the responsibility of the midwifery team and checklists were in place to prompt staff to clean all items.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that hand sanitiser was available on entry to clinical areas and across all units. Staff were prompted to maintain good hand hygiene and visitors were encouraged to sanitise their hands on arrival to the departments. Staff were observed wearing PPE when completing clinical tasks. Trust data showed that hand hygiene audits were completed monthly and the service achieved 100% compliance in April, May and June 2021.

There was also designated rooms for the use of women with suspected COVID-19. These rooms had ensuite facilities and there was clear guidance and PPE for staff to use outside each room. Rooms requiring isolation were clearly labelled with posters ensuring staff and visitors did not enter without either the correct equipment or in error. All staff and visitors were required to wear face masks through the department.

The service reported no cases of hospital acquired bloodstream MRSA infections of C. Difficile in the six months preceding the inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of women and their families. The service was co located and enabled a streamlined pathway from admission to the delivery suite and then to the post-natal inpatient area. Theatres, urgent and emergency care and the neonate unit were easily accessible in an emergency. There were two theatres which were used for elective and emergency cases.

The design of the environment followed national guidance. Rooms were sufficiently sized to enable treatment and any adjustments such as the introduction of a birthing pool. Rooms were ensuite.

The service had enough suitable equipment to help them to safely care for women and babies. Staff carried out daily safety checks of specialist equipment and we saw that resuscitation equipment was checked daily and following any usage. We saw that annual equipment checks were completed.

Women could reach call bells and we saw that call bells were responded to quickly.

Staff disposed of clinical waste safely and we saw that it was removed from departments in a timely manner.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration. However, the handover between teams was not always structured and triage times and processes were not always recorded.

Maternity

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. We reviewed nine women's records and saw that risk assessments were completed for each woman on admission or arrival to the unit, using a recognised tool. Risk assessments were completed and detailed clinical findings.

Staff knew about and dealt with any specific risk issues. We saw that venous thromboembolism (VTE) assessments were completed for all inpatients and consideration was taken for risks such as sepsis, depending on the woman's clinical presentation.

We saw that carbon monoxide (CO) monitoring was not always recorded within women's records. Risks associated with smoking were planned to be recorded at the initial assessment, and at 36 weeks. The service audited staffs recording of CO, which showed an increase from 45% to 65% for CO measurements at initial assessment and 25% to 35% measurements at 36 weeks. There was an action plan in place to improve monitoring which included training and spot checks.

Staff completed modified early obstetric warning score (MEOWS) as necessary to monitor women's conditions. We saw that these were calculated and escalated appropriately, and audits completed to ensure compliance. Audit data for August 2021 showed 91% compliance with completion of charts and 95% compliance with observations being recorded and calculated accurately. We saw that any abnormal readings were escalated in line with local policy.

There were clear escalation processes for doctors to call for support from consultants in and out of hours. For example, we saw the clinical conditions for escalation to a consultant briefing which described the process for escalating concerns for conditions such as eclampsia, maternal collapse, post-partum haemorrhage or concerns with MEOWS over six. The briefing also detailed the need for a consultant for specific types of high risk procedures and for ongoing briefing/ handovers.

Staff shared key information to keep women safe when handing over their care to others. We saw that written and verbal handovers of care were detailed and considered all aspects of care.

There was daily multidisciplinary team (MDT) meetings to discuss current and any planned activity. We saw that this meeting was not structured and did not follow a standardised approach to handing over key information. The meeting appeared disorganised with staff not fully aware of what was happening or handing over consistent information. Although there had been two emergencies that morning which may have impacted on staff attending and their ability to gather / handover information. We saw that safety huddles and MDT meetings were generally well attended.

We saw that telephone triage could take place within the delivery suite or the antenatal area. Calls were not directed to a specific number and therefore there was not one person oversight to potential admissions. Staff working in both areas answered calls, and either took details or referred to the midwife in charge of the antenatal/ triage area. During inspection we saw that this included the receptionist who asked the woman to call back as the midwife was busy. This could cause some delay to advise.

Triage was completed by any midwife available in the assessment unit. Women were prioritised for treatment using the Red, Amber and Green (RAG) rating tool, with women rated red requiring urgent reviews. The service captured waiting times for triage which showed that women were mostly seen within 30 to 60 minutes of arrival in the department. However, times were not always recorded, and we saw that in June 2021, times were recorded for 249 out of 738 women attending the department. There was therefore no assurance that women were seen within 15 minutes of arriving in the department. We saw that some delays were reported as an incident, with 30 occasions reported in July 2021.

Maternity

The service was in the process of introducing the Birmingham Symptom-specific Obstetric Triage System, however this had been temporarily placed on hold in response to pressure with staffing.

There was a dedicated coordinator who worked in the delivery suite. During inspection it was not clear whether the coordinator had oversight of activity across all clinical areas. This could lead to a disjointed service with potential delays of women working through the department.

Trust data showed that there was a consultant present on the delivery suite greater than 60 hours per week in line with guidance, there was an aim to increase this to over 98 hours and this was recorded on the service risk register.

There were two theatres used by maternity services, and one dedicated theatre team for elective procedures. We were told that in the event of an emergency, theatres would provide a second operating department practitioner, however the elective team would usually stop the elective list to support the emergency activity if it was safe to do so. This was recorded on the risk register.

The service used the World Health Organisation (WHO); five steps to safer surgery checklist for all theatre procedures. We saw that the steps were followed and audited monthly to confirm ongoing compliance. Audits observed showed 100% compliance with the checklist.

Fresh eyes were routinely completed and clearly recorded in women's notes. This is a buddy system for reviewing continuous cardiotocography (CTG) records, to ensure appropriate escalation. The service audited compliance with fresh eyes and we saw that from April to June 2021, 50 women's records were reviewed and showed 100% compliance with four categories, fresh eyes sticker in notes, signatures present, hourly reviews and escalation pathway followed.

The service had 24-hour access to mental health liaison and specialist mental health support. There was a dedicated mental health midwife who was accessible to staff offering advice and support where necessary.

There were processes in place to protect babies and prevent abduction. All babies were required to be accompanied by a midwife when leaving the clinical area. We saw that staff challenged any visitors and confirmed identify before enabling access. All entrances were pass controlled to prevent unauthorised access.

Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Prior to inspection, CQC had received two concerns from staff working on the unit regarding the lack of staff and the negative impact on women's safety and care.

During inspection we saw that the number of midwives and maternity support workers did not match the planned numbers. There was a deficit of at least one midwife in each clinical area, and numbers were being substituted by the use of non-clinical midwives. Staff told us that they routinely worked shifts with reduced numbers of staff. The coordinator should have been working a non-clinical office day, and specialist midwives were either included in numbers or covering breaks. This impacted on both staff's morale and workload.

Maternity

The service did not have enough midwifery staff with a number of shortages caused by vacancies and COVID-19 isolating restrictions. We were told that in addition to additional pressures relating to COVID-19, the unit had a large number of midwives on maternity leave.

Although there had been concerns relating to staff shortages raised with CQC prior to inspection, during our visit we saw that there were sufficient staff to meet the demands of the service. However, this was because staff had been moved from non-clinical roles to work clinically. Managers were working flexibly to support staff to ensure numbers were in line with demands on the service. We also, did not see any harm as a result of staffing.

Managers could adjust staffing levels daily according to the needs of women although we heard that the uptake of additional shift or agency cover had reduced over the recent weeks. Managers and service leads flexed their working days to ensure adequate cover and clinically if they were able. Practice development and specialist midwives told us they regularly worked clinically to supplement numbers, although there were some concerns that this had become 'normal practice' rather than managing breaks within the team.

Staff were frustrated from working on reduced numbers, and the impact cover had on their ability to complete their normal roles.

Matron's and the head of midwifery provided an on call service out of hours and told us they regularly attended site to support teams clinically. They had also planned to increase the number of clinical shifts worked following inspection in response to additional self isolating demands amongst the teams. Whilst this helped with some of the pressures on staffing, it did impact their ability to perform their roles and management tasks were impacted by the leads working clinically.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support assistants needed for each shift in accordance with national guidance. Data showed that there had been an uplift in midwifery staffing numbers in November 2020. This was equal to around 10% of the previous establishment. Staffing levels were reported as being the biggest demand on managers time, with flexible working and constant reviews of available staff to cover demands.

The service had introduced the safer staffing tool which calculated the impact of staffing deficits. We saw that data for April to June 2021, which highlighted that staffing met acuity for 62.3% of the time, with a shortfall of two midwives 15.4% and shortfall of three midwives for 2.7% of the occasions recorded (80.4% of total shifts). The impact of staffing shortages was noted as being delays in accepting transfers, and delays in treatments.

The service had completed an extended recruitment campaign to secure midwives who were about to qualify. The service had seven midwifery vacancies and were expecting 11 new staff members. Although staff were pleased with the planned new team, they were concerned that staff were not as experienced placing additional pressures on the midwives in charge. There was a plan to recruit qualified nurses to the team with an aim of one nurse per shift, which would enable additional support for midwives for non-midwife specific tasks.

The service had a low vacancy rate in comparison to the national standard of 17%. The overall trust wide vacancy rate for midwives for May 2021 was reported as 8.4% which was an improvement from 14.3% in April 2021.

The service had a lower turnover rate than the national standard of 12%. The turnover rate of midwives was reported as 9.6% in June 2021. This was lower than the five months preceding the inspection however, there had been a gradual increase in the turnover of staff since December 2019.

Trust data showed that the non- COVID-19 related sickness rate was reported as 4.45% at the time of inspection. Staff told us that sickness had also increased with COVID-19 and the number of staff shielding or self-isolating. This had dramatically increased in the weeks immediately preceding the inspection.

The service used bank and agency midwives where possible. Managers used bank and agency staff who knew the unit and requested staff familiar with the service where possible. Managers made sure all bank and agency staff had a full induction and understood the service. There was an agency induction folder which detailed aspects such as fire safety, how to escalate concerns and contact details.

The staff birth to midwife ratios were in line with targets for April to June 2021. Trust data showed that the ratio was 1.28 in April and 1.25 in May and June 2021. This was in line with the trust target of below 1.3. The service monitored one to one care for women in labour. Audit data showed that women received one to one care between 98 and 99.5% of the time.

Continuity of carer to women ratios were monitored by the service and we saw that trust data showed that the continuity of carer team had on average 38 women to each midwife This was similar to services across the trust.

Stand-alone birthing unit ratios were slightly higher than continuity of carer services with the community sites reporting a ratio of one midwife to 91 to 99 women. This was slightly higher than the rest of the trust.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The medical staff matched the planned number. The service had enough medical staff to keep women and babies safe. The service had ten whole time equivalent (WTE) consultants and there were sufficient numbers of registrars and senior house officers (SHO) to ensure that there were doctors available in all clinical areas.

The service had a good skill mix of medical staff on each shift and managers reviewed this regularly. There were two doctors available 24 hours per day, including a registrar and a SHO.

Any uncovered shifts were covered by locum staff and managers could access locums when they needed too. Managers made sure locums had a full induction to the service before they started work. The locums were usually in post for extended periods which enabled them to become familiar with the service, processes and policies.

The service always had a consultant on call during evenings and weekends and they were present in the delivery suite daily. There were clear escalation processes for consultants to come into the hospital and doctors told us consultants were always responsive. Trainee doctors reported that they felt supported in their roles and were able to develop.

The service turnover rate for medical staff was reported as 11.56% for June 2021. Service leads reported that they were in the process of recruiting.

There was no reported sickness amongst medical staff at the time of inspection.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive, and all staff could access them easily. We saw that records were complete and reflected regular assessments and reviews. Staff wrote clear descriptions of care given and planned.

When women transferred to a new team, there were no delays in staff accessing their records.

The trust audited women's records to ensure that there were personalised care plans in place. Trust data shows that there were plans in place for 96 to 99% of all women's records reviewed in April to June 2021.

Records were not always stored securely. We saw that notes trolleys on the delivery suite was left unlocked, however this was located next to the reception, so unlikely to be accessed by unauthorised persons.

All computers were locked when not in use preventing unauthorised access.

Key information was shared electronically with women's GPs. The electronic system used, enabled staff to choose information being shared securely with GPs, including discharge summary's, delivery summaries or pregnancy records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw five prescription charts and saw that medicines were given in line with prescriptions with no omissions.

Staff followed current national practice to check women had the correct medicines. Women were asked to confirm their identity prior to any administration and where necessary two midwives checked and administered controlled drugs.

Staff reviewed women's medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We saw that medicines were largely stored in locked cupboards in treatment rooms, although there was one occasion where medicine cupboards were unlocked. This was escalated to the staff who took immediate action to address this.

Stock was managed by the pharmacy department and stock rotated to prevent expiry before use. Medicine fridges had temperatures checked daily to ensure they were safe for the storage of temperature sensitive medicines. Ambient temperatures were also recorded daily.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely.

Medicine charts were audited monthly and data showed that there was largely good compliance (over 97%) with the trust policy for all areas from April to June 2021. The exception was the use of block capitals and women's weights, which showed compliance had improved from 60% to 65% respectively to 92% to 88%.

Maternity

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff knew what incidents to report and how to report them. Staff told us that they reported incident using the new electronic report tool. We saw that the service reported the higher portion of the trust wide maternity incidents with 488 out of 1059 reported at Broomfield hospital from May to July 2021.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. We saw that incidents from January to July 2021, largely related to clinical occurrences, such as delays in treatment, transfers, shoulder dystocia, post-partum haemorrhages.

The service had no never events in the year preceding the inspection.

Staff reported serious incidents clearly and in line with trust policy. Where appropriate incidents were reported to the Healthcare Safety Investigation Branch (HSIB) and staff told us that they had been involved with HSIB investigations.

Managers investigated incidents thoroughly and debriefed and supported staff after any serious incident. Staff told us they were aware of incidents and actions taken in response to them. We were given examples of when the senior team held debriefing support sessions for all involved.

Staff received feedback from serious incidents and their investigation, both internal and external to the service. However, reported that they did not always receive feedback about other incidents reported which did not fall into the serious incident category.

Incidents were reviewed daily by the risk team and the senior leads. During daily meetings, incidents were reviewed and graded, and any that required escalation or further investigation were escalated and allocated to the most appropriate person to complete the review.

There had been changes to the risk team, however the service had two risk midwives who worked collaboratively with the clinical team. The risk midwives reviewed incidents and shared any themes with the service leads to inform practice. For example the risk team reported an increase in the number of post-partum haemorrhages (PPHs), however, noted that this was largely due to the change in clinical practice where all swabs were now being weighed which gave staff a more accurate recording of blood loss and therefore the number of PPHs had increased.

All serious incident investigations were reviewed by the non-executive director safety champions, this ensures oversight at board level of incidents, and their investigation outcomes.

Is the service effective?

Requires Improvement

This was the services first inspection. We rated it as requires improvement.

Maternity

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies and saw that they were largely in date and all followed national guidance. Those policies and guidelines which were not in date were in process of being reviewed as part of the merger to Mid and South Essex NHS Foundation trust (MSE). All policies were planned to be amended to be an MSE version to facilitate standardisation across the hospital sites.

Staff told us that they could easily access policies and guideline which were held centrally and available via the intranet. Policies referring to emergency admissions were also available in paper format to ensure easy access. Staff told us these were replaced any time there was an updated version.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We saw that staff considered any additional support needed by women and their families.

There was an audit programme to confirm staff compliance with policies. For example, we saw that World Health Organisation: safer surgery checklist audits were completed monthly alongside local audits such as hand hygiene audits.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. This included the saving babies lives bundle which was reviewed at each governance meeting. Data showed that the services had varied outcomes against all elements. For example, in element one (smoking) the service achieved 100% for conversations with women about smoking, and referrals to smoking cessation support. However, did not always record carbon monoxide (CO) monitoring, with 10 to 30% in February to April 2021 audits.

Clinical leads reported that they achieved nine out of the ten Clinical Negligence Scheme for Trusts (CNST) safety actions. The exception was the implementation of transitional care which the teams were working towards.

Outcomes for women were positive, consistent and met expectations, such as national standards. We saw the key performance indicator report for the October to December 2020, showed that compliance was in line with targets. The only exception was antenatal screening which achieved 43.5% against a target of 75%. This was a recognised pressure and recorded on the service risk register. Managers and staff used the results to improve women's outcomes. We saw that audit data informed discussions at performance meetings giving leads areas to target work in response to findings.

Trust data showed that from April to June 2021, the service had 0.5 to 0.8% unexpected admissions to the neonate intensive care unit. This was much lower than the trust target of less than 5%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers shared and made sure staff understood information from the audits. Performance dashboard were displayed across clinical areas and staff openly discussed performance and compliance with targets.

Improvement is checked and monitored. Service leads met regularly to review performance and identify areas for further development. We were told of several improvement plans; however, these were hampered by the focus on staffing and ensuring safe cover.

Competent staff

The service made sure staff were competent for their roles. However, compliance with some specialist training and appraisals was not always in line with trust target and newborn screening training was low.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Although mandatory training compliance was below the trust target there was provision by the practice development midwives to ensure that staff had clinical skills necessary to perform their roles.

Managers gave all new midwifery staff a full induction tailored to their role before they started work. New staff were provided with an induction programme and newly registered midwives were provided with a robust preceptorship. Staff were supported by the practice development team who offered clinical teaching targeted to the individual's needs.

Managers made sure staff received any specialist training for their role. For example, Practical Obstetric Multi-Professional Training (PROMPT) was completed regularly by all staff and training compliance was reported as being 97.1% for consultant, medical staff and anaesthetic consultants, 89.1% midwifery staff and 54.5% for theatre nurses in May 2021.

Trust data showed that 37.8% of staff were trained in new-born screening and in July 2021, cardiotocography (CTG) training had been completed by 91% of midwives and 100% of doctors, which was better than the trust target of 90%.

Managers had an appraisal framework; however, compliance was not always in line with trust targets. Staffing shortages had impacted on staff's ability to complete appraisal. Staff appraisal rates at the time of inspection were recorded as 85% for nursing and midwifery staff which was slightly below the trust target of 90%. The medical staff appraisal rate was 100%. We saw that there was a planned trajectory of full compliance within the women's and children's care group for March 2022.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Doctors reported being able to attend training sessions and felt supported by their supervisors and consultants. Some consultants took on additional lead roles in areas of clinical interest such as fetal medicine and maternal medicine. Part of this role included the clinical teaching of their chosen topic and the insurance that polices, and processes followed the latest guidance

Medical revalidation was completed by 100% of consultants and trust doctors as of July 2021.

There was an established practice development team who worked cohesively with the teams and managers. We were given details of proposed development plans which included trust wide preceptorship programmes, staff development days and targeted training on 'hot topics. The team were passionate about the service and what could be achieved, however, this was hampered by the need to work clinically.

Staff had the opportunity to discuss training needs with their line manager and the development team and were supported to develop their skills and knowledge. Individuals were given the opportunity to develop their skills and knowledge where possible.

. **Multidisciplinary working**

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff reported and we saw that there was positive multidisciplinary team (MDT) working. Conversations were respectful and inclusive. We heard that doctors were very supportive of midwifery staff and acted accordingly when there were staffing pressures, taking on additional tasks.

Staff held regular and MDT meetings to discuss patients and plan their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. We were given examples of when women had been referred to other agencies or teams for support. For example, midwives referred women for mental health assessments when they showed signs of mental ill health illnesses or depression.

The service reported that due to the lack of consistent staffing they had not been able to fully undertake Avoiding Term Admissions to Neonate Intensive Care Units (NICU) ((ATAIN)) activities. We saw that the number of admissions to the neonate unit were monitored daily and information regarding trends were shared at performance meetings. Additional activities such as ATAIN meetings and the audit of compliance were planned to be implemented when staffing had improved and there was capacity to embed practice.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women are reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services we were told that the service held daily trust wide meetings to identify areas of increased pressure, and agree on actions to take in response to them. and diagnostic tests, 24 hours a day, seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw that consent was always recorded for clinical interactions with women or their babies.

Maternity

Consent for clinical procedure such as caesarean sections were clearly documented and held in women's records. Consent forms gave details of risks and clearly recorded discussions with women.

Is the service responsive?

Good

This was the services first inspection. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service had been working collaboratively with their peers across the Mid and South Essex NHS Foundation Trust since their merger. There was an appreciation that service ran slightly differently and that there was a need to standardise some practices.

The service worked collaboratively with the peers across the Local Maternity and Neonatal Service (LMNS). Teams met regularly to discuss national guidance and share experiences.

Facilities and premises were appropriate for the services being delivered there was additional space for the service to grow into if necessary.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services.

Women using the service were able to make decisions about the type of birth they wanted. The service provided a midwife led birthing unit and home births for low risk women. Service data showed that personalised care plans were in place for 100% of women using the service, this was above the trust target of over 95%.

The service had two established continuity of carer teams, who provided consistent midwifery support through the woman's three stages of the pregnancy (pregnancy, labour and post-natal care). Trust data showed that the service achieved continuity of carer for 24.6% to 28.1% of women from April to June 2021. This was lower than the trust target of 35% but recognised to be in response to staffing challenges with COVID-19 and the movement of staff to support inpatient areas. There were plans to extend the teams once new staff had started.

The service reported a higher percentage of total caesarean sections (c-sections) with 34.4% in April, 36.9% in May and 37.9% in June 2021. This was higher than the trust target of 28.6%. The number of c- sections had been consistently higher than the trust target and we were told that the service was in the process of reviewing the cases to identify the rationale for the choice of delivery. The World Health Organisation (WHO) recommends a population c- section rate of 10% to 15% to ensure mortality rates are kept low for mothers and babies.

Women could access support when necessary. For example, women could access a breast-feeding specialist midwife. Trust data showed that breast feeding initiation was completed from 75% to 79% for April to June 2021, which was higher than the trust target of 70%. Similarly, breast feeding at ten days was above the trust target of 75% for the same period, achieving 86%.

The service had bereavement midwives who worked across all clinical areas. There was a dedicated bereavement suite which was sufficiently sized to enable extended family to attend.

There were posters and information boards for women and their families to review. We saw that all information was in English, however, staff reported that they were able to access translating services if necessary and that there was less than 4% ethnicity and 3% deprivation in the area.

Staff reported a recent increase in women requiring mental health support and there were nominated mental health midwives and access to the mental health team if needed.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service delivered around 350 to 400 babies each month. Trust data showed that there were 360 babies born in April, 366 in May and 393 in June 2021 at the hospital. Staff reported that there had been an increase in babies being delivered over the weeks preceding the inspection.

The service routinely monitored the types of delivery and recorded this on a dashboard. Trust data showed that 62.9% to 65.6% of all deliveries for April to June 2021 had been normal vaginal deliveries (NVDs). Elective and emergency caesarean sections (C- sections) were reported as being consistently around 15 to 20%. For April to June 2021, elective C-sections were 15.6%, 15.3%, and 19.34%. The trust target was less than 12.6%. Emergency C-sections were reported as 18.9%, 21.6%, and 18.58% for the same period which was higher than the 16% target. Around 2% of all babies delivered by the service were born at home.

Managers and staff worked to make sure women did not stay longer than they needed to. Once women were deemed fit, they were encouraged to go home. However, we saw that some women stayed longer than anticipated due to requiring community support or changes to accommodation. When this occurred, staff encouraged mothers to be as independent as possible.

Managers worked to keep the number of cancelled appointments/treatments to a minimum. We were told that clinical pressures and emergencies sometimes impacted on elective cases which meant that women sometimes stayed in hospital slightly longer than planned. Staff told us that women may be moved to the following day for a procedure, although this was rare.

The service moved women only when there was a clear medical reason or in their best interest. Women were cared for in the most appropriate area for their clinical condition.

Staff supported women and babies when they were referred or transferred between services. We saw that there was a clear transition between services with staff accompanying women to the new area. When babies were transferred to neonate intensive care units, women were able to accompany them.

Maternity

Managers monitored transfers and followed national standards. Staff reported all transfers of care through the incident reporting system, and these were escalated where necessary for investigation. The service reported no incidents where they had diverted care to another provider from April to June 2021.

There were no reported maternal deaths and for the period April to July 2021 and there were less than one percent of babies admitted to the neonate intensive care unit from April to June 2021, against a target of less than 5%.

Service data showed that the service had not diverted care to another provider on or closed the service from April to June 2021.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Staff understood the policy on complaints and knew how to handle them. Where possible concerns were addressed at the time. Staff escalated to the midwife in charge or matron when issues arose, enabling concerns to be addressed immediately.

Managers investigated complaints and identified themes. Concerns were usually around treatment plans and communication.

Is the service well-led?

Requires Improvement

This was the services first inspection. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. However, the leadership structure was not fully embedded.

Local leadership consisted of a head of midwifery and a clinical lead. The team was well established, and staff told us they were accessible, and supportive. The teams were supported by three matrons and ward/ unit managers.

The service leads reported directly to the trusts senior leadership team (SLT) and there were clear escalation pathways and meetings for reviewing performance. Progress against national and local targets were monitored by the SLT and service leads were held to account for performance.

Staff told us that the SLT were visible and approachable and service leads told us that they felt supported by the SLT. The chief nurse was the designated board member lead for maternity services.

Please see the Southend University Hospital report for further details of the trust wide leadership for this service.

Maternity

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Please see the Southend University Hospital report for further details of the trust wide vision and strategy for this service.

Culture

Staff did not always feel respected, supported and valued. However, they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Prior to inspection, CQC had received two concerns from members of staff, relating to poor staffing and the impact this had on women's care and staff morale. We heard that staff were feeling pressured by the senior leadership team and service leads to work in particular ways. Staff felt unsupported and were generally unhappy in their work.

During inspection, we found that staff were frustrated by consistent issues with staffing levels, the turnover of staff and the impact this had on them being able to complete their jobs. Some staff felt overwhelmed with the activity, felt unsupported by managers and vulnerable to risk. Staff told us that COVID-19 had placed additional pressures on the team and that staff had lost their good will, becoming less likely to work additional shifts.

Despite this, teams spoke positively of each other and worked cohesively. They were respectful of each other offering support when necessary. Staff told us that the head of midwifery, matrons and practice development team were supportive and offered help when able.

Matrons and service leads spoke positively about their teams and their achievements during a very stressful and difficult time.

Matrons had started to work more closely with their peers across all sites. Matrons and heads of midwifery had daily morning calls to discuss any pressures and activity. They reported that this had been beneficial and enabled cross service developments. They had also commenced external coaching.

Staff used a closed social media account to share information.

Some staff told us that there had been a focus on the Basildon site and that they felt they had been 'forgotten' in the development of services. Although they understood the reason for development and risks, some staff felt that the focus meant that they had not been given equal opportunities or that their service had been developed. We also heard that there had been minimal cross site working, with teams only recently having the opportunity to meet/ work together.

We completed a staff survey which showed that staff did not feel able to escalate concerns and did not think action would be taken when they did and 40% of staff did not feel valued. Please see the Southend University Hospital report for full details of the survey.

Maternity

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, governance processes were not embedded.

The governance structure was under review following the merger, with an expectation for the Mid and South Essex governance structure and processes to be in place by the end of the year.

Local meeting minutes were detailed and showed good attendance across the multidisciplinary team. Agendas were standardised and minutes were shared across teams to keep staff informed.

We saw that the service reported to the trust board every quarter detail of any stillbirth or neonate deaths as part of the perinatal mortality review process. Reports shared, detailed cases, actions taken and involvement with families.

Leads told us that there was a monthly newsletter that shared information relating to audit results, feedback from complaints and women's feedback about the service.

Please see the Southend University Hospital report for further details of the trust wide governance of this service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. However, processes for monitoring risk were under review and not fully embedded.

Due to ongoing concerns with pressures on the service, delays in triage times and the ability to manage care safely, the senior leadership team were looking at how they could support the team through the movement of some service to other hospital sites. It was planned to move some elective cases to Southend University Hospital to alleviate some pressures on the team, however, due to staff communications this had not been completed at the time of inspection. Service leads and the senior leadership team recognised that there was an increased risk at the site due to reductions in staffing and increased activity and were endeavouring to make significant impact by extending women's pathways. The leadership team were in the process of consulting the medical staff who would be required to transfer to Southend Hospital for approximately one or two days per month.

Additional actions being taken by the trust to manage activity was to review satellite unit provision, staffing and activity to identify whether staff or services could be moved to reduce pressures on the main hospital site.

Locally the service had two risk midwives who tracked risks and reviewed incidents, escalating any concerns to service leads. We saw how the team shared information and discussed incidents and risks on a daily basis.

Risks identified locally included clinical risks and non-clinical risks, such as staffing, environment and risks associated with having one funded theatre team. All risks were reviewed regularly and discussed at risk meetings.

The service had benchmarked their service against the recommendations in the Ockenden and developed an action plan to address any areas that required improvement.

Maternity

Please see the Southend University Hospital report for further details of the trust wide management of risk for this service.

Information Management

The service collected reliable data and analysed it. However, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Staff reported that since the merger information required for their work was not always accessible. We were given examples where training information did not match local records or were not accessible. Other staff told us that budget information, human resources forms and information was not available as previously. This impacted on staff's ability to complete their jobs in a timely manner taking more time to locate the correct records.

Please see the Southend University Hospital report for further details of the trust wide information management for this service.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Trust leads had been working towards improving services, but this had not always been effective, and staff reported that communication was not always timely. There were multiple concerns within the midwifery cohort about the lack of support and understanding from the senior leadership team. The trust leads were completing regular engagement calls and visits with the team to improve communications across the service.

Changes to women's care pathways and revisions of services had not been fully accepted and whilst there was an understanding of the pressures on the service, some staff were reluctant to accept changes. This directly impacted on the ability to address concerns. Staff were anxious about changes planned.

The service had a closed social media group which was used to share information. Staff reported that this was a good way of catching up with any changes or with seeking support or cover. The service also used newsletters to keep staff informed.

Staff reported that the transition to Mid and South Essex NHS Hospital Foundation Trust had been hard on staff, and they felt like the 'poor relations' with the focus being on the other two sites.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

The practice development team worked closely with the service leads to develop the team and ensure that they were up to date with guidance. The team offered individual and group training and support using structured methodology. They were very driven to improving the service and had plans to develop the team.

Surgery

Requires Improvement

Is the service safe?

Requires Improvement

This was our first inspection since the service merged in April 2020. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but could not evidence that everyone had completed it.

The mandatory training was delivered by a blend of online and face to face training depending on the topic. Data supplied by the trust following our inspection showed that nursing staff met the 85% training mandatory target in nine of the seventeen modules. For example, nursing staff were complaint in equality, diversity and human rights, health safety and welfare, infection prevention and control, moving and handling level 1, preventing radicalisation – basic prevent awareness, safeguarding adults' level 1 and 2, safeguarding children level 1 and 2.

Medical staff did not meet the trust target in any of their seventeen modules. This included resuscitation, with 33% of medical staff and 42% of nursing staff completing adult basic life support training. This meant that there was a potential risk to patients when an emergency arose. There was an improving trajectory of mandatory training compliance as of September 2021.

Staff told us that pressures of responding to COVID-19 had meant that face to face training sessions had been cancelled, postponed or offered with reduced numbers. Staff said they could complete training if the wards activity allowed, however, this was challenging due to pressures with staffing.

The service implemented a new learning system in April 2021 and managers said that during the transition between the two systems there had been some issues with line managers accessing the correct electronic staff records. The expected timeframe for the service to meet trust target was January 2022.

Safeguarding

Not all staff completed safeguarding training on how to recognise and report abuse. However, staff understood how to protect patients from abuse and the service worked with other agencies to do so.

The hospital met the trust target of 85% across all staff within surgery for safeguarding adults and children level 1 and 2. Data provided by the trust showed that safeguarding adults training compliance for level 1 was 87.9% and for level 2 was 89.4%. The trust mandatory training target was 85%.

Data provided by the trust showed that safeguarding children training compliance for level 1 was 84% and for level 2 was 85%. Level 3 training was in progress for appropriate staff with 95% compliance expected by August 2023.

Data for level 3 safeguarding training was not provided. Leaders told us that this was a known issue and was a result of migrating data to a different system. There was a plan in place to address this issue however, at the time of the inspection there was no data available to evidence that training for safeguarding level 3 adults and children was completed. Following inspection, we were told that safeguarding adults level 3 training had recently been introduced and was planned to be delivered to staff with compliance of 95% expected by August 2023.

All staff said they knew how to make a safeguarding referral and told us they would contact their line manager and could refer to the intranet for additional guidance.

The service had safeguarding leads who supported staff with any concerns. We saw that there were clear safeguarding policies which described escalation and reporting processes.

Cleanliness, infection control and hygiene

The service controlled infection risk and ensured that control measures were in place to protect patients, themselves and others from infection. However, infection prevention and control audits were not routinely completed.

Ward areas visited, were visibly clean and had suitable furnishings which were clean and well-maintained.

The trusts infection prevention and control audit programme referenced monthly audit activity. However, we saw that not all wards completed audits for hand hygiene, invasive devices and decontamination in line with local policy. Between April 2021 to July 2021, only Billericay ward had consistently completed monthly audits their compliance was 100%. In July 2021 hand hygiene audits were completed by the surgical emergency ward and were 96.61%compliant, the mayflower ward was 99.17 compliant and john Ray and Billericay were both 100% compliant. There was no data for the other wards within surgery.

The service monitored surgical site infections and data showed that there had been one surgical site infection in the past 4 months which had resulted in readmission.

Staff followed infection prevention control principles including the use of appropriate personal protective equipment (PPE). We saw the correct use of PPE such as disposable gloves and aprons. PPE was available in all clinical areas. Hand sanitiser was located across wards and staff and visitors were encouraged to use it.

Surgical equipment was sent for decontamination offsite. The holding area for equipment ready to be decontaminated was secure.

The trust told us that there was no current data on surgical site infections. Surgical site infections surveillance was paused nationally due to the pandemic and is expected to recommence later in 2021 / 2022.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Surgery

The design of the environment followed national guidance. The location of theatres was divided in a 'H' configuration with a mix of original and newer build. The older area of theatres had limited space where we saw equipment being stored in corridors. We also saw that some wards were cluttered and did not have enough room for all equipment, for example on the John Ray ward we saw equipment being stored in corridors.

There were single side rooms available on most wards, with priority given to patients who were at the end of their lives or needed to be isolated because of infection.

The service had enough suitable equipment to help them to safely care for patients. We checked fifteen items of equipment, for example blood pressure machines and wall suction instruments and found all but one to be within service date, visibly clean and ready for use. On Mayflower ward we found a suction machine that was overdue for its service date as it was due July 2020.

Staff carried out daily safety checks of specialist equipment. We were told that the anaesthetic machines were checked daily however, there was no logbook to evidence and audit these checks. We also saw some gaps in equipment checks on some wards, for example, on Billericay ward, we saw a total of seven days where the difficult intubation trolley had not been checked between May and August 2021.

The resuscitation trolleys were safely secured with tamper proof seals and records showed that staff conducted daily checks in line with the trust policy. In all wards we visited we observed that resuscitation trolleys had been checked again after being used.

Patients could reach call bells and staff responded quickly when called.

Staff wore the appropriate level of personal protective equipment (PPE) for the environment they were entering. Staff within theatres wore appropriate gowns and ensured these were clean or changed before leaving the department.

Staff disposed of clinical waste safely. Appropriate facilities were in place for storage and disposal of household and clinical waste, including 'sharps. A 'sharps' bin is a container that can be filled with used medical needles and all categories of 'sharps' waste, before being disposed of safely. 'Sharps' bins we observed were appropriately labelled and stored correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, safety checklists and assessments were inconsistently completed.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score system (NEWS2) for recording clinical observations. The NEWS2 is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify changes in the physiological condition enabling escalation of any concerns. We reviewed ten patient records and found staff largely recorded NEWS2 appropriately, however, there were two instances where observations had not been followed up this was escalated to the ward nurse who addressed this on shift. The trust audited NEWS2 records and audit data from May 2021 that found good escalation of unwell patients and prompt reviews by the medical teams.

Surgery

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The trust had suspended the venous thromboembolic (VTE) audit due to the COVID-19 pandemic and resumed in February 2021. The service audited the patients VTE assessments and reported these monthly. We reviewed VTE audit data from February 2021 to June 2021 and saw that against the trust target of 95%, division four (trauma and orthopaedics) had not met the trust target with compliance of 83% in June 2021. Division five was just below the trust target at 94% and all other surgery divisions were meeting the trust target.

Nursing staff recorded the level of risk to patients on admission and the risks for surgery were recorded by an anaesthetist. Patients were assessed using the ASA physical status classification system. ASA is a system for assessing the fitness of patients before surgery. Medical and nursing staff completed risk assessments when patients were admitted for surgery. We reviewed three patient records and saw risk assessments were completed appropriately.

The hospital conducted harm reviews for patients whose surgery had been delayed. These reviews were completed in each clinical specialty by consultants. This process aimed to minimise the risk to patients waiting for procedures and to ensure that patients were treated in line with clinical risk.

The World Health Organisation's (WHO) five steps to safer surgery checklist was used across all theatres as a tool to prevent avoidable harm. The checklists were audited regularly. Trust data showed that staff did not complete all aspects consistently. In April 2021, when the trust resumed its audit schedule, the average for completed debriefs was 43%, although there was an improvement in compliance in June 2021. We were told that theatre staff were emailed to emphasise the importance of completing the WHO checklist to improve compliance. Mangers told us that the trust was working to standardise the WHO checklist across the three hospital sites.

The service had 24-hour access to mental health liaison and specialist mental health support. We were told that staff could access this support via the emergency departments CRISIS team.

Staff shared key information to keep patients safe when handing over their care to others. We observed shift changes and handovers included all necessary key information to keep patients safe.

The surgical emergency ward was some distance across the hospital from diagnostic scanning. Staff told us that, particularly out of hours, a member of staff had to accompany the patient to the scan. This reduced the number of staff on the ward as well as being some distance for acutely unwell patients to travel.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff. We saw that the number of nurses and healthcare assistants on duty did not match the planned numbers and staffing levels were below planned in most of the areas we visited. On multiple wards visited we saw that the actual staff numbers did not match the planned or establishment. For example, on Mayflower ward we saw that the early shift and late shifts staffing was below the planned level by one registered nurse on each shift.

A staffing acuity tool was in use to track staffing against acuity/ activity this enabled managers to make decisions about staffing requirements and flex numbers accordingly. The ward manager could adjust staffing levels daily according to the needs of patients.

The service had high vacancy rates for registered nurses at 12.5%. The trust was expecting this to come down as a number of recruitment drives were taking place to draw in more nurses, including sourcing staff from overseas and student nurses. Leaders said that new starters were expected to start in August and September 2021. On the surgical emergency ward (SEW) there were two registered nurse vacancies and two health care assistant vacancies. Numerous staff on SEW told us that they did not have sufficient staff to adequately care for patients. In the last twelve months, the hospital had a nursing turnover of 9.5% within surgery. This was broadly in line with performance across the trust.

The sickness rates were 5.1% for registered nurses in surgery which is higher than the trust target of 3.5%. Leaders were aware the higher rates of staff sickness were due to COVID-19 and the need for staff to isolate.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. We reviewed staff folders and saw that staff received an induction.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills and training. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had consultants available 24 hours per day with and on call service at night and weekends. Patients admitted would be seen within 12 hours by a consultant and prioritised according to clinical presentation. The service did not always have enough medical staff to keep patients safe. The medical staff did not always match the planned number. On Heybridge and Notely ward clinical staff told us that medical staffing was challenged.

Doctors completed daily ward rounds and planned patient care and treatment accordingly. At weekends, consultants saw those patients referred to them by their peers to ensure ongoing reviews.

The vacancy rates were high, at 15% for medical staff in surgery. Any shortfall in cover was managed by using locum staff. Senior leaders at the trust told us that medical staffing was a significant risk and there was an ongoing recruitment plan to address the shortfall. However, medical staff told us that the vacancies were having an impact on the delivery of care, particularly during the COVID-19 pandemic.

In the last twelve months the hospital had a medical staff turnover of 10%. This was broadly in line with performance across the trust.

According to data submitted by the trust there was a sickness rate of 0% for medical staff in surgery and across the other sites. However, this was not consistent with what we were told by medical staff on inspection.

Managers made sure locums had a full induction to the service before they started work. Medical staff told us that they had been orientated to the service.

The service had a skill mix of medical staff on each shift and reviewed this regularly.

Surgery

Records

Staff kept records of patients' care and treatment. Records were always completed however, paper records were not always clear, and not stored securely.

We reviewed ten patient records and found them difficult to navigate in places. People's individual care records, including clinical data, were not consistently written and managed in a way that kept people safe. We found there was no set order for the paper-based notes which meant that information could not be easily located.

All records included details of patient's admission, risk assessments, pre-assessment forms, treatment plans and consent.

Patient notes were a mixture of electronic and paper records. Staff told us of their frustration of working with different systems and the combination of paper and electronic records.

Paper records within surgery were stored in trolleys that could be locked. On inspection we saw paper records were not always stored appropriately and were sometimes left unattended.

Staff said when patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service did not always ensure the safe use of medicines. However, there were systems and processes to safely prescribe, administer and record medicines.

Staff followed systems and processes when safely prescribing, administering and recording medicines. Checks completed showed all drugs were stored in locked cupboards and were within the expiry date. However, in theatre one, we found a tray of medicines that staff had left out on a worktop which were not being supervised by staff. The medicines were all labelled and included a controlled drug. We were concerned that this posed a safety risk as no one was supervising or accountable for the medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

We reviewed prescription charts and we saw that medicines were given in a timely way and in line policy. We saw that medicine charts clearly recorded any patient allergies.

Ambient and fridge temperature checks were conducted by staff and recorded appropriately. Staff said they would escalate if there was a temperature reading that was outside the permitted range.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. These were discussed at huddle meetings and were sent via email to staff.

Incidents

Surgery

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The trust had implemented a new electronic incident reporting tool across all sites which meant that staff could report an incident anywhere. Staff raised concerns and reported incidents and near misses in line with trust policy. However, staff had to opt into the incident reporting process to receive feedback from investigation of incidents and this meant learning was not always shared.

Staff said they would also contact their line manager to raise a concern and that information on incidents was circulated over email.

The service had reported two never events at the hospital in the past year. Both involved administering blocking anaesthesia. We reviewed the investigation reports for these never events and the actions taken. The action plan had actions assigned to individual staff members and was reviewed regularly to ensure the actions have been implemented. Managers shared learning about never events with their staff and across the trust. We saw information being shared at daily huddles. Staff were aware of incidents that occurred within the hospital, but some were not aware of never events and incidents on other sites. We were told by managers that one of the identified learnings from the never events included a change to the World Health Organisation (WHO) checklist. However, they were unable to make this change whilst the checklist was being harmonised across the organisation. We were concerned that identified learning from incidents were not address or implemented in a timely manner.

Staff reported serious incidents clearly and in line with trust policy. Staff understood duty of candour and were able to outline the principles being open and transparent when things went wrong and were able to give examples where duty of candour had been applied.

Is the service effective?

Good

This was our first inspection since the service merged in April 2020. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. At the time of the inspection the trust was implementing a plan to standardise guidelines and policies across the merged hospital sites. The standardisation process was delayed due to the COVID-19 pandemic, senior leaders said some guidance was past their review date.

The service updated guidance and policies in line with NICE guidance. For example, we saw that pathways followed NG180 (perioperative care in adults). The service had National safety standards for invasive procedures guidance in place (NatSSIPs) and adapted these for local practice (LocSIPs).

Surgery

The World Health Organisation (WHO) produced a checklist to improve the safety of surgical care around the world by defining a core set of safety standards. On inspection, we saw that the WHO checklist was being used, although trust data showed that the WHO checklist was not always audited across surgery. We saw that there were gaps in audits for most surgical specialities from April to June 2021.

We observed handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients were complimentary of the range of food offered.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The patient records' we reviewed all had a nutrition and hydration assessment using the malnutrition screening tool (MUST). The MUST assessments were fully completed on the wards we visited.

Patients waiting to have surgery were not left nil by mouth for long periods. We spoke to patients on the surgical wards who had been instructed about the fasting arrangements on admission.

Patients with any dietary needs or requiring additional support could be referred to the dietitians. There were a range of invasive and non-invasive nutritional supplements used to maintain patients' conditions. For example, we saw Total Parenteral Nutrition (TPN) in use.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff had access to tools, including picture cards to help assess the level of pain felt by patients who were non-verbal, living with dementia or had other difficulties with communication.

We saw that a variety of pain relief methods was available including oral, and patient controlled analgesia (PCA) and epidural.

Patients received pain relief soon after requesting it. Patients told us that staff were responsive when they were in pain and were treated with compassion.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits and produced action plans from the findings. We reviewed the National Emergency Laparotomy Audit from January 2021 and the National Joint Registry 17th Annual report from September 2020 and saw actions were put in place to increase staff awareness and improve the input of patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There was an ongoing local audit programme with action plans. Although during the COVID-19 pandemic, some local audit programmes were suspended as staff were pulled into clinical roles. At the time of the inspection senior leaders told us that the local audit programme was in progress and we saw evidence of this.

Managers used information from the audits to improve care and treatment. Staff told us that there were action plans to improve services following the identification of areas for development.

Competent staff

The service had staff were competent for their roles. However not all staff received an appraisal in the last 12 months.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. On Rayne Ward we reviewed the staff competency folder and all staff had competencies signed off specific to the role.

The combined nursing and medical staff appraisal completion rate across surgery was 69% and below the trust target of 90%. Registered nurses achieved 66% compliance against the trust's 90% target. Managers told us that appraisals rates had slipped in response to reprioritising their efforts to manage the COVID-19 pandemic. Managers said there was a plan to make sure staff were appraised by the end of the year. Some areas kept records of compliance and we were told that appraisals were 100% on Rayne ward. We saw team meeting minutes encouraging staff to contact their manager to arrange their appraisals.

The trust's clinical educators supported the learning and development needs of staff. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff we spoke with were optimistic about developing their skills within the hospital however, some said this was a challenge due to staffing levels.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers and staff told us meeting minutes were sent via email.

Some of the wards used agency staff and wards had processes in place to ensure that they were inducted appropriately. For example, on Heybridge ward there was a completed checklist for agency staff to complete.

Multidisciplinary working

Surgery

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. Patients referred into the service were discussed at MDT meetings to agree treatment plans prior to admission. We were told that pre- operative assessment staff attended all multi-disciplinary team meetings regarding patients they had reviewed.

We observed two handover meetings and they were well attended by doctors, physiotherapists, nurses, the senior sister and the discharge coordinator. All staff focused on providing patient centred care and prioritised those ready for discharge.

We observed effective informal MDT working in all areas we visited.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, with weekend reviews completed by the on-call team. Patients were reviewed by consultants depending on their care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Staff told us that they had commenced additional theatre list at weekends to manage waiting lists and meet demand following the COVID-19 pandemic.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information and leaflets promoting healthy lifestyles and support on wards/units. Pre-operative staff discussed patients' habits and gave information on smoking cessation, and how to lead healthier lives as part of the patient's assessment for theatre.

Staff assessed each patient's health on admission and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were able to tell us what actions they would take to assess whether a patient had capacity.

Surgery

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. In all records we reviewed, consent forms had been signed. We saw that in four records reviewed consent forms had been appropriately completed. Risks and benefits of procedures had been discussed and there was evidence of patient involvement in decision making.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We did not see any examples of where patients had been unable to give consent.

Is the service caring?

Good

This was our first inspection since the service merged in April 2020. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Throughout our inspection was observed several episodes of care where staff were kind, respectful and maintained patient dignity.

We spoke to five patients during our inspection, and all were positive about their care and treatment. Patients informed us they were happy with the care they received. They described the care as 'excellent' and felt staff were nice, comforting and re-assuring.

Patient satisfaction survey results showed positive responses for wards and clinical areas. For example, the day surgery unit had a 100% positive satisfaction score for July 2021, ophthalmology had an 88% positive response score, and John Ray ward had an 85% positive scores in July 2021.

Staff followed policy to keep patient care and treatment confidential. We saw staff use the curtains when to maintain privacy and dignity.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw staff taking time to make sure patients were comfortable in bed and adjusting pillows to make them comfortable. A patient we spoke to told us staff supported them emotionally when they expressed that they were anxious about their surgical procedure. They said that staff took time to reassure and make them feel at ease.

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Patients, relatives and staff had access to psychological support and counselling services. There was a multi-faith chaplaincy service available for patients.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. All patients said that staff took time to explain their journey through hospital and what their treatment may involve.

Staff talked with patients, families and carers in a way they could understand. The wards had communication aids in folders and staff told us they were used where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement

This was our first inspection since the service merged in April 2020. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. The service was divided into specialties and the senior management team of each specialty had oversight of the entire patient pathway.

The service worked with peers to improve patient pathways and reduce pressures across the healthcare system. We saw that where possible, the service relieved pressure on other departments when they could treat patients in a day. The same day emergency care (SDEC) pathways were in their early stages of implementation, however, they aimed to reduce the number of patients who would otherwise be admitted to the hospital or wait for extended periods of time. This was part of the trusts response to patient flow and aiming to reduce patient waiting times.

We were told that where possible the service ensured that patients were admitted as day surgery cases. Elective day surgery had a strict green COVID-19 pathway and patients were tested and required to self-isolating prior to their admission.

Surgery

Facilities and premises were appropriate for the services being delivered. Patients who required a higher level of care were referred to the high dependency or intensive therapy units. If the need for additional care was known prior to the patient operation, a bed was booked in advance, and staff worked collaboratively with the critical care team to ensure that patients were cared for in the most appropriate location according to the patient's condition. There were also process for patients who were deteriorating to be seen by the critical care outreach team, for support and advise.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. During the reporting period no mixed sex breaches were reported.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service used an electronic database which captured any specific needs for each patient which enabled services to facilitate additional time for appointments, pre-admission visits or ensure that patients had the support in place they required.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was telephone translation service available for patients whose first language was not English as well as interpreters. Translation requirements were identified at pre-assessment. The service had information leaflets available in languages spoken by the patients and local community.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. There were dementia specialists across the trust who could provide support if required.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff recorded patient's food needs and preferences on patient menus and on patient whiteboards at the bedside.

Staff could access specialist equipment for example, bariatric chairs and beds, when necessary. Pressure relieving equipment was accessible and staff told us there were no concerns or issues accessing equipment.

Access and flow

People could mostly access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards. Patients did not always have new appointments for procedures booked within 28 days of being cancelled.

Managers monitored waiting times. However, patients could not always access services when needed or receive treatment within agreed timeframes and national targets. The referral to treatment times (RTT) had been affected by the COVID-19 pandemic and trust data showed that there were significant numbers of patients awaiting procedures. Data from May 2021 showed there were 32,552 new referrals across the trust.

Surgery

The trust did not meet any of the national standards for cancer waits in May 2021. The trust performed second worst in the east of England region for treatment within 30 days (87.6% compared to 96%) and for 62 days they achieved 61% against a target of 85%. 86.7% of patients were seen within two weeks against a national target of 93%. The trust completed harm reviews for all patients waiting for procedures greater than 52 weeks. Harm reviews were also completed for all patients within specific specialities, to ensure there was oversight of risk and harm. Patients identified as requiring urgent treatment were prioritised.

Trust board papers for September 2021 stated that the trust performance for two week waits (2WW) for cancer was 84.3% in June 2021 against a trust target of 90.3%. This was better than the 79.8% regional average and similar to the national average of 84.9%. There were 801 breaches in the 2WW which was gradually increasing month on month this year.

The 62-day urgent GP referral data was slightly below the trust target of 65.1% at 60.3% for June 202. This was lower than the regional and national averages (72.3% and 73.3% respectively). There were 380, 62 day wait patients and 75, 104 day waiting patients. These figures were similar to the preceding months.

The 18 weeks wait referral to treatment times for June 2021were better than the regional (67.1%) and National (68.8%) at 69.9%.

There was a robust process for monitoring patients awaiting surgical procedures and staff reviewed waiting lists regularly, monitored waiting times and reported these to the trust board. Each division had a waiting list and each patient on that waiting list was discussed weekly to identify what was needed to admit the patient for their planned procedure. The service reported waiting times and plans to reduce them to the trust board.

We were told that bed capacity and workforce challenges greatly impacted on the services ability to meet demands.

Managers worked to keep the number of cancelled operations to a minimum. During our inspection staff worked collaboratively to ensure theatre optimisation across the three sites. Staff reported that at theatre planning meetings they reviewed the schedule for elective patients and where necessary cancelled patients in advance to avoid on the day cancellations. However, there had been significant cancellations whilst the trust responded to the COVID-19 pandemic.

Data provided by the trust following our inspection showed that the number of patients who had days their operation cancelled increased from 29 in April 21, to 37 in June 2021. The trust monitored the number of patients that were not operated on within 28 days of a cancelled procedure. As of June 2021, 35% of cancelled procedures were not re booked within the 28 days.

Managers and staff worked to make sure patients did not stay longer than they needed to. We saw discharge coordinators working with nursing staff to make sure that patients were discharged with the appropriate care package in place.

Managers worked to minimise the number of surgical patients on non-surgical wards and made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. We saw surgical staff talking to patients ahead of their surgery and consulting them about their care.

Surgery

Managers monitored that patient moves between wards were kept to a minimum and moved patients only when there was a clear medical reason or in their best interest. The majority of patient moves was noted as being in response to changes in patient's COVID-19 status. Staff told us they tried to minimise the number of moves, however the lead in time to receive a test result had an impacted on the number of moves. Staff did not move patients between wards at night.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients asked told us they knew how to complain or raise concerns but had had no cause to do so and we saw that there was information on how to make a complaint on notice boards.

We saw that there were 62 complaints regarding the service for the 12 months preceding the inspection. We reviewed these complaints and saw that they were usually around care and treatment plans, or communication.

The trust reported 409 complaints from August 2020 to July 2021, across all services. The response rate was recorded as between 40 to 61% within the trusts timeline.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff told us they knew how to acknowledge complaints and patients received feedback from managers.

Is the service well-led?

Requires Improvement

This was our first inspection since the service merged in April 2020. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

Since the hospital merged with Southend and Basildon hospitals there was one executive team responsible for the three hospitals. There was also a leadership team on each site, which consisted of a managing director, medical director, operational director and director of nursing. Some staff we spoke with said that since the merger, executive leaders were less visible, and this was because they could be based across the other hospital sites.

The trust managed all services through care groups and divisions within each care group. Surgical services were split across two care groups with each care group being led by clinical leads. Each division had a leadership team which included a clinical director, general manager and head of nursing. The leadership team was supported by speciality leads, ward managers and matrons who provided local leadership at ward/ department level.

Surgery

Staff described matrons and the ward managers as visible, approachable and supportive. Ward managers told us they felt supported by the matrons. Medical and nursing staff understood management reporting structures and told us they were supported by their managers. Staff, in most cases, were able to tell us who the senior management team were and could describe instances when they had visited wards/department.

Leaders we spoke with understood the challenges faced by the service and could explain how they were working with staff to support them. We were told governance leads were attending staff meetings within surgery and saw evidence of increased engagement in team meeting minutes.

Leaders understood the challenges to quality and sustainability and could identify the actions being taken to address them. Staff told us, and we saw during our inspection, that matrons and the surgery director of nursing were visible on the wards. Matrons attended trust wide bed occupancy and staff briefings three times daily to discuss nurse staffing to ensure safe numbers of staff for the acuity of patients. There was daily oversight of staffing issues, which were reviewed and mostly mitigated.

Daily theatre meetings were held where they discussed staffing, theatre lists and potential cancellations. There was a weekly theatre oversight group that looked retrospectively at theatre lists and theatre managers across the trust met monthly. Other leaders also met across the three sites to identify and discuss concerns and issues such as mandatory training for prioritisation.

Vision and Strategy

The service had a strategy for what it wanted to achieve and how to turn it into action, developed with all relevant stakeholders. Leaders and staff understood and knew how to apply them and monitor progress. However, not all staff were aware of the trust vision.

There was a trust strategy with objectives to achieve their ambition ‘to improve health and wellbeing through excellent, financially sustainable services, provided by staff supported to develop, innovate and build rewarding careers’. Staff were aware of the trust objectives and values. This three year strategy was developed and aligned to the wider Essex Health and Care Partnership five-year strategy and delivery plan.

Senior leader told us that following the merger of the three hospitals into the trust, the overall aim of the surgical services was to align procedures, share best practise and work collaboratively across the three sites. The teams had commenced working on patient pathways to enable joint working.

Staff were not aware of the trust vision for future services. They told us they had been working towards the formation of the new trust and focusing on the COVID-19 response.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Surgery

Staff we spoke with said that the COVID-19 pandemic had presented an unprecedented challenge and there were increased pressures with surgical speciality staff supporting medical wards. This caused some anxiety across nursing staff, who were concerned about moving to different wards and this impacted negatively on morale. Staff were anxious about staffing levels but supported each other when needed.

Leaders told us they were proud of the hard work and dedication of their staff to improve patients care, especially in response to the COVID-19 pandemic and the post pandemic recovery. Leaders were also concerned that staff were fatigued and had provided staff wellbeing measures to help with wellbeing. All staff we spoke with said they know about the wellbeing support being offered by the hospital though most staff had not used these services.

Staff at all levels were clear about their roles and understood what they were accountable for, and to who. Staff said they were encouraged to develop and were supported by their managers to learn new skills.

Staff told us there was good teamwork within the service and we observed this during our inspection. Staff were prepared to work flexibly to accommodate service needs. All staff spoke highly of their colleagues then describing the culture of the workplace. There was evidence of team working and cooperative, supportive and appreciative relationships amongst staff. We observed friendly and professional relationships amongst staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, the governance processes were not embedded, and the surgical team were not always represented at all governance meetings.

The service was in the process of reviewing the governance structure and aligning process across all three sites. The new governance structure was in place however, this was not embedded. The leadership team were in the process of standardising processes across all sites, however, this had been delayed due to the impact of COVID-19.

Specialities held monthly meetings to allow oversight of the service, which were then fed into divisional governance meetings. Clinical governance meetings had been postponed during the pandemic but had been recommenced and were well attended. Any relevant information was escalated to the board through monthly meetings, where leads were held to account for their actions and performance.

We reviewed the January and May minutes of the mortality review group meeting and found that attendance from Surgery was not always present. According to the minutes of the meetings no structured judgement reviews had been made from surgery since January 2021. Structured judgement reviews help to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

Most wards across surgery used ‘SQUAD’ books as a centralised handbook kept on the ward to communicate key messages such as handovers, learning from incidents and cleaning records.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The trust had updated it electronic reporting tool, and as a result had begun migrating information onto the new system in July 2021. The trust was expected to complete the transition of risks by 31 August 2021. The aim was to deliver appropriate and effective visibility of all risks across the organisation.

There was a care group and service risk register which was reviewed and updated at the clinical governance meetings. Service risks sat within the division responsible for the service. The top risk identified by leaders was staffing. Leads told us that they were working with local universities and the community to recruit students to the trust. Other risks identified by the leadership team were capacity and aging equipment in some areas of the services. Where necessary, risks were mitigated. The senior management team were aware of the procedure to escalate any of the service risks to the trust risk register, enabling trust board oversight. However, there remained significant risks in relation to nursing and medical staffing and the impact this had on services.

The service had a quality assurance dashboard report which detailed performance as well as including the top risks by division. The dashboard was used to enable effective monitoring and managing performance. The dashboard reported on performance information such as waiting list numbers, referral to treatment times, theatre utilisation, length of stay and unexpected returns to theatre. The dashboard allowed the service leads to compare performance over time and against targets and seek ways in which to improve.

We reviewed performance management reports between April and May 2020. As management information had not fully migrated across to the new system the safety dashboard used to manage safety was incomplete in key areas such as pressure ulcers and infection control. The service was also behind on completing referral to treatment harm reviews. The data for May 2021 was at 43% across colorectal, ophthalmology and dermatology. The overall performance for cancer referral to treatment harm review was 54%. The trust had an action plan to improve performance. However, significant numbers of patients faced delays in accessing care and treatment.

There was a significant number of patients waiting for procedures, and there were effective processes in place to monitor patients waiting for surgery and performance against the post COVID-19 recovery plan. There had been harm reviews to make sure that the most unwell patients were prioritised as the service worked to address the backlog of patient appointments. A patient tracking list was in place, and this was reviewed at weekly meetings. Clinical urgency was reviewed by clinical specialists to ensure that patients were prioritised in line with clinical need. Senior leaders told us that capacity issues were addressed by effectively utilising independent health providers and the vanguard theatres across all three sites.

There were processes in place to give leaders oversight of patients waiting for appointments and referral to treatment performance and these were used to plan access for patients. The service reported waiting times and plans to reduce them to the trust board.

Senior managers told us that incidents, near misses and complaints were monitored for trends and improvements via action plans. Staff we spoke with were aware of never events and serious incidents that had happened within the hospital but were not informed then they happened within the trust. The hospital has had two never events regarding wrong site blocks. At the time of the inspection the Trust was working to standardise the World Health Organisation (WHO) checklist and during the interim each site was working on its own local way of working. Audits showed poor compliance with the WHO checklist and identified learning had not been put into place. We were concerned that leaders were not taken effective action despite two never events at Broomfield hospital and others across the trust.

Information Management

Surgery

The service collected data and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements. However, staff felt that there was a lack in consistency between electronic and paper records.

Staff had access to a trust intranet system which provided a range of internal and external resource material to assist staff in their daily tasks. All referrals and diagnostic requests were made electronically, and staff told us that they had access to the information that was needed for them to undertake their roles.

Staff used multiple systems for recording patient care, including paper and electronic records. Staff told us they were frustrated with the lack of consistency in records.

Information stored electronically was secure. Computer access was password protected and we observed staff logging out of computer systems or hand-held devices they had completed tasks.

There were arrangements to submit relevant data to national audit programmes. The trust had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements.

The service collected patient feedback where possible and a monthly quality assurance report for surgery included feedback from patients in the form of complaints and compliments. These were discussed at the meetings and staff received training on information governance as part of their mandatory training.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Senior leaders had regular walk arounds and drop-in sessions where staff could speak to them. Managers engaged with staff using different methods, including team meetings, newsletters via email and a group messaging service app. Staff in the areas we visited told us that local leaders were visible and offered opportunities to listen and feedback to staff. Senior managers were less visible, following the merger to Mid and South Essex NHS Foundation Trust.

The service gathered patients' feedback and views through the friends and family test (FFT), which gathered data on whether patients or their families or carers would recommend the service to their friends or family.

Staff told us that cross-site working was limited, and they were aware of plans to improve this in future. Staff said there had not been consulted about how to improve cross site working. Senior leaders told us that this had been delayed due the pandemic, but work was under way to start staff engagement by senior leaders attending forthcoming local team meetings.