Care Quality Commission

Mid Essex Hospital Services NHS Trust

Broomfield Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Good**
Urgent and emergency services	**Requires improvement**
Medical care (including older people's care)	**Good**
Surgery	**Good**
Specialist burns and plastic services	**Outstanding**
Maternity and gynaecology	**Good**
End of life care	**Good**
Outpatients and diagnostic imaging	**Good**

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

- The leadership of the interim chief executive has driven significant improvements at the trust and this was evident during our inspection. Staff spoke positively of the Chief Nurse, and her role as the interim chief executive. A new chief executive had recently been appointed as part of the Essex Success Regime.
- Throughout the organisation staff were dedicated, passionate and cared about patients
- Whilst the trust had completed a successful oversees nursing recruitment programme, there still remained a high number of qualified nurse vacancies, which impacted on skill mix and the use of bank and agency. However, maternity had successfully recruited to midiwifery vacancies.
- The emergency department was under pressure from the number of attendances. Between April 2015 and March 2016 the department had seen a 16% increase, which was double that of the England average of 8%.
- The increased number of attendances affected the flow of the emergency department. However, the department had introduced the Early Senior Assessment & Treatment (ESAT) and the "risk stamp"and"escalation criteria for patients with a 45 minute delay off load or delay in department for more than six hours. Both of these initiatives were working to ensure that patients were triaged, placed on appropriate pathways and re assessed when delays occurred.

Summary of findings

- The burns service was extremely good and the service had innovative developments and plans.Their patient outcomes also show that they are one of the best burns centres in the world.
- Access and flow throughout the burns service was seamless, and in the plastic surgery service significant improvement and action had taken to enhance seamlessness. However, there had been 795 plastics operations cancelled by the hospital in the last 12 months, though there were suitable plans in place which were being actioned to address this. Cancellation rates for trauma patients were not being monitored robustly
- There had been significant improvements in gynaecology with the move from Writtle ward to Gosfiled ward. Although we found general surgical outliers at the time of inspection, the numbers of outliers had reduced and there was clear criteria for outlying into a gynaecology bed.
- Overdue outpatient appointments of more than six weeks were referred to the supervising clinician for risk assessment to ensure it was safe to delay appointment. Ad hoc clinics could then be organised to meet demand.
- The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.The data provided by NHS England (September 2014 – February 2016) confirmed RTT times were in line with the England average. For general surgery 82.2% of patients were seen within 18 weeks of referral, Ear,nose and throat (ENT) 91.4%, Urology 93%, oral surgery 90.6% trauma and orthopaedics 79.6%, ophthalmology 77.8% and plastic surgery 88.8%.
- There were robust processes in place in relation to governance and risk assessment throughout all of the services inspected. The introduction of the “safety huddles” meant that staffing, risks, incidents an other patient safety issues were discussed with a view to reducing harm and improving the safety culture within the trust.
- The trust had responded to the withdrawal of the Liverpool Care Pathway, which had previously been seen as best practice when someone reached the last days and, hours of life. The trust used a holistic document which was in line with the five priorities of care. This care plan was called the ‘Last Days of Life Care Plan’
- Trust feedback from the 2014 / 2015 national vascular registry (NVR) showed the trust had excellent outcome figures for abdominal aortic aneurysm repairs. The standardised mortality ratio was 0.7 (national average 1) which meant that survival was more likely at the trust compared to the national average.
- Risk of patient readmission was lower than the England national average. The standardised relative risk of readmission at Broomfield hospital was 70 for elective patients and 87 for non-elective patents (100 is the expected level of patient readmission)
- The Sentinel National Stroke Audit Programme (SSNAP) for October to December 2015 showed the hospital achieved an overall rating of band B for both patient–centred and team-centred key performance indicators (where band A is the highest and band E the lowest).The Myocardial Ischaemia National Audit Project (MINAP) audit scores were similar to the England average in both 2012/13 and 2013/14.

We saw several areas of outstanding practice including:

- The burns and plastics services were extremely good and ensured that services users were involved and central to the innovation in services. The directorate had recently introduced an electronic live trauma database. This meant that staff had up-to-date information about the trauma service. Outcomes for patients with serious burns were comparable among the best in the world and were consistently exceptional.
- The ‘trigger and response team’ team were an exceptional team supporting acutely unwell patients throughout the hospital. The team were recognised throughout the hospital as being very responsive.
- The mortuary team were innovative and passionate about providing a good patient experience at the end of life
- The trusts upper gastro-intestinal (UGI) surgery was internationally recognised and had recently introduced leading edge robotic technology.
- The trust had worked to decreasing caesarean rates and had run an internal project called ‘project two per cent’. The aim was to reduce caesarean section rates and promote vaginal birth. The maternity dashboard results showed that elective clinical caesarean had decreased from 12.8% in April 2016 to 8.4% in May 2016 against a target of less than 7%.This project remains on going.All staff were engaged in this project and there was clear leadership from the senior team.

Summary of findings

- There was a dedicated 'birth reflections' clinic, which helped women who had felt that they had not experienced the birth that they had planned for, or felt levels of anxiety or stress which related to the birth experience.

Importantly, the trust must:

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

In addition the trust should:

- Consider consultant cover in the emergency department to meet 16 hours per day as recommended by The Royal College of Emergency Medicine.
- The provider should take action to improve MRSA screening for elective and emergency patients
- The provider should take action to reduce the number of cancelled elective plastic surgery operations and monitor cancellation rates for trauma patients
- The provider should improve the percentage of patients receiving treatment within 62 days of referral.
- The provider should ensure that all resuscitation equipment have identified expiry dates.
- The provider should ensure that glucometers are checked as per hospital policy.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated the Urgent and emergency services as requires improvement overall. The caring domain has been rated as good. The recruitment of emergency department staff remains an issue for the trust. Patient records in the emergency department were not routinely signed or dated. The trust audit results for the Royal Emergency College of Medicine (RCEM) were below the required standard. Training rates fell short of the trust's target for both medical and nursing staff and medical staff. Staff had not received regular appraisals in the emergency department and we were not assured that skills and competences were being measured or staff development supported. Friends and family test data has been consistently below the England average since August 2014. Between March 2015 and March 2016, the hospital did not meet the England NHS national target for seeing, treating, admitting, or discharging 95% of patients within four hours.The percentage of patients waiting between 4-12 hours between April 2015 and May 2015 increased to 16%, which was worse than the 8% England NHS average during the same period. The average time spent by patients in the Broomfield Hospital emergency department between January 2015 and January 2016, was consistently higher than the average England NHS trust for the same period Staff were not aware of the trust vision. The strategy for the emergency department was being developed in line with changes from the Essex Success Regime. Changes in staffing and recruitment had affected staff morale, which placed the department under increased pressure to meet the demands of the service especially over the winter months. However: There was a good culture of incident reporting and learning from complaints and incidents. The department had introduced ESAT (Early Senior Assessment & Treatment) streaming process. This allowed a dedicated senior nurse to assess adult

patients in a timely manner and determine the most appropriate pathways for those arriving by ambulance. This ensured that patients were assessed in a timely manner.
The department had developed “risk stamp”and“escalation criteria. This was used when patients had a 45 minute delay in ambulance of load and if there was a delay in leaving the department of over 6 hours. This assessed if patient are safe to continue to be where they are or if they need assessment.
There was evidence of good multi disciplinary working in the department. Staff felt supported by senior nurses and medical staff . Staff showed a commitment to the service and demonstrated a kind, compassionate and caring approach to patients.

Medical care (including older people’s care)

Good

We rated the medical care services at Broomfield Hospital as good overall.
We rated the medical care services at Broomfield Hospital as good overall.

- Incident reporting was embedded amongst nursing and allied health care professionals and learning from incidents was promoted.
- Patients were protected from avoidable harm and abuse, e and the concept of ‘safe’ was embedded in medical care service practice, for example through the implementation of “safety huddles”.
- Standards of hand washing and cleanliness were consistently good and regularly audited. Wards were visibly clean and uncluttered. Staff were provided with personal protective equipment and we saw it being used appropriately.
- The risk of patient readmission at Broomfield hospital was better than the England national average. The hospital participated in national audits, including Myocardial Ischaemia National Audit Project (MINAP), The Sentinel National Stroke Audit Programme (SSNAP) and the National Diabetes Inpatient Audit (NADIA), which shows the trust is monitoring its effectiveness.
- Patients we spoke with told us that staff were caring and kept them involved and up to date

Summary of findings

with their care and treatment. Referral to treatment times (RTT) from September 2014 to February 2016 were better than the England national average and the trust had developed effective ways of caring for people living with dementia.

- Quality improvement strategies were developed and outcomes were monitored and acted upon to ensure patients received harm free care. Complaints were used as a means to improve services and the trust was able to provide evidence of changes made as a direct result of complaints made.
- Leadership within the medical care service was good. Clear accountable governance structures existed and risks were identified and owned by individuals who were appropriately held to account.

However:

- There were variable standards of record keeping across the medical wards.
- The storage of medicines was not always satisfactory and prescribing of medicines did not always follow National Institute of Health and Clinical Excellence (NICE) guidelines
- Compliance with safeguarding training in medical staff was not in line with the trusts target. Safeguarding adults training level 1 had been completed by 71.7% of medical staff and Safeguarding Adults at level 2 had been completed by 55.1% of medical staff
- Results from the 2015 National Diabetes Inpatient Audit showed that trust scores have declined in 11 indicators compared with 2013.
- The Friends and Family test results for Goldhanger Ward for in June 2016 was 67%, which is significantly worse than the England average.

Surgery

Good

We rated surgical services overall as good.The reponsive domain was rated as requires improvement.
Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incident

Summary of findings

management was in line with 'being open' and the 'duty of candour.' The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff were caring, compassionate and respectful and were positive about working in the service.

Medical staffing levels and skill mix were recognised as being satisfactory within the service.

Trust wide monitoring of staffing against acuity had taken place bi-annually to determine whether current staffing levels and skill mix were appropriate for the acuity of patients who used the service. Shortfalls existed in nurse staffing levels across the service but ongoing recruitment and the introduction of new ways of working ensured sufficient staff worked within the service.

We observed good infection prevention practices by staff. Clinical equipment was serviced and generally daily checks had taken place on equipment. One exception was two glucometer machines on Lister ward whose weekend checks were not completed. Daily monitoring of resuscitation equipment had taken place.

Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time. Consent processes were robust and documentation associated with these processes was adapted to the individual patient's needs and understanding.

Patients received evidenced based care and treatment and patient outcomes had improved.

Good multi-disciplinary working existed between the trust, local clinical commissioning groups and community services.

Service planning and delivery considered patients' needs, which meant changes to the service and how it was delivered benefited the patient. Support was in place for those patients and their families who had either learning disabilities or dementia type conditions. The trust had identified a lead nurse for dementia who was also a 'Dementia friends champion.'

Summary of findings

The service was well led and a clear leadership structure in place. Individual management of the different areas were well led. Cultural work had taken place to strengthen the multi-disciplinary teams. Feedback from staff and patients had resulted in changes to aspects within the service.
However:
Some staff had a limited knowledge of the 'duty of candour' regulation
Operating theatres were established against the 'Association for Perioperative Practice (AfPP staffing recommendations). Theatres had a vacancy rate of 62 whole time equivalent (wte) which included 42 trained nurses at band five and six and 20 theatre assistants at bands two and three. An additional recruitment event was planned for the 20 June 2016 alongside ongoing recruitment
The national referral to treatment data (RTT) target was 90%. The data provided by NHS England (September 2014 – February 2016) confirmed RTT times were in line with the England average, although the trust was not meeting standards in four out of seven specialties. These specialities included general surgery (82.2%), trauma and orthopaedics (79.6%), ophthalmology (77.8%) and plastic surgery (88.8%). The trust had identified measures to meet these standards.
Following the inspection the RTT data from March to May 2016 for these specialities was analysed to determine progress made against each speciality. The data showed a decline in RTT performance for all four specialities. The May 2016 data was general surgery (53.6%), trauma and orthopaedics (47.5%), ophthalmology (77.4%) and plastic surgery (71%).
The safeguarding training target was 95%, however, medical and nursing staff compliance rate was from 60% - 97%.

Specialist burns and plastic services

Outstanding ☆

We rated the Specialist burns and plastics service as outstanding overall. The Safety and Responsive domain has been rated as good, and the effective, caring and well-led domains have all been rated as outstanding.
Safety performance since our last visit in 2014 had improved significantly in the plastic's trauma service, and performance remained outstanding in the burns service.

Summary of findings

Compliance with mandatory training for all staff was was well above the trust average, and there was always a sufficient number of staff on duty to meet the needs of people who used the service.Lessons were learnt following incidents and appropriate action taken to improve safety beyond the affected team.
There was an abundance of service specific policies and procedures available developed by the directorate, which reflected evidence based practice, national guidance and relevant legislation.
There was dedicated research team for the directorate, and audit results showed that outcomes for people using the burns service were good.
All nursing and support staff had either completed or were working through service specific competencies.
Pain management was effective and delivered through a multidisciplinary team approach.
The Friends and Family Test (FFT) results for the directorate were consistently high and the best in the trust, and feedback from people who used the service was consistently and overwhelmingly positive.
The service was innovative in ensuring patients understood and were involved in their care.Emotional support available was extensive and tailored to individual need. Services were planned and delivered to meet the needs of people using the service, and they were constantly evolving to improve continuity, flexibility and choice of care.
Formal complaints were low and managed effectively.
Access and flow throughout the burns service was seamless, and in the plastic surgery service significant improvement and action had been taken to enhance seamlessness. Leaders were quick to respond to concerns, were visible and approachable, and staff could not speak more highly of them.
We found an extensive amount of examples which demonstrated the directorate was innovative, made improvements where needed and ensured

sustainability of service provision. Throughout services staff were extremely positive, energised, passionate about their role and felt involved in service development.
However :
MRSA screening for elective and emergency patients was below trust expectation, and the service was not monitoring trauma surgery cancellations.
Staff appraisal rates on some wards was below trust expectation, however we found that appropriate action was being taken to improve compliance.
The Friends and Family Test was not carried out on Mayflower ward.

Maternity and gynaecology

Good

We rated the Maternity and Gyneacology service as good overall. We found that the current safety arrangements in maternity and gynaecology services had substantially improved since our previous visit in 2014.
Staff reported incidents and there was evidence of thorough investigations and learning from incidents that was shared with staff.
The trust had successfully recruited to midwifery vacancies and had introduced a dedicated supervisory coordinator shift which ensured that an oversight of capacity and clinical need was monitored through a 24 hour period .
Complaince with mandatory training, skills and drills training, appraisals and induction for bank and agency staff were consistent high throughout the service.
There was clear engagement with both national and local audits and evidence of self-assessment to benchmark against recommendations. Guidelines were reviewed were in date and had been updated in line with changes
The trust had responded to the high level of caesarean rates, through a dedicated project to reduce the number of caesarean rates and increase the number of natural births. This project was known as “project 2%.This had been successful in reducing caesarean rates.

Summary of findings

There were excellent examples of strong leadership both in the HoM and clinical directorate level, but also in the maternity and gynaecology teams, including gynaecology outpatients, maternity unit and early pregnancy unit
Governance meetings were well recorded and learning disseminated down to staff through newsletters and team meetings
There were good examples of public engagement for example through forums and the engagement of service users in study days
However:
There was no fast track dedicated pathway for women admitted with gynaecology problems through the emergency department.This had been identified in the previous inspection in 2014.
The number of Gynaecology incomplete pathways for May 2016 was 1020. This is higher than expected for an elective list and there were no assured plans in place to reduce this list.
HSA4 forms (used to notify government in termination of pregnancies carried out) were not sent to the Chief Medical Office, within the 14 days in line with the Abortion Act 1967. This is a breech of Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

End of life care

Good

We rated the service as good overall. The safety, effective, caring and well-led domains have all been rated as good, and the responsive domain has all been rated as requires improvement.
End of life care to patients was good overall. The specialist palliative care team (SPCT) and the ward staff involved in end of life care were passionate, caring and maintained patients' dignity throughout their care.
Since our last inspection visit in 2014 the completion of do not attempt cardiopulmonary resuscitation (DNACPR) forms had improved significantly.
The 'Last Days of Life Care Plan', a holistic document which was in line with the five priorities of care has been rolled out in all the adult wards. This document not only guides staff to consider the

clinical needs of the patient but also prompts to consider and discuss the patient's physical, emotional, spiritual, psychological and social needs.
The SPCT delivered end of life care education for medical, nursing and allied health care professionals as part of the mandatory trust induction, Preceptorship programme, Health Care Assistant and Healthcare Professionals study days, and also on the medical training programme.
The trust had put in place an end of life care facilitator which worked across the trust and each ward had a palliative/end of life care champion to support staff with any end of life training needs.
However:
Patients who had requested to be cared for in their own homes had experienced delayed discharges.
There was no rapid discharge process in place.
There was no formal audit process of peoples preferred place of care/death or discharge times

Outpatients and diagnostic imaging

Good

We rated outpatients and diganostics as good because:
Incident reporting was well embedded and there was evidence of learning from investigation.Staff had a good understanding of duty of candour and their responsibilities in relation to the protection of vulnerable adults and children. There was appropriate safeguarding trained staff available in outpatient clinics when required.
Main outpatients and diagnostic imaging services had strong effective leadership. Specialist clinics such as urology, ophthalmology, cardiology, diabetes and pain services were well managed by their own specialist teams, with the exception of the orthopaedic and fracture clinics which lacked nursing leadership and supervision.
Staff worked to recent National Institute for Health and Care Excellence (NICE) guidance. There was evidence of working towards participation in national quality assessments such as Improving Quality in Physiological Services (IQIPs) and Imaging Services Accreditation Scheme (ISAS).
Staff provided compassionate and respectful care to patients. We observed that staff were understanding and maintained patient dignity. The

Summary of findings

majority of patient feedback that we received during our inspection was positive, and the latest Friends and Family Test (FFT) results demonstrated 82% of patients would recommend the service.
The appointment booking team had good leadership and a risk management system for follow up appointments that were overdue. The trust was performing better than the national average in seeing patients within the two-week cancer wait and the incomplete pathway targets.
There were consultant staff shortages, in diagnostic imaging, neurology and dermatology but there was a continued effort to recruit to the vacant posts.
Where there were shortfalls in staffing, there were arrangements in place to access cover. Diagnostic imaging and main outpatients nursing staff shortages were in the process of recruiting.
However:
Patients waiting times in clinic were long, on average 27 minutes, and 35% of patients waited longer than this. The percentage of patients receiving treatment within 62 days of referral has continued to decline below the England standard of 85% (72.4% in February 2016).

Broomfield Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Specialist Burns and Plastics; Maternity and Gynaecology;End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Broomfield Hospital

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

The trust, based in the city of Chelmsford in Essex, employs over 3,800 staff, and provides services from five sites in and around Chelmsford, Maldon and Braintree. The main site is Broomfield Hospital in Chelmsford, which has been redeveloped as part of a £148m private finance initiative (PFI). The trust provides the majority of services at the Broomfield Hospital site.

Our inspection team

Our inspection team was led by:

Chair: Richard Quirk

Head of Hospital Inspections: Fiona Allinson, Care Quality Commission.

The team included CQC inspectors and a variety of specialists, including a general practioner, a director of nursing, chief nurse, a pharmacist, a consultant surgeon, a consultant palliative care, a consultant obstetrician, a head of midwifery, a junior doctor, an emergency department nurse consultant and a head of outpatients.

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

How we carried out this inspection

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

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

Detailed findings

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

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

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

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

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

Facts and data about Broomfield Hospital

Broomfield Hospital overview:

Beds: 642

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

Activity Summary:

Activity type

2015- 2016

Inpatient admissions

15,376

Outpatient attendances

655,793

Accident & emergency

(attendances)

91,047

Population Served:

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

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

Deprivation:

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The urgent and emergency services at Broomfield Hospital are located within the private finance initiative funded (PFI) wing of the hospital, which was purpose-built and opened in 2010. Broomfield Hospital had 91,047 attendances to their emergency department between April 2015 and March 2016, 19,923 attendees were under 17 years of age. The number of patients attending urgent and emergency care services at Broomfield Hospital during 2105/16 increased by 10% on the previous year and has increased by 21% since 2013/14. Patients presented to the department by walk in, by ambulance or the use of the hospitals air ambulance-landing pad.

The emergency department is a member of a regional trauma network and offers immediate emergency and urgent care to the patients of Mid Essex providing a 24 hour, seven day a week service. The department has facilities for assessment and treatment of minor and major injuries and illness with 15 major cubicles, four resuscitation spaces, dedicated children's area, emergency nurse practitioner (ENP), and general practitioner (GP) led services. The emergency department includes an emergency assessment unit (EAU) with 30 beds; its purpose is to support patients who can be managed in a short stay environment without the need for onward admissions or an extended stay in hospital. There is an ambulatory care unit (ACU), situated adjacent to the EAU that receives patients via the ED and GP referral. The emergency senior assessment team (ESAT), used a four-bedded bay adjacent to the ACU to triage patients who arrived via the ambulance bay.

We used a variety of methods to help us gather evidence in order to assess and judge the emergency services at Broomfield Hospital. We spoke with 43 staff, 12 adults, which were either patients or relatives and one child. We reviewed 40 patient records during this inspection, five of which related to children. We interviewed the Associate Director of Operations, Deputy Associate Chief Nurse, Acting Clinical Director and we spoke with professionally qualified and auxiliary staff. We observed the environment, checked the safety and currency of equipment, we looked at records in relation to patient's treatment and medication and do not attempt cardiopulmonary resuscitation (DNACPR). We also looked at a range of documents relevant to the service including policies, minutes of meetings, action plans, risk assessments, and audit results.

Urgent and emergency services

Summary of findings

Overall, we rated the urgent and emergency services at Broomfield Hospital as requires improvement.

- The recruitment of emergency department staff remains an issue for the trust. Whilst there was adequate staff on duty during our inspection, the department relies on agency and bank staff and has a 26% vacancy rate.
- Patient records in the emergency department were not routinely signed or dated and sepsis flow charts, frailty, and Meticillin-Resistant Staphylococcus Aureus (MRSA) screenings were not completed to the required standards.
- The trust audit results for the Royal Emergency College of Medicine (RCEM) were below the required standard.
- Training rates for the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) fell short of the trust's target for both medical and nursing staff and medical staff compliance with medicines management training was also below the trust compliance target.
- Staff had not received regular appraisals in the emergency department and we were not assured that skills and competences were being measured or staff development supported.
- Friends and family test data has been consistently below the England average since August 2014, falling as low as 70% in May 2015.
- Between March 2015 and March 2016, the hospital did not meet the England NHS national target for seeing, treating, admitting, or discharging 95% of patients within four hours; this issue was ongoing during inspection. The percentage of patients waiting between 4-12 hours between April 2015 and May 2015 increased to 16%, which was worse than the 8% England NHS average during the same period.
- Staff were not aware of the trust vision. The strategy for the emergency department was being developed in line with changes from the Essex Success Regime.

Changes in staffing and recruitment had affected staff morale, which placed the department under increased pressure to meet the demands of the service especially over the winter months.

However:

- Incident reporting and learning from incidents was embedded within the service
- There was good leadership of the emergency department at local level and staff thought highly of the senior clinician, matrons, and sisters.
- Infection prevention, promotion, and protection was very good and provided clean, safe, and fresh environments for the patients and staff. Compliance with infection control training was above the trust target of 80%.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated the safety of urgent and emergency care services as requires improvement because:

- Recruitment of emergency department staff remains an issue for the trust.
- Patient records were not always competed to the required standards within the emergency department.
- Mandatory training rates were below the trust compliance rates, medical staff achieved 66% compliance with statutory training, which is worse than the trust 80% compliance target.
- Risk assessments for the management of sepsis was not consistent with the trust sepsis pathways.
- Equipment trolleys within the major resuscitation bays had equipment checklists attached, but regular reviews of equipment were not documented.
- For safeguarding adults, 85% of staff had completed level one safeguarding adults training, 71% had completed level two and 74% had completed level three, against the trust target of 95%.
- Consultant cover was not available for more than 16 hours per day in line with the recommendations of the College of Emergency Medicine. This was under review at the time of inspection.

However;

- Incident reporting and learning from incidents was embedded in everyday practice.
- Safeguarding procedures and activities prevented patients from avoidable harm.
- Infection prevention, promotion, and protection was very good and provided clean, safe, and fresh environments for the patients and staff.
- Medication was managed safely and in line with the trust policy, patients were assessed and given timely pain relief and records of medication administration were accurate, legible, and dated at all times.
- The trust had clear processes in place for escalating concerns of deteriorating patients.

Incidents

- There had been no 'Never Events' in the urgent and emergency care services between February 2015 and January 2016. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Between April 2015 and March 2016, the trust used its electronic incident reporting system to report and record 1430 incidents within urgent and emergency services, 76.7% of these incidents resulted in no harm. Incidents that were a near miss or had the potential to cause harm accounted for 12.4% of incidents, 6.3% of incidents caused minor harm, 3.3% minimal harm, 0.5% caused moderate harm, 0.4% caused major or severe harm 0.2% resulted in fatality, 0.2% were categorised as having the potential to cause adverse publicity for the trust.
- The trust reported 32 serious incidents (SI) between May 2015 and May 2016, eight in relation to diagnostic delay, two regarding abuse or alleged abuse, two incidents of self-inflicted harm, three incidents of a slip, trip or fall, three regarding treatment delay, two in relation to maternity and obstetrics. There were two incidents of suboptimal care, one medication error, one incident that posed adverse media impact, one regarding a commissioning incident, one failure to find a bed for a child patient, one incident with regard to preparedness for a major incident and five other serious incidents that the trust categorised as other. All of the incidents had been fully investigated and where necessary action plans put in place to minimise future risks.
- Staff reported incidents using an electronic reporting system and we saw records where staff had used the system to report concerns. All staff we spoke with were aware of the reporting system and knew how to raise issues and escalate concerns.
- Learning from incidents was evident, with incidents reported daily to the senior incident management group (SIMG). The SIMG was a group of senior staff that would review and make decisions on the level and impact of incidents, whether further investigation was required, or escalation to external agencies.

- Safety huddles were held twice per day (this is where staff meet at the start and end of shifts to discuss various issues in relation to the safe operation of the department, for example, patient flow, staffing levels, current themes, or safety concerns). Safety huddles always covered incidents, and the team had developed the serious incident learning initiative (SILI) where staff were encouraged to specifically discuss incidents and learning from incidents.
- Team meeting records showed where learning from incidents had been recorded, along with agreed actions. Staff were briefed on incident content, reasons, and how learning was fed back to the wider staff team. Learning from incidents was shared with staff via email and newsletters.
- Mortality and morbidity meetings were held to share learning from patient deaths, covering general, paediatric, mental health, and trauma cases.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain notifiable safety incidentsandprovide reasonable support to that person. All senior staff understood this; however, the majority of nursing and health care staff in the emergency department (ED) were unaware of the process. Staff we spoke with in the paediatrics team and emergency admissions unit knew about duty of candour and its relationship to being open and honest in dealing with significant events.

Cleanliness, infection control and hygiene

- The department was visibly clean, domestic staff used 'I am clean' stickers that were in date at the time of inspection. Hand washing facilities, alcohol gel and hand conditioner was available throughout the department. We saw clear signage informing people to clean their hands when entering the department.
- We observed staff following hand hygiene, 'Bare below the Elbow' guidance, and wearing personal protective equipment such as gloves and aprons whilst delivering care in line with the trust's policy.
- Domestic staff were visible in the department throughout our inspection and constantly engaged in cleaning activities. Waste bins were emptied frequently during the course of the day.
- Patient trolleys and equipment were visibly clean throughout the department. We observed staff routinely cleaning equipment between patients. Disposable curtains providing privacy were clean and in date at the time of inspection.
- Hand hygiene compliance audits on the emergency assessment unit (EAU) were at 96% in December 2015, 100% in January 2016, and 90% in February 2016. The emergency short stay ward achieved 100% hand hygiene compliance in December 2015 and 94% in February 2016, the trust was aiming to achieve a 100% compliance rate.
- Staff had exceeded their infection prevention training targets. The trust target for completion of infection control training was 80%. All (100%) allied health professionals, 89% of medical staff and 87% of nursing staff had completed the training.
- The trust carried out cleaning audits routinely as part of its infection control processes. The emergency department cleaning audit for March 2016 showed a 99% compliance rate across all functional areas. The audit included the cleanliness of equipment, for example commodes, bathroom hoists, drip stands, linen trolleys, as well as the physical environment, for example walls and ceilings.
- Personal protective clothing audits showed that staff wore appropriate gloves and aprons 100% of the time during February 2016, demonstrating that staff followed the trusts policy on infection prevention, protection, and control. However, we noticed at times staff would wear gloves whilst walking around the ward areas and between cubicles. According the World Health Organisation (WHO) the use of gloves when not indicated represents a waste of resources and does not contribute to a reduction of cross-transmission, it may also result in missed opportunities for hand hygiene.

Environment and equipment

- Medical engineering staff routinely checked equipment which was clearly labelled with stickers showing when equipment was checked and equipment renewal dates

Urgent and emergency services

- The emergency department staff used a security swipe card system to enter various areas of the ED. This reduced the risk of unauthorised persons entering clinical areas. Office doors, medication rooms, and storerooms had combination locks to reduce access and these were secure during inspection. The paediatrics area utilised a combination of staff swipe card, intercom and closed circuit television cameras for security.We saw staff ensuring that all visitors identified themselves on entry and departments were secure at all times during our inspection.
- The emergency department had a designated room for mental health patients. The room had been risk-assessed and adapted to remove specific dangers such as ligature points (places where someone could tie a ligature to strangle themselves). The room had two entrance and exit points with panic alarms installed that summoned immediate assistance to patients and staff in the room.
- A room within the emergency department was set aside specifically for viewing the deceased patient prior to transport to the mortuary. This was to support families in immediate need, and staff told us how beneficial the room had been in supporting families.
- Resuscitation equipment was readily available within the emergency department and we found some equipment checked daily and records of checks were up to date at inspection. However, other resuscitation equipment was checked sporadically and in some cases, no records of checks were in place, specifically in the ED major resuscitation bays.
- Equipment trolleys within the major resuscitation bays had equipment checklists attached, but regular reviews of equipment were not documented. This meant that it was unclear that equipment was safe, fit for purpose, or had been replenished appropriately. We brought this to the attention of the nurse in charge that showed us a new system for checking equipment that was under development. The new system was in place at our unannounced inspection and equipment checklists appropriately used by staff.
- The paediatric waiting area was visibly clean and had a number of toys and activity books for children as well a large wall mural to create a vibrant child friendly environment.

Medicines

- We saw that records and stock levels of controlled drugs in the paediatric area, resuscitation, and the emergency department were accurate, showing the correct amount of stock stored at the time of inspection.
- During our unannounced inspection, we found one bag of intravenous fluid in the fluid warming cabinet that had passed its use by date. Fluids warmed in this area were to be used within 20 days or discarded after this time to ensure integrity of their contents. We reviewed the check sheets of this stock and noted that checks should have taken place twice per day. Records revealed that checks had not been carried out on 27 occasions during a 30 day period. We identified our concerns to a staff nurse regarding the fluid which was passed its use by date, who immediately removed it from this area.
- The trust carried out routine audits of medications. In May 2016, the ED audit identified issues in relation to medication fridges, 67% of fridges were locked, and 33% of fridge temperatures were between the correct 2-8 degrees centigrade. This meant that medication was not being stored securely or in the correct temperature to maintain their integrity. In all cases, the failure to meet the standard was due to unexplained gaps in monitoring. The trust had developed an action plan in response to the concerns and set timescales for improvement. During our inspection, we found that fridge temperatures were monitored on a daily basis and temperatures within the required range.
- Controlled drugs, which should be stored following secure storage guidelines, were stored securely in controlled drug cabinets. Only the nurse in charge had secure access to the controlled drugs. Twice daily checks were made on controlled drugs to ensure records were accurate and up to date.
- If patients were allergic to any medicines, this was recorded on their prescription chart.
- Staff knew how to report medicine incidents. We were told that lessons were learnt and positive action taken to prevent them happening again. For example, following one incident where the incorrect amount of medicine was administered this was reported and lessons learnt.
- We witnessed the preparation of an intravenous antibiotic done by two nurses who checked each stage of the preparation process together. This helped to ensure that the correct medicine was being prepared for the right patient.

- The emergency department has no dedicated clinical pharmacist but they were able to contact the clinical EAU clinical pharmacist for any advice or support.
- Although medicines were stored in a secure room we found that the security arrangements in place meant that unauthorised members of staff could have access to medicines
- Glucose and saline bags were stored in a lower cabinet draw in the adult resuscitation area; these looked identical to the naked eye and could easily have been confused unless the labels were thoroughly checked. We brought this to the attention of the staff on duty at the time who took appropriate action to separate the two.

Records

- Written patient record completion varied greatly, in the EAU, ambulatory care unit (ACU), and paediatrics area In the emergency department, we found that out of 21 sets of patient records we reviewed, 16 were either not signed or dated and sepsis flow charts, frailty, and MRSA screening checks were not routinely completed. We discussed this with the nurse in charge and raised our concerns and we were told that this would be raised with the departmental team and discussed at future safety huddles.
- The trust carried out clinical records audits on a weekly basis. The emergency department scored 74% accuracy rate on 14 June 2016, against a target of 100%. Patient information is initially recorded on an emergency department card, which is filed into the patient's hospital medical records on transfer to a ward or discharge to ensure patients' needs are communicated to the ward or discharge team.
- Patient records were secured at all times during our inspection, either in locked cabinets or behind nursing stations to ensure the confidentially of patient information.

Safeguarding

- For safeguarding adults 85% of staff had completed level one safeguarding adults training, 71% had completed level two and 74% had completed level three, against the trust target of 95%.
- For safeguarding children 96% of staff had completed level one safeguarding children training, 90% had completed level two and 88% had completed level three, against the trust target of 95%. There are three levels of safeguarding children training. Level one provides a baseline understanding, level two provides greater knowledge for those working regularly with children and level three provides high level of knowledge for staff working in complex situations and who have to assess, plan, intervene and evaluate needs of children (Working together to safeguard children: HM Gov 2015).
- The trust had a policy for safeguarding adults reviewed in March 2016, and a safeguarding children policy reviewed in 2013, due for review in February 2016. The trust produced annual safeguarding reviews for both adults and children during 2014/15 identifying the main achievements and any areas for improvement.
- The emergency department weekly document review in May 2016 identified that documentation completion for safeguarding at initial patient assessment was 80%.During our inspection the 40 patient records we reviewed all had safeguarding assessment details recorded, showing improvement since the last review.
- We found there were clear processes and procedures in place for safeguarding children and adults. Policies and procedures on managing concerns or the risk of abuse were available to staff via the intranet and staff we spoke with knew how to raise concerns about adults and children at risk of abuse.
- The safeguarding team checked the children and adult emergency areas each morning in order to manage and monitor risks to patients within the department and liaise with staff on any specific patient concerns. The paediatrics team checked all attendances on the trusts computer system for any child safeguarding concerns that may have been identified at initial patient assessment.
- The paediatrics department staff used a Red Teddy symbol as part of the departments safeguarding triggers within children's notes to identify any safeguarding issues with the child and ensure staff have an awareness that a child may be at risk. This meant staff could quickly identify a child that may be at increased risk of abuse and liaise quickly and effectively with the safeguarding staff or external agencies to safeguard the child.

Mandatory training

- Data showed that nursing staff had achieved 81% compliance with statutory training, 92% of allied health

professionals also achieved compliance, both were better than the trust 80% compliance target. Medical staff achieved 66% compliance with statutory training, which is worse than the trust 80% compliance target.

- Sixty-five percent of medical staff had completed advanced life support training and 33% had completed advanced paediatric life support training, which is worse than the 80% trust mandatory training target.
- Nursing staff achieved 83% compliance in medicines management, which is better than the trust compliance target of 80%, and medical staff achieved 14%, which is worse than the trust compliance target.

Assessing and responding to patient risk

- In April 2016 the trust introduced ESAT ((Early Senior Assessment & Treatment) streaming process. This allowed a dedicated senior nurse to assess and determine the most appropriate pathways for adult patients arriving by ambulance. The ESAT area in the emergency department consisted of four beds and operated between the hours of 9am-6pm seven days per week. Staff told us that there had been an improvement in triage times of patients and as patients were moved in to a cubicle more quickly,this avoided waits in the ambulance offload area and corridors. However the steaming service was dependent on staffing and not always open.
- Due to concerns regarding the increase in the number of patients that may be required to wait on an ambulance prior to entry to the emergency department, the department developed a risk stamp and escalation criteria. This was used when patients had a 45 minute delay in ambulance of load and if there was a delay in leaving the department of over 6 hours. This risk assessment is to assess if patient are safe to continue to be where they are or if they need assessment.
- The trust had consistently exceeded the median time to assessment between January 2015 and January 2016, peaking at 19 minutes in January 2015, and has been consistently higher than the England average of seven minutes.
- We observed a trust mental health worker in the emergency department with patients and saw how they specifically worked towards identifying risks to the patients and the staff. Staff identified a patient who was likely to cause harm and had a history of violence and aggression. The mental health staff worked with external agencies and advised staff on how best to manage their behaviour and minimise the potential for violence or aggression towards other patients and staff.
- We saw staff undertake rapid assessments of patients admitted to the department both by ambulance or other means. We saw that the patient treatment bays were close to the ambulance entrance and were staffed by senior nurses and medical staff who provided prompt assessments and diagnostic testing.
- A National Early Warning Scoring (NEWS) system was in use to assist staff in identifying patients at risk of a sudden deterioration in their condition. The use of the tool is regularly audited and demonstrates good levels of compliance. We reviewed the notes of 5 children in relation to Paediatric Early Warning Scores (PEWS); all had been triaged within fifteen minutes, complying with the standards for children and young people in emergency care settings set by the Royal College of Paediatrics and Child Health (RCPCH 2012).
- The department had a sepsis pathway that was in line with National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine standards. However, the use of the tool was inconsistent within the patient notes. The trust had a 90% compliance rate for sepsis screening during our inspection, but we were not assured that staff were routinely following or recording the sepsis pathway which could have placed patients at risk.
- A separate paediatric sepsis-screening tool was in use for children presenting at the emergency department with potential sepsis and a Paediatric Early Warning Scoring (PEWS). We looked at the records relating to five children and noted these assessments completed appropriately in all cases.
- The trust reported 1,085 black breaches between June 2015 and April 2016 (black breaches are ambulance handovers that took longer than 60 minutes from arrival at a hospital to the patient being taken into a hospital emergency department). The trust stated that delays to ambulance off loads have predominantly been due to capacity into the emergency department. All black breaches were reviewed as part of the trust governance harm review process and outcomes are reported to the Care Quality Commission each month. Learning from the reviews are shared at departmental safety huddles to support staff learning & improvement.

Urgent and emergency services

- The trust reported 2,204 ambulance handovers that were delayed by 30 minutes or more bewteen November 2014- March 2015, putting it in the worst-performing quintile for this measure nationally.
- The trust consistently exceeded the standard 60 minute median time to treatment between January 2013 and January 2016.
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Nursing staffing

- The trust undertook a staffing review of the emergency department in 2015 using the Baseline Estimated Staffing Tool (BEST) and the Jones Dependency Tool (to assess patient acuity and dependency) hourly over a seven-day period). The results from this suggested a requirement for an additional 41.22 whole time equivalent (WTE) Registered Nurses (RN) 5.51 WTE Health Care Support Workers. The Board of Directors had approved this uplift, and recruitment to fill vacancies was active at the time of inspection.
- The children's emergency department was open 24 hrs a day seven days a week. Between 7.30am and 8pm, the department has two Registered Nurse (Child Branch) and between 2pm and 8.30pm, a further nurse joins the team. Between 8pm and 12am, the department had two nurses and two health care support worker (HCSW), there was also a dedicate night shift between 9pm and 7.30am with one nurse and one HCSW.
- The adult emergency department used agency and bank staff frequently to provide cover for shifts. The department tried to fill shift through Bank first but then utilised agency staff. Bank and agency staff were effectively inducted into the department and we saw records of agency staff induction including the induction topics covered
- Data provided by the trust showed that adult emergency department bank staff usage was 11% and agency staff usage was 23% against a 75.53 hours establishment.
- We observed the EAU staffing rota and saw staffing shortfalls covered via internal hospital bank staff and agency staff. During May 2016, the department had funding for 42.44 qualified nursing hours to reach its full establishment. However, the department had 74% of its required establishment giving a 26% vacancy rate.
- EAU bank staff usage was 12% and agency staff usage was 9% against its 42.44 hours establishment. The department had similar issues to those felt in the emergency department, and had actively been trying to recruit to establishment.
- Sickness absence for emergency department and EAU departments was 4%, which is better than the most recently published NHS staff sickness absence rate of 4.24% from October 2015. Sickness absence rates for nursing staff in the emergency department were variable between November 2015 and April 2016 but never higher than 3% during that period. Sickness absence rates for nursing staff in the emergency admissions unit were also variable between November 2015 and April 2016 but never higher than 4% during that period.
- Safety huddles were held throughout twice a day where staffing levels were a key feature and action was taken to ensure safe staffing levels, for example calling in bank or agency staff to cover any shortfall based on the demands within the department.

Medical staffing

- Between April 2015 and March 2016, the emergency department saw over 16,000 patients that were less than 17 years of age. The Royal College for Emergency Medicine (RCEM) recommends that emergency departments seeing more than 16,000 children per year should have at least one paediatric emergency consultant.Although not meeting this standard, the the trust had a consultant with an interest in paediatrics and was out to advert. There was also a middle grade doctor covering paediatrics from 10am to 7pm seven days per week.
- Consultant cover was not available for more than 16 hours per day in line with the recommendations of the College of Emergency Medicine. The trust had recently increased consultant hours from 11 hours per day to 14 hours per day in job plans in an aim to meet this standard.
- We saw there was consultant cover in the emergency department throughout the day from 8am to 10pm. Consultant medical staff were available to manage care throughout the department as needed. One person was allocated as the emergency physician in charge so that there was clear leadership at all times internally and in dealing with other departments or services.

Urgent and emergency services

- We saw the departmental staffing rotas that showed two consultants 8am to 1pm, three consultants 1pm to 5pm, two consultants 5pm to 7pm and one consultant 7pm to 10pm. During the hours of 10pm to 8am, the trust had a consultant on call available off site outside of core hours. At the time our inspection, staffing was appropriate to the needs of the department.
- Medical cover was available for the paediatric emergency department Monday to Friday 10am to 7pm via a middle grade doctor. After 7pm and before 10 am week days and at weekends a junior doctor was available, the doctor had to discuss all patients with a consultant either via on call or at the hospital before any discharge could take place.
- The consultant ratio at 19% is lower than the England average of 23% and the ration for middle grade doctors was 4%, which is also lower than the England average of 13%. The trust does have a higher proportion of registrars at 58% against the England average of 39%, but a ratio of 19% junior doctors, which is lower than the England average of 24%.
- Middle grade staff told us that shifts are matched overall to the department based on activity. There are three middle grades between 8am and 6pm, two between 2.30pm and 12pm, and one middle grade between 10pm and 8am. Three junior doctors worked between 8am and 5.30pm, one between 12am and 10pm, one between 2pm and 12pm, and three junior doctors between 10pm and 8am, providing effective staff cover for the department during our inspection.
- Staff roles and areas of work were clearly identified and staff were aware of their roles and responsibilities in the department.
- We observed “Board rounds” where key issues in relation to patient’s needs and safety as well as the flow through the department and bed state were discussed around a white board containing pertinent patient details. This was also used as an opportunity for more senior medical staff to challenge junior staff on patient’s needs, condition management, and the department situation. This was managed very professionally and effectively and staff found this very good for their professional development.

Major incident awareness and training

- We saw that the department had major incident plans as part of the hospital and community-wide arrangements for dealing with a major emergency.
- Over 60 members of nursing and medical staff had completed Hazerdous Material (Hazmat) and Chmical, Biological, Radiological and Nucelar (CBRN) training in the department.
- There are clear protocols for dealing with patients with suspected highly infectious diseases.We observed that patients arriving by ambulance were asked specific questions to identify any possible risk of serious infection or other conditions likely to cause risks to the staff or public.
- We reviewed the major incident store area, which was in an area outside the emergency department main entrance. The store area had no external signage, staff told us this was to ensure that the area was not visible to the general public.
- All emergency equipment was in date and reviewed by maintenance engineers in June 2016. Batteries for hand held communication devices were charged and a new decontamination tent was ready to be deployed in an emergency to separate and hold patients, signage was up to date and clear protocols were in place to promote a chain of command during a major emergency event.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated the effectiveness of urgent and emergency care services as requires improvement because

- The trust audit results for the Royal College of Emergency Medicine (RCEM) were below the required standard.
- Training rates for the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) fell short of the trust’s target of 95% for both medical and nursing staff.
- Medical staff compliance with medicines management training was 14%, which is below the trust target of 80% minimum compliance.

- Staff had not received regular appraisals in the emergency department and we were not assured that skills and competences were being measured or staff development supported.

However:

- The nutritional and hydration needs of patients were being met.
- Both adults and paediatrics received pain relief in a timely manner.
- The trust had taken steps to improve pathways for mental health patients and clear risk assessments were in place to minimise harm to patients and staff.
- Between March 2015 and March 2016, the number of patients leaving the department without being seen ranged between 1.8% and 2.2%, this was better than the England average NHS trust performance indicator which was 2.7% during the same period.

Evidence-based care and treatment

- The RCEM audit for severe sepsis and septic shock 2013/14 showed the trust were in the lower England quartile for two of the eight areas. The RCEM standards for the measurement and recording of blood glucose monitoring on arrival and within 15/20 minutes of arrival were set at 100%. The trust were failing to reach this standard in the measuring and recording blood glucose levels on arrival (50%) and after 15-20 minutes (22%). Audit data revealed that clinical notes lacked evidence that blood cultures had been obtained within the emergency department, with 62% of patient's notes showing this. The RCEM standard for this measure is 100%.
- The emergency department carried out a local audit in 2015 to assess compliance with regard to NICE guidelines for CT scanning for head injuries. This audit identified shortcomings however a clear re-audit date was in place, planned for August 2016.
- Pathways were in place for patients with a fractured neck of femur. We saw this pathway clearly displayed on the walls in the emergency department and resuscitation areas.
- Staff had access to local policies and procedures relevant to the service on the intranet and these were also available in the department. Information and access to patient treatment pathways and algorithms were clearly displayed in the resuscitation area.

Pain relief

- Data from the Care Quality Commission accident and emergency survey (2014) showed the emergency department was performing 'about the same' as other trusts in relation to the provision of pain relief and control of pain.
- We reviewed five sets of paediatric notes, which revealed children had been offered pain relief, if clinically required within 20 minutes. This demonstrated compliance with the RCEM management of pain in children (July 2013).
- We reviewed audit reports in relation to pain relief in patients with fractured neck of femur. Between January 2016 to April 2016, the trust carried out a re-audit in relation to pain relief in fractured neck of femurs. They reviewed 40 patients' case notes to see how many patients were in receipt of a fascia iliaca compartment block (FICB) pre theatre. This procedure is used to reduce pain in patients with hip fractures. Results demonstrated that 12 out 40 patients received an FICB, 10 of which were carried out by an anaesthetist, one by an emergency consultant (reported as the quickest administered pain relief in whole audit) and one by a trauma co-ordinator.
- We observed staff asking patients if they were comfortable, checking pain levels and ensuring timely analgesia was administered.

Nutrition and hydration

- Staff offered patients drinks if clinically safe to do so and they had been in the department for some time. Drinking water was available to patients in bed and within reach.
- There was provision for food out of hours. Domestic staff ensured a selection of sandwiches were available for patients should this be required. Drinks were offered at set times of the day in addition to when being required. Due to the transient nature of stays within the emergency department, hot food was not offered.
- The emergency assessment unit offered hot meals to patients with choice from a menu. This included health choice options and was available at lunch and supper times.
- We spoke to a patient who said, "Staff bought me food and a drink, when they could, they explained things to me, and I would recommend the trust."

Patient outcomes

- The unplanned patient re-attendance rate in the emergency department within seven days between January 2015 and January 2016 was consistently higher than the required standard of 5%, with an average of 5.9%, but better than the England average of 7.5%.
- The department took part in the RCEM audit for the assessment of cognitive impairment in older people, 2014/2015. The trust failed to meet the 100% target for documentation of an early warning score, achieving 79% compliance. The trust were performing in the upper England quartile for three aspirational standards which included the communication of assessment findings with GP's, carers and admitting services. For the remaining two developmental standards relating to cognitive assessment and the use of a structured cognitive assessment tool, the trust were between the upper and lower England quartiles.
- The department used the Royal College of Emergency Medicine (RCEM) clinical standards for emergency departments. It participated in national RCEM audits including the Initial Management of a Fitting Child (2014/2015).These audit results revealed that whilst no actively fitting children had been received during the audit period, the department was falling short of two developmental standards which were; eye witness history taking and recording in records (83%) and provision of written safety information to parents/carers on discharge (21%). The required compliance with these standards was 100%.
- Results from the Asthma in Children audit (2013/2014) showed the trust was in the lower England quartile for eight out of 10 of clinical measures of which the RCEM standard is 100%. These measures were; respiratory rate and oxygen saturation rate (40%), pulse rate (43%), temperature (43%), peak flow (3%), treatment with a nebuliser (medication which is inhaled to treat difficulty in breathing within 10 minutes of arrival, 10%), intravenous or oral steroid administration (37%) and discharge of patients with an oral steroid (36%).
- The department took part in the RCEM standards for consultant sign off. This identifies three types of patient, which should be either seen or discussed by a consultant or middle grade doctor prior to discharge. These are adults with non-traumatic chest pain, febrile children (less than one year old) and patients, which make an unscheduled return to the emergency department, with the same condition within 72 hours of discharge. Audit data (2013) told us that the department fell below this target and were in the lower England quartile for two out of the four measures. Audits revealed that 51% of patients were seen or discussed by a consultant or middle grade doctor, which fell short of the 100% compliance target.
- The trusts participated in the Trauma Audit and Research Network (TARN), dated April 2014 to March 2015. The trust made 281 submissions as part of the audit, 60.3% of the submissions were complete and the trust achieved an 85.4% accreditation rate.
- The emergency department participated in the RCEM mental health audit, 2014/2015. Out of the two fundamental standards, the trust were achieving compliance with one of these by providing a dedicated assessment room for mental health patients. The department was failing to achieve 100% compliance with the remaining fundamental standard, which was the carrying out of a risk assessment, with documentation in patient records. Trust compliance with this standard was at 68% for this period.
- Between March 2015 and March 2016, the number of patients leaving the department without being seen ranged between 1.8% and 2.2%, this was better than the England average NHS trust performance indicator which was 2.7% during the same period.

Competent staff

- The emergency department did not have a dedicated practice development nurse.
- Paediatrics staff practice complied with the Royal College of Paediatrics and Child Health (RCPCH 2012).
- Training compliance for advanced paediatric life support (APLS) fell short of the trust's target of 80% compliance with 33% of medical staff completing this training.
- Trust appraisal data for 2014/2015 showed that medical staff in the emergency department and emergency assessment unit achieved 100% compliance with appraisals, exceeding the trust target of 90%. Nursing staff achieved a 36% compliance rate, which is worse than the trust target. Nursing staff in the paediatrics department achieved a 33% compliance rate which is again, worse than the trust target of 90%.
- For the period of April 2015 to March 2016, five staff in the emergency department required revalidation. Data provided by the trust stated three of these medical staff within the department had been revalidated, with the

exception of two members of staff who have had this deferred, as they were new to the country. Supervision and guidance was in place to ensure they were meeting the required competencies within their respective roles.

- Training data provided by the trust showed that nursing and medical staff both fell short of the 95% compliance rate for training in MCA and DoLs. Nursing staff achieved 74% and medical staff 81% compliance in relation to this subject.
- We were given very mixed views from the staff team on the opportunities for development and training within the departments. Staff on the emergency assessment unit (EAU) and paediatrics area felt very supported and that they had been opportunities to develop

Multidisciplinary working

- There was good multidisciplinary team working and integration with the rest of the hospital. All admissions were assessed in the emergency department and seen emergency department or medical staff interchangeably.
- There was effective internal multidisciplinary team working within the emergency department. We saw that physiotherapists and occupational therapists worked effectively as part of a team enabling patients to be discharged safely and efficiently.
- Staff told us they could access multidisciplinary staff and that the occupational therapy team were available seven days per weeks. We saw the rota and the service was available from 8am to 6pm seven days per week, with planned time for the emergency department.
- We saw good communication taking place in the resuscitation area between various speciality staff including an anaesthetist, Consultant and paramedics when an alert call was received for a seriously unwell patient. The handover and commencement of care was fluent.
- The emergency department had access to mental health workers who provided support to adults, seven days per week, either by direct contact with patients or via advice on the phone or email, this enabled access to early intervention to support patients' mental health.
- The emergency department had access to a specialist alcohol advice worker who liaised with the mental health team and emergency department staff to support patients with alcohol dependency issues.
- The emergency department had access to mental health workers, who liaised with psychiatrists and consultants to support patients with mental health conditions. The mental health team implemented a mental health action plan. This encouraged multidisciplinary working as staff now had a clear pathway to follow for completion of risk assessing patients with dementia and other mental health conditions.
- There was a Hospital Ambulance Liaison Officer (HALO) in the emergency department. The role of the HALO was to work with ambulance crews and hospital staff to reduce the time spent by crews in the emergency department. The HALO was in place between the hours of 10am to 10pm. Nursing staff and the ambulance crews felt the presence of this role aided communication and flow through the department in a positive way.

Seven-day services

- The emergency department had consultant cover between the hours of 8am-10pm. There was an out of hour's on-call system in place with staff also having access to junior and registrar grade staff when required.
- Occupational therapy team were available seven days per week 8am to 6pm, but times varied at weekends. Physiotherapists were also available within the department Monday to Friday 8am to 6pm and an on call available at weekends for specific conditions, for example respiratory needs.
- Occupational therapy and mental health services were available seven days a week. Staff told us this had a positive impact on patients, as they would be able to see a professional for guidance on their wellbeing or condition that may enable them to return home more quickly or avoid admission.
- Physiotherapy services were available seven days a week between the hours of 8am and 6pm.

- There were two computerised tomography scanners available and a radiographer available 24hrs a day seven days a week enabling patients to access scanning services at any time.

Access to information

- Staff were able to access notes in both the emergency department and the EAU in a timely manner. Patient notes within the EAU were stored in locked cabinets, clearly identifying which patient they pertained to. Staff we saw were able to retrieve records in a timely manner. In addition, staff had use of 'a handheld IT device' which enabled staff in the EAU to record and access patient observations. This timely access to information improved patient care as readings were available immediately by any clinician with access to the device, rather than relying on one set of paper patient notes. All medical staff within the department had a unique user code to access this system when required.
- Drugs charts, care plans, and risk assessment were clearly identifiable in patient records. We found these to be secure at all times whilst easily accessible to clinical staff in both the emergency department and EAU.
- Staff had access to pathology, radiology and pharmacy results via online computer systems and this enabled them to access results in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff compliance with the mental capacity act (MCA 2005) and deprivation of liberty safeguards (DoLS 2009) training was below trust target level of 95%. Medical staff achieved 81% compliance and nursing staff achieved 74% compliance. However, staff we spoke with had a good understanding of the MCA and DoLS. Staff had access to both the MCA and DoLs policy online and paper copies for reference if required.
- Staff had access to a trust wide policy on consent to examination or treatment. This policy was accessible online or in paper format. This policy was in date and made clear reference to obtaining consent for both adults and children and young people under the age of 16. It clearly referenced the use of the 'Gillick competence', in which persons below the age of 16 can demonstrate capacity to consent to treatment.
- Staff had access to MCA and DoLS policies online and knew who to contact to seek advice should the need arise.
- During our inspection we reviewed 35 sets of adult notes. On review, one patient required a mental capacity assessment. This was completed correctly, accurately documenting the reasons why a patient had refused their medication.

Are urgent and emergency services caring?

Good

We rated the caring of urgent and emergency care services as good because:

- All patients that we spoke with reported staff to be caring and kind.
- We observed staff treating patients in a respectful and caring manner.
- Emotional and bereavement support was in place along with dedicated areas for relatives and those recently bereaved.

However:

- Friends and family test data has been consistently below the England average since August 2014, falling as low as 70% in May 2015.

Compassionate care

- The Care Quality Commission accident and emergency patient survey results from 2014 showed the trust were performing about the same as other trusts in relation to all of the 24 questions for patient experience in the emergency department. Survey results revealed positive findings in questions relating to staff discussing medical conditions with patients, which tests were required and explanation of medications prescribed prior to discharge for use at home. Patients reported that they felt listened to by both the doctors and nurses and that they had confidence in those treating them.
- Staff interaction with patients was good and we observed staff communicating with patients in compassionate and timely ways.

Urgent and emergency services

- The emergency department Friends and Family Test (FFT) asked 'Would you recommend this service to friends or family if they needed similar care or treatment?' Over 20% of patients who used the services gave feedback for the period April 2014 to March 2015. Seventy four percent of patients said they would be extremely likely or likely to recommend it to friends or family.
- We routinely observed staff using privacy curtains to protect patient privacy. In addition, staff were seen to close cubicle doors when clinically safe to do so. All patients we saw had their dignity maintained with the use of robes and blankets.
- Patients told us they felt safe and secure in the department, reporting that staff were supportive whilst providing care.

Understanding and involvement of patients and those close to them

- Staff informed patients of their plan of care and about any procedures or tests that were proposed in a way that they could understand, giving time for questions and reassurance.
- There was a dedicated relative's room in the emergency department, which provided a quiet area for relatives, with drinks provided. We saw staff entering this room to speak with relatives, explaining how the care in relation to the person they were accompanying was progressing.
- We spoke with six patients who described staff as friendly and caring. One patient said, "They are all so kind and caring here, they have told me what is wrong and they said a physiotherapist is coming to see me."
- Another patient said, "10 out of 10, the nurses and doctors have been kind and caring, I have had pain relief and am as comfortable as I can be. They have told me what is wrong."

Emotional support

- Bereavement counselling services were available in the emergency department including for parents of children. Support was also available for staff involved in caring for families where there was severe trauma or a sudden infant death. The department had a specific room set aside for this purpose.
- We spoke with two patients who said they felt safe when entering the emergency department and that they had prompt assessment of their needs and that explanations in relation to their conditions was done in a timely fashion and in a way they could understand.
- Whilst no specific counselling services were available patients and staff had access to the chaplaincy service who offered support to patients and staff seven days per week, and they walked through the department, which we observed during our inspection

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated the responsiveness of urgent and emergency care services as requires improvement because:

- Between March 2015 and March 2016, the hospital did not meet the England NHS national target for seeing, treating, admitting, or discharging 95% of patients within four hours; this issue was on going during inspection.
- The average time spent by patients in the Broomfield Hospital emergency department between January 2015 and January 2016, was consistently higher than the average England NHS trust for the same period.

However:

- Learning from complaints was evidenced in team and committee meeting minutes.
- Senior medical staff told us that medical geriatricians were helping to establish a frailty service in the emergency department.
- The trust had dedicated dementia and learning disability nurses to support patients and staff in meeting individual patient needs.

Service planning and delivery to meet the needs of local people

- The health care commissioners contracted directly with a third party" for the provision of a general practitioner service within the department. The Trust worked

collaboratively with this service to enable patients to be screened and either treated by the general practitioner or diverted to other services such as home care or pharmacy advice.

- Elderly care consultants were working to establish a frailty service in the emergency department. The service would be available 9am to 5pm Monday to Friday with cover provided at weekends; the service aims to alleviate some of the pressures on the emergency department.

Meeting people's individual needs

- The emergency department had access to a telephone based translation service. We saw leaflets and information in relation to these services within the department.
- The emergency department had a specific room identified to support family and relatives at times of bereavement.
- The trust has one full time learning disability specialist nurse who receives referrals from hospital staff, general practitioners, health and social care staff, voluntary sectors and family or carers, more than half of all referrals received this year have come from the hospital clinical staff.
- Patients with learning disabilities are identified to the learning disabilities nurse, through a flagging system on the trusts computer system. The specialist nurse will assist and support staff, patient and family/carers in assessment of dependency, risks, capacity and communication to ensure the right level of support is available throughout the hospital episode, and any reasonable adjustments required, for example carer of parent staying with the patient overnight. Carers are included as partners in their care and patients with learning disabilities are involved in the decision making process as far as possible.
- Patients are screened for dementia in line with national guidance, and the trust had a dedicated elderly assessment team (EAT) consisting of a band eight lead nurse (adult safeguarding), two band seven nurses fulltime and one band seven nurse part time.
- A pictorial flower forget-me-not was used to signify dementia patients subtly to staff. The EAT staff were actively engaged in raising staff awareness of dementia and the use of the FAIR assessment (Find Assess Investigate and Refer) alongside the 'This is me' document to improve direct support to patients who are admitted via the emergency department.
- Patients living with dementia carried a 'This is me' document which is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. We found that the 'this is me'' document had been used effectively to provide support patient centred care. We saw completed copies of the document in patient's notes and staff we spoke with told us that this enabled them to meet individual needs effectively.
- We witnessed handover between ambulance crews and emergency department staff, which included a detailed assessment of individual needs. The HALO (Hospital Administration Liaison Officer) supported this process by encouraging flow through the department and often staying with patients while ambulance crews handed over to the triage nurse in the ambulance bay.

Access and flow

- Between March 2015 and March 2016, the hospital did not meet the NHS target for seeing, treating, admitting, or discharging 95% of patients within four hours. In March 2015, the percentage of patients seen within four hours was 80% and in July 2015 92.8%.However, from August 2015, performance against the 95% target worsened on a month-by-month basis, finally reaching 72% in March 2016, which is below the England average for other NHS trusts.
- The percentage of emergency patient admissions via the emergency department waiting between 4-12 hours from the decision to admit to actual admission was similar to the England NHS trust average between March 2015 and March 2016. The percentage of patients waiting between 4 -12 hours between April 2016 and May 2016 increased to 16%, which was worse than the 8% England NHS trust average during the same period.
- The average time spent by patients at Broomfield Hospital emergency department was approximately 190 minutes, which is worse than the England NHS trust average, which in January 2015, was approximately 130

minutes. The average time spent by patients in the Broomfield Hospital emergency department between January 2015 and January 2016, was consistently higher than the average England NHS trust for the same period.

- Since September 2014, the percentage of patients leaving Broomfield Hospital emergency department before being seen has been consistently below the England average. In January 2016, the percentage of patients leaving before being seen was 1.7%; the England average for the same period was 3%.
- Between January 2015 and January 2016, waiting times for initial treatment at the Broomfield Hospital emergency department were consistently worse than the England NHS trust average. In January 2015, the average time between arrival at the Broomfield Hospital emergency department and initial treatment was approximately 20 minutes; this reduced to six minutes in July 2015 and steadily increased to approximately 10 minutes in January 2016.
- The senior nurse and the emergency physician in charge on each shift proactively managed delays or problems. They supported the transfer of patients to other departments and monitored the flow of patients and activity levels in the emergency department as part of the wider bed management process.
- Data related to admission avoidance was not audited by the trust at the time of our inspection but will form part of their planned frailty model during 2016/17. Data for the ambulatory care unit (ACU) showed the increased use of ambulatory care pathways reduced the need for hospital admission. Since 6 October 2015, there were 879 admissions to the ACU, 808 of these patients were not admitted to the hospital equating to an admission avoidance rate of 92%.
- We observed regular handovers between medical staff about the status of the department at shift changes and clear clinical handovers when transferring or referring patients. Staff were aware of procedures to promote safe working and guide staff through escalation procedures when the department was full or the hospital bed state was causing a backlog to the emergency department.

Learning from complaints and concerns

- Between April 2015 and February 2016, the emergency department received 40 complaints. Complaints in relation to aspects of clinical practice accounted for 72.5%, 10% were in relation to staff attitudes, 10% were classified by the trust as other or no subject, 2.5% were in relation to communication, 2.5% with regard to not following procedure and 2.5% related to not promoting patients privacy and dignity.
- Between April 2015 and Sept 2015, the EAU received nine complaints, three in relation to aspects of clinical care, two in relation to staff attitudes, two regarding communication and two complaints were not categorised.
- We examined the team meeting and governance meeting minutes. All of them detailed feedback and learning by staff from complaints which had been received.
- We specifically asked staff about any feedback or learning they were aware of following complaints. All were able to provide examples of where information had been shared through meetings, during handovers and at safety huddles. We were assured that feedback to staff and lessons learnt from complaints were being provided and we saw a central record of incidents that contained feedback and lessons learnt.

Are urgent and emergency services well-led?

Requires improvement

We rated well led for urgent and emergency care services as requires improvement because:

- Staff were not aware of the trust vision. The strategy for the emergency department was being developed in line with changes from the Essex Success Regime
- Changes in staffing and recruitment had affected staff morale and placed the department under increased pressure to meet the demands of the service especially over the winter months.
- Public engagement and innovation within the department was minimal.

However:

- Local leadership was good and staff felt valued by managers.
- Governance and risk management was embedded within the service.

Vision and strategy for this service

- Staffing and service configuration for the medium and long term were being developed at the time of our inspection. Staff we spoke with told us that there had been significant uncertainty on the management and leadership of the department over the last twelve months and that this had affected morale and performance.
- With the exception of senior staff, the trust vision and values was not known by the majority of staff we spoke with, and we saw very little evidence of any posters or information on then hospital vision or values displayed anywhere on the emergency floor.
- The senior emergency department staff had been involved in planning future service configuration. This had included discussion and planning about short, medium, and long term plans for the future in the context of the Essex Success Regime with a specific reference to the trust's own vision. However, operational staff we spoke with were unclear of the strategy for the trust going forward or the impact of the Essex Success Regime.

Governance, risk management and quality measurement

- There were established systems to ensure good governance and monitor performance led by the acting clinical director, supported by the associate director of operations and Deputy Associate Chief Nurse.
- The trust had a clinical governance group that met monthly. The purpose of the group is to provide a forum to review performance in all areas of patient safety and quality of care so that appropriate actions can be developed and implemented to address any deficiencies. The group oversaw the development and implementation of the trust's risk management strategy and safety and quality strategy. It ensures that any concerns relating to compliance with relevant Care Quality Commissions fundamental standards are acted upon, and escalated to the patient safety and quality committee.
- Concerns from ward staff and managers within the emergency department could be escalated to the clinical governance group for action. The clinical governance group receives quarterly reports from, the Clinical Audit Group, Infection Prevention and Control Group, Medicines Management and Safety Group, Mortality Review Group, Deteriorating Patient Group, Hospital Transfusion Group, Thrombosis Group, Safeguarding Vulnerable Adults & Children and Young People, Tissue Viability Group and Falls Group. These reports identify any specific risks and actions required to minimise harm to patients, for example, near misses with drug errors, patient falls deemed as avoidable.
- The department had a risk register which identified current risks and the mitigating actions taken to minimise risks to patients and the staff team. These were reviewed at appropriate clinical governance forums and staff we spoke with were aware of the risks identified. An example of the risks identified was one of patients presenting to the emergency department with mental health problems who may be at risk of leaving the department and potentially coming to harm. The emergency department had a protocol in place when capacity and demand may increase, for example, weekends to identify concerns, high-risk attenders and take action to reduce risks.
- Incidents that occurrence within the emergency department were reviewed daily to the senior incident management group (SIMG), which was a group of senior staff that would review and make decisions on the level and impact of incidents, whether further investigation was required, or escalation to external agencies.
- The emergency department had developed the serious incident learning initiative (SILI) where staff were encouraged to attend meetings on an adhoc basis dependent on need, to discuss incidents and learning from incidents. Staff would be given the opportunity to present their own incident findings and share this with the team and we saw a central record of incidents that contained feedback and lessons learnt. The SILI could also refer incidents directly to the serious incident management group (SIMG), to establish if further actions or escalation of the issues identified in the incident were required.
- Any delays between patients leaving the ambulance and entering the emergency department are reviewed as

part of the trust governance harm review process and outcomes are reported to the Care Quality Commission each month. Learning from the reviews are shared at departmental safety huddles to support staff learning and improvement.

Leadership of service

- The emergency department was led by the acting clinical director, supported by the associate director of operations, Deputy Associate Chief Nurse, and matrons within the department.
- There was good leadership of the emergency department at local level and staff thought highly of the senior clinician, matrons, and sisters in charge, but felt the previous constant changes in staffing had led to a lack of leadership in recent times and this had affected staff morale. Staff particularly recognised the Acting Clinical Director and Matrons for their on-going support during the winter periods.
- Staff senior and ward leadership roles were clearly identified within the department. Staff knew who was in charge and staff were effectively deployed to various work areas. All staff were aware of the respective roles and responsibilities within the department.
- Staff told us they felt valued by colleagues and there was a whole team ethos towards meeting patient needs. Senior staff deployed staff based on their competencies and experience within the department. The team were looking at ways to improve the skills mix, but said this was affected by the current recruitment position, newly qualified staff or staff that had just joined the department.
- The senior matron in the emergency assessment unit (EAU) was particularly valued by colleagues, who saw him as a positive role model, focus on meeting patients' needs and encouraging staff towards excellence in their day-to-day work.

Culture within the service

- Nursing staff told us they felt it was a supportive department to work in, and said staff worked well together across the professional disciplines.
- We saw staff interact in a supportive way to ensure safety and efficiency for patient care.
- Staff particularly noted the leadership of the consultants and senior nurses, and described them as extremely approachable and supportive.
- Staff spoke about working very hard especially over the winter months under a temporary staff structure, feeling like the emergency department were not supported and due to recruitment issues and vacancies the department's ability to meet the needs of the service were affected.
- Junior doctors told us it was a good place to work, in particular, the attitude of all staff with each other was seen as supportive, and a good place to develop skills and experience.
- Domestic staff reported that the emergency department was a good place to work; they added that they were seen as part of the department team and felt pride in maintaining clean areas for patient care, but it could be very demanding at times when the department got busy.

Public engagement and staff engagement

- Patients were invited to provide feedback using comment cards and patient themes were identified and discussed with the team. At the time of our inspection, the staff had received 42 sets of feedback including 18 on the positive attitudes of staff, 17 on the positive patient experience, six positive about waiting times and one other comment. The team had also received five negative comments on staff attitudes, three on negative patient experience, five negative comments on waiting times and one other comment. These were all listed on the quality and safety information board for staff to discuss and take action on.
- Staff told us they are informed and included in developments of the service. There were daily team safety huddles and weekly notices with useful information and latest important changes and learning from incidents or complaints.

Innovation, improvement and sustainability

- The emergency department team have developed the serious incident learning initiative (SILI) where staff were encouraged to attend meetings to specifically discuss incidents and learning from incidents, staff would be given the opportunity to present their own incident findings and share this with the team to minimise

incidents in the future. The SILI could also refer incidents directly to the serious incident management group (SIMG), affectionately called SMIG by the team, to establish if further actions or escalation of the issues identified in the incident were required.

- The emergency assessment unit team were instrumental in developing the #MEHTlove nursing on line social media platform to share information and updates across the internet, for professionals and families to access facts and updates on the services offered at the hospital.
- The use of VitalPAC within the EAU, had enabled staff to smartly use patient data to promote and meet patient needs in a timely and effective manner.

Medical care (including older people's care)

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

Information about the service

The medical care services at Broomfield Hospital covered a wide range of specialities including stroke, respiratory, cardiology, renal, oncology, and diabetes.

Broomfield Hospital has 237 inpatient beds within the medical directorate. The trust had 36,373 patient admissions between September 2014 and August 2015.

46% were emergency admissions,1% were elective and 54% were day cases.

During our inspection, we visited ten medical ward areas; Danbury, Terling, Felsted, Goldhanger, Baddow, Braxted. Emergency Short Stay ward (ESS), Endoscopy unit, cardiac unit, and the stroke unit.

We spoke with a wide range of staff, including 32 nursing staff of all grades, seven healthcare assistants, occupational and physiotherapist leads, 26 consultants, five middle grade and junior doctors, a pharmacist and a member of hospital security staff. We also spoke with 23 patients receiving care, and 11 of their relatives, as well as looking at 23 sets of medical and nursing records and 16 prescription cards.

Summary of findings

We rated the medical care services at Broomfield Hospital as good overall.

We rated the medical care services at Broomfield Hospital as good overall.

- Incident reporting was embedded amongst nursing and allied health care professionals and learning from incidents was promoted.
- Patients were protected from avoidable harm and abuse, e and the concept of 'safe' was embedded in medical care service practice, for example through the implementation of "safety huddles".
- Standards of hand washing and cleanliness were consistently good and regularly audited. Wards were visibly clean and uncluttered. Staff were provided with personal protective equipment and we saw it being used appropriately.
- The risk of patient readmission at Broomfield hospital was better than the England national average. The hospital participated in national audits, including Myocardial Ischaemia National Audit Project (MINAP), The Sentinel National Stroke Audit Programme (SSNAP) and the National Diabetes Inpatient Audit (NADIA), which shows the trust is monitoring its effectiveness.
- Patients we spoke with told us that staff were caring and kept them involved and up to date with their care and treatment. Referral to treatment times (RTT)

Medical care (including older people's care)

from September 2014 to February 2016 were better than the England national average and the trust had developed effective ways of caring for people living with dementia.

- Quality improvement strategies were developed and outcomes were monitored and acted upon to ensure patients received harm free care. Complaints were used as a means to improve services and the trust was able to provide evidence of changes made as a direct result of complaints made.
- Leadership within the medical care service was good. Clear accountable governance structures existed and risks were identified and owned by individuals who were appropriately held to account.

However:

- There were variable standards of record keeping across the medical wards.
- The storage of medicines was not always satisfactory and prescribing of medicines did not always follow National Institute of Health and Clinical Excellence (NICE) guidelines
- Compliance with safeguarding training in medical staff was not in line with the trusts target. Safeguarding adults training level 1 had been completed by 71.7% of medical staff and Safeguarding Adults at level 2 had been completed by 55.1% of medical staff
- Results from the 2015 National Diabetes Inpatient Audit showed that trust scores have declined in 11 indicators compared with 2013.
- The Friends and Family test results for Goldhanger Ward for in June 2016 was 67%, which is significantly worse than the England average.

Are medical care services safe?

Requires improvement

We rated medical services as Requires Improvement with regard to safety because:

- We found variable standards of record keeping with regard to patients care planning and review of care planning. Records were not stored securely, and we found patient identifiable data accessible to the general public.
- Storage of medicines was not always satisfactory on two wards, with medications not being stored correctly.
- Compliance with safeguarding training in medical staff was not compliant with the trusts target. Safeguarding adults training level 1 had been completed by 71.7% of medical staff and Safeguarding Adults at level 2 had been completed by 55.1% of medical staff
- All medical wards were below their planned whole time equivalent nursing staff levels, with some areas only having 50% of their recommended whole time equivalents
- However:
- Incident reporting was embedded across medicine. There was a clear process in place for the review of incidents at directorate, departmental and ward level.
- Root cause analysis and investigations were carried out on incidents. Learning and actions were shared with staff, and duty of candour was discharged.
- Wards were visibly clean and uncluttered. Staff were provided with personal protective equipment and we saw it being used appropriately
- Hand hygiene scores ranged between 92% to 99% between September 2015 to January 2016, against the trust target of 95%.
- Compliance with mandatory training was above the trusts target of 80%. 83.5% of medical staff and 92.6% of nursing staff had completed their mandatory training

Medical care (including older people's care)

- Nursing compliance with safeguarding training was above the trusts target of 80%. Safeguarding adults training level 1 had been completed by 93% of nursing staff, and Safeguarding Adults at level 2 had been completed by 86.1% of nursing staff
- Wards used the yellow reminder sticker 'People with Parkinson's need their medication on time – every time' on the front of the prescription charts. This meant that time critical medications were administered to patients on time.
-

Incidents

- The trust reported 35 serious incidents between March 2015 and March 2016 and 1743 incidents during the same period.
- All Incidents were discussed and reviewed at directorate, departmental and ward governance meetings. Four sets of meeting minutes were reviewed, and there was evidence of incidents such as falls and pressure ulcers being reviewed.
- No Never Events (serious incidents that are wholly preventable) had been reported by the trust between March 2015 and March 2016.
- All staff, including bank and agency staff, had access to the trust's electronic reporting Datix system in order to add incidents.
- Staff said they reported incidents and received feedback in regard to incident outcomes. Learning from events was passed onto staff at monthly team meetings, safety huddles(daily morning hand over period for clinical staff) and through communications such as "lessons of the month".
- We reviewed three incidents that had been reported regarding patient falls and one issue of a delayed discharge. A comprehensive description of each incident was documented along with any actions needed to reduce the risk of the incident happening again.
- We reviewed the mortality and morbidity minutes from January 2016 respiratory meeting. However, the minutes were of poor quality and did not record who attended the meetings. There was very limited detail and evidence of learning and how it was disseminated was not clear. Mortality and morbidity meetings were held in all areas across medicine including renal, diabetes and cardiology.
- Nursing and medical staff we spoke with had a good understanding of the duty of candour (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'and provides reasonable support to that person). We saw a reply to a complaint letter which had been sent to a relative; evidencing the duty of candour was being upheld and an example where it had been carried out after a patient fall.

Safety thermometer

- The NHS safety thermometer is a national initiative and local improvement tool for measuring, monitoring, and analysing harm free care. Staff reported the number of falls, urinary tract infections (UTI) and venous thrombolisms (VTE) on a monthly basis
- Data from the safety thermometer was not clearly displayed in all ward areas for staff and public to view.
- The trust reported 22 pressure ulcers, 13 falls with harm and 14 catheter-acquired UTIs from February 2015 to January 2016.

Cleanliness, infection control and hygiene

- There was one reported case of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia between January 2015 and January 2016 in Medicine. A Root Cause Analysis had been carried out, and reviewed by external commissioners. Learning had been disseminated through the governance meeting, and this was evidenced in the minutes. .
- There had been 15 cases of Clostridium Difficile (C. Diff-.an infection that can infect the bowel and cause diarrhoea.) From April 2016 to October 2016 against a ceiling of 13 (from April 2016 to March 2017).A full investigation (post infection review) had been completed on each episode and reviewed by external commissioners. It was found that 10 were attributed to the community and not to the trust. The management of the patient had been in line with national and local guidance.
- wards were visibly clean and uncluttered, protecting patients from risks of infection or falls.
- Staff adhered to the trusts hand hygiene and 'Bare below the Elbow' policy, and wore personal protective equipment such as gloves and aprons during care.

However, on Goldhanger ward and Danbury ward, staff were entering and leaving isolation rooms without gloves, aprons or hand washing. This meant that there was an increased risk of infection on the ward.

- All wards had antibacterial gel dispensers at their entrances and near patient bedsides. However, at the entrance to Danbury ward trolleys blocked access to the gel dispenser and the dispenser at an entrance to Terling ward was blocked by wheelchairs.
- Appropriate signage regarding hand washing was visible at the entrance to all wards in line with World Health Organisation (WHO) guidance.
- Staffs hand hygiene compliance audits were displayed on all wards. Medical Specialities hand hygiene scores ranged between 92% to 99% between September 2015 to January 2016, against the trust target of 95%.
- On Goldhanger ward, we saw bathroom cleaning records had not been completed on numerous days. Medical supplies were stored in window bays

Environment and equipment

- The clinical areas we visited were bright and well organised, which would aid patients who were frail, elderly or with visual impairment to navigate the wards.
- We inspected 11 resuscitation trolleys. The trolleys were scheduled to have an inspection every day. Nine of the trolleys had been inspected in line with trust policy. However, one piece of resuscitation equipment on Danbury Ward had not been checked on seven days during the previous four weeks; 13th, 14th, 15th and 16th May and 9th, 10th and 13th June and one trolley inspection sheet had two dates missing from the previous four weeks.
- Systems were in place to maintain and service pieces of equipment. We checked two hoists on Danbury Ward which had been serviced in February 2016, with the next service due for August 2016.
- We checked a number of electrical appliances, such as blood presuure monitors and infusion pumps. All had been serviced.
- Oxygen cylinders were not always stored safely. On Goldhanger two cylinders were standing unsecured on the resuscitation trolley and would have fallen if the trolley had been moved. In the discharge lounge, oxygen cylinders were discarded by the hand wash basin.
- On Goldhanger ward there were no "I am clean" stickers on equipment such as hoists, therefore we were not assured that equipment had been cleaned in between patients. This matter was brought to the attention of the Chief Nurse and on return to the ward later the same day all equipment had been cleaned and stickers were attached.

Medicines

- One medicine cupboard in the pharmacy storage room on Danbury ward was found to be unlocked. The cupboard contained a variety of medicines for treating infections. The sign on the front of the cupboard stated that it should be kept locked.
- One drawer in the pharmacy storage room on Danbury ward was found to contain two bags of out of date Intravenous Fluids. This was raised to the matron who removed the bags and arranged for their disposal.
- All medicine trolleys we inspected were found to be locked and secured to the wall according to trust policy. However, on Braxted ward we observed a medicine trolley was left open and unattended for approximately 10 minutes while the nurse responsible was in a side room. A senior sister saw the trolley was open and advised the nurse responsible to close the trolley while it was not in use.
- Contents of three medicine trollies on Danbury ward were checked. We found two trollies contained loose open strips of oral medications and mixed medications stored in the same boxes. One of the trollies contained boxes of medicines that were stuck to the trolley due to a medication spillage that had not been cleaned up. The ward manager was informed.
- Contents of three medicine trollies on Goldhanger ward were checked. Two trollies had different strips of oral medicine stored in one box, which could lead to medications being mixed up and incorrectly dispensed.
- The medicine refrigerators were locked with daily temperature records available, which showed medicines were stored safely and within the correct temperatures.
- Patients we spoke with told us that they received their medicines on time.
- A clinical pharmacist visited all of the wards five days a week, Monday to Friday. They were involved in discussions with doctors and nurses about patients' individual medicine requirements and helped identify medicine issues which could then be dealt with.

- Three prescription charts were reviewed on Felsted ward. All showed that medications administered were recorded appropriately.
- Allergies were recorded on prescription charts. Six prescription charts on Felsted ward were reviewed and found to have the allergy sections completed appropriately.
- We looked at two prescription charts which showed patients' were getting their medicines when they needed them. One patient was prescribed medicines for Parkinson's disease. We observed that a yellow reminder sticker 'People with Parkinson's need their medication on time – every time' was clearly visible on the front of the prescription chart.
- Staff knew how to report a medicine incident. We were also told how the team learnt and shared information from regular ward meetings and e-mails from pharmacy.

Records

- We reviewed 23 sets of medical and nursing records and 16 prescription cards were reviewed across the medical service. The quality and level of completion of records was inconsistent across the service. For example, in one record the venous thromboembolism risk assessment (VTE) and safeguarding documentation was not completed and the Malnutrition Universal Screening Tool (MUST) score was incorrectly calculated. This was raised with staff at the time of the inspection.
- Nursing records on Danbury ward showed that two long stay patients had not had their falls assessment or nutritional assessment reassessed during their stay. This was reported to the ward sister at the time of inspection.
- On Goldhanger ward, we saw evidence in medical notes that a referral to a dietitian had not been followed up by the staff.
- A 'This Is Me' (tool for people living with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes) form had not been completed for a patient living with dementia . A patient on Goldhanger ward had a 'This is me' form completed, but it was kept with their clinical notes and was therefore not immediately available for all staff to access, which could lead to a patient not receiving their care in the way they or their family would wish.
- Patient's records were kept in a paper-based format, in mobile lockable trolleys on each ward. We found that the trolleys were frequently unlocked and placed in corridors on the wards. This meant that confidential patient information could be accessed by anyone visiting the ward areas.
- On Danbury ward we saw a cardiac arrest audit form in a transparent folder that had been left on a resuscitation trolley. The audit form included personal patient information, including their name, date of birth and the hospital number. This information was viewable to anyone visiting the ward.
- Staff told us the patient records booklet "inpatients nursing documentation" was easy to complete and less clumsy than sheets of paper which could get mixed up and "buried".

Safeguarding

- All the staff we spoke with were aware of the trust's safeguarding procedures for adults and children, what constituted abuse, and how to report it.
- All staff undertook safeguarding training as part of their mandatory training units.
- Safeguarding Adults Level training 1 is intended for all staff working within health and care organisations. Safeguarding Adults Level 2 training is intended for staff with professional and organisational responsibility for safeguarding adults.Safeguarding adults training level 1 had been completed by 71.7% of medical staff and 93% of nursing staff, which is worse than the trust 95% target. Safeguarding Adults at level 2 had been completed by 55.1% of medical staff and 86.1% of nursing staff, which is also worse than the trust target of 95%.
- Staff spoke positively about the trust safeguarding team who were available to support staff with safeguarding concerns from 9am-5pm Monday to Friday.

Mandatory training

- Mandatory training was provided by e-learning or face-to face classroom sessions and included moving and handling, waste management, health and safety, hygiene and basic life support.
- The trusts target for completion of mandatory training was 80%. Compliance levels varied between staff groups. For example, 83.5% of medical staff and 92.6% of nursing staff had completed their mandatory training, which is better than the trust target.

Assessing and responding to patient risk

Medical care (including older people's care)

- The trust used the national early warning score (NEWS) for managing deteriorating patients. The national early warning score is a simple, physiological score with a primary purpose to prevent delay in intervention or transfer of critically ill patients.
- Staff on medical wards used software to record patient's vital signs, for example pulse, blood pressure, and breathing rate. Staff record the data on hand held devices. The data entered is automatically assimilated and if the patient is deteriorating a prompt advising the staff member to seek medical support is generated
- Staff told us that Broomfield Hospital did not operate a 'Hospital at Night' system. Hospital at Night is a system that uses both a multi-professional and multi-speciality approach to delivering care at night to meet the immediate needs of patients. Staff on wards and on call had to cover all areas of patient care.
- During the hours of 8am and 11.30pm, a member of the trigger and response team (TART) was alerted to go to the ward, as well as members of the medical team for patients requiring prompt management or that were at risk of deterioration. Staff who were members of the TART team were trained in resuscitation.
- There was evidence that audits and changes were made in response to the National Institute of Clinical Excellence Guidance. For example, the falls document had been updated in line with NICE guidance CG16. This meant that patients were assessed for the risk of falling, with a "multi factorial" document, taking into consideration all aspects of their needs, for example vision and hearing.

Nursing staffing

- All the medical wards had undergone a review in December 2015 of their nurse staffing levels, using the verified nurse staffing tool Safer Nursing Care Tool (SNCT), which took the acuity and dependency of patients into account.
- All medical wards were below their planned whole time equivalent nursing staff levels with Baddow and Braxted wards approximately 50% below planned levels of employed staff.
- Agency and bank staff were used to cover for planned and unplanned shortfalls in staffing, covering vacancies and staff absences, as well as bringing specific required skills for short periods of time.
- The number of bank and agency staff being used across medical wards had decreased since our last inspection. Trust data for data February 2016 showed bank and agency use at 27.9% on Goldhanger, 26.5% on Emergency Short Stay (ESS), 35.7% on Danbury, 29.1% on Terling, 33.6% on Baddow, 41.6% on Braxted, 33.7% on Felsted and 40.3% on the Stroke Unit.
- We looked at the actual staffing levels against planned staffing levels on eight medical wards during the inspection. We found them to operating in line with planned levels. However, on one shift on Baddow ward they were one care assistant short for two shifts on one of the days of our visit.
- Staffing levels were displayed on whiteboards near the entrance to the wards for patients and visitors to see.

Medical staffing

- The trust had a higher proportion of consultants than the England average comprising 39% of the medical workforce compared to the England average of 34%. There were slightly fewer middle grade (3%) and registrars (33%) than the England average with a similar number of junior doctors (25%). Medical staffing levels were slightly below the planned whole time equivalent (WTE). The planned WTE was 153.4 posts, compared to the actual WTE in post, which was 135.0
- Two medical registrars were available at night supported by six doctors, this was an increase of one registrar and 2 doctors since our last visit.
- There was one consultant on-call off site during weekday nights (9.30pm-9am). During the weekend, the following cover was arranged at consultant level; 8am-8pm one consultant, 9am-6pm one consultant (covering the Emergency Assessment Unit (EAU) and Emergency Short Stay ESS), 9am – 12pm one discharge consultant.
- Junior and middle grade doctors informed us that consultants could always be contacted on call for help and advice when necessary, and would come into the hospital when required.
- All junior doctors we spoke with were very positive about their experience in the hospital. They had received a 'good induction' at the commencement of their employment, and felt they had been given all the information they required. They had met with senior medical leaders and managers.

Major incident awareness and training

- We saw copies of the major incident plan on Danbury and Braxted wards.

Medical care (including older people's care)

- The associate director of operations told us the hospital had started planning for the implementation of the winter pressures ward, which included reviewing additional beds that may be required and how these would be staffed.

Are medical care services effective?

Good

We rated effectiveness of medical services good because:

- Care was provided in line with national best practice guidelines.
- Risk of patient readmission at Broomfield hospital was lower than the England national average. The standardised relative risk of readmission at Broomfield hospital was 70 for elective patients and 87 for non-elective patents (100 is the expected level of patient readmission)
- The hospital participated in a range national audits including Myocardial Ischaemia National Audit Project (MINAP) and The Sentinel National Stroke Audit Programme (SSNAP)
- Patients told us that their pain was well managed and the trust wide pain team were involved in delivering pain relief on wards.
- The average length of stay at the hospital is below the national average for both elective and non-elective patients.

However,

- Results form the 2015 National Diabetes Inpatient Audit showed that trust scores have declined in 11 indicators compared with 2013

Evidence-based care and treatment

- The trust's policies and procedures could be accessed by staff via the trust intranet.
- National Institute for Health (NICE) guidelines were being followed across the medical directorate for example falls assessments, reducing the risk of falls in older people

Pain relief

- We spoke to 23 patients across the medical wards. All Patients told us they had sufficient pain relief and were regularly asked about their pain relief requirements.
- We saw 16 prescription cards evidencing that patients had been prescribed and adminsitered pain relief when required.
- The trust wide pain service was involved in training and support for staff. They were involved in the multi disciplinary team (MDT) meetings within the wards to help ensure patients were receiving appropriate pain relief regimes and that these were administered in a timely manner.

Nutrition and hydration

- All the patients and relatives we spoke with were satisfied with the quality, range and choice of food provided.
- We saw meal times were calm and well managed. Staff were on-hand to assist patients if required and volunteers were available to assist and chat with patients.
- Patients who required assistance eating were given their meals on red trays to make them more easily identifiable to staff.
- During our visits, we observed that patients had water jugs left within easy reach so they could access them when they wanted to.
- Patient's nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. Staff recorded scores and care plans were put into place for patients with identified risks such as loss of weight or those unable to take food orally. Staff made referrals to a dietician when patients were at high risk of malnutrition.
- Patients were able to make their choices for meals at mealtimes on Baddow and Braxted wards, opposed to the day before. This helped those patients who had difficulty remembering, make an informed choice.

Patient outcomes

- There was an outstanding Care Quality Commission (CQC) Mortality Outlier alert for Acute Cerebrovascular Disease at the trust from August 2015. The trust undertook a comprehensive retrospective notes review, and produced an action plan in response to areas requiring improvement, including clinical documentation and coding, delays in referral to stroke team and delays in Nasogastric Tube (NGT) insertions.
- The trust participated in the Joint Advisory Group on GI Endoscopy (JAG), and had acheived Level 1

accreditation. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale Standards. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant that the endoscopy department was operating within this guidance.

- The Sentinel National Stroke Audit Programme (SSNAP) for October to December 2015 showed the hospital achieved an overall rating of band B for both patient–centred and team-centred key performance indicators (where band A is the highest and band E the lowest).
- The Myocardial Ischaemia National Audit Project (MINAP) audit scores were similar to the England average in both 2012/13 and 2013/14, except for admission to appropriate cardiac ward.This showed the trust at 16% against the national average of 55%.However, this was due to the patient pathway and the way in which data was recorded. All cardiac patients were admitted to the emergency assessment unit, where they would be cardiac monitored, reviewed by a cardiac consultant and then admitted to appropriate cardiac bed, or transferred out to the local tertiary centre.
- The National Heart Failure Audit 2014/15, showed that the percentage of patients the received an echocardiogram (scan of the heart), and those receiving appropriate cardiac medication, were equal or above the national average.
- We reviewed the heart failure action plan, which included the further training of staff and the purchase of a third echocardiogram scanner to be implemented by March 2017.
- In the 2015 National Diabetes Inpatient Audit, trust scores had declined in 11 indicators compared with 2013.For example; visits by specialist diabetes team, seen by the multi-disciplinary foot care team (MDFT) within 24 hours, and staff knowledge.However, the trust scores have improved in four areas including medication errors, prescription errors, management errors and insulin errors.
- We reviewed the action plan that the trust had put into place following the audit. This showed improvements in areas, for example an additional diabetes specialist nurse had been recruited to in February 2016, to ensure patients were seen in a timely manner. New blood glucose software had been installed, meaning patients with high glucose reading were alerted to the team, meaning potentially unwell patients were seen promptly (the reporting element of this was due for completion by November 2016).
- However, there continued to be limited commissioning for podiatry funding, and patients would be reviewed by a Consultant with an interest in podiatry, with a podiatrist being available once a week.
- The lung cancer audit (2014) identified the trust had performed better than the England average against the three indicators identified.
- The average length of stay at Broomfield hospital is 3.5 days for elective patients, which is better than the England national average of 3.8 days and 5.7 days for non-elective patients, which is better than the England national average of 6.8 days.
- The standardised relative risk of readmission at Broomfield hospital was 70 for elective patients and 87 for non-elective patents (100 is the expected level of patient readmission). A value below 100 is interpreted as a positive finding, because this means there were less observed readmissions than expected.

Competent staff

- Staff we spoke to had received an appraisal in the last 12 months, in line with trust policy. We saw evidence on Baddow, ESS and Braxted wards that staff appraisals were up to date. Trust data showed that 83% of cardiology medical staff, 100% of chest staff, and 100% staff on the elderly care wards had received their appraisals in the 12 months between March 2015 and April 2016
- There was a staff induction programme for staff joining the wards. All members of staff we spoke with confirmed they had received their induction.
- Agency and bank staff are required to undertake an induction process and orientation of the relevant ward. Orientation included a tour of the ward and facilities, fire procedure, cardiac arrest procedure, bleep system, and risk event reporting. The induction and orientation paperwork was signed by the agency/bank worker and inducting member of staff.
- Pre-registration nurses had mentorship and competency frameworks to complete. They told us they felt well supported by their mentors and were never left alone to complete tasks. This was the same on all

medical wards we visited. We observed a pre-registration overseas nurse shadowing a more senior nurse during a drug round as part of their training and mentorship.
- The organisation and individual doctors took responsibility to ensure their revalidation was up to date. The trust had produced a comprehensive document outlining the revalidation process. The responsible officer for the process was the medical director for the trust. The trust had a 100% rate of revalidation for doctors covering the medical core service for the period April 2015 to March 2016.

Multidisciplinary working

- There was a multidisciplinary (MDT) co-ordinated approach to care and treatment across the medical wards that involved a range of professionals, both internally and externally.
- The executive lead we spoke with said they felt MDT working was going well.
- Occupational therapy and physiotherapy staff were given bases to work within each ward and said they were included in planning patients care.
- Ward areas carried out morning and afternoon board rounds, which were attended by a multidisciplinary team (MDT).
- Stroke nurses were available 24 hours a day seven days a week and a fourth stroke consultant was due to be appointed into post by the trust.

Seven-day services

- There was a consultant out-of-hour's service provided via an on-call system across the trust seven days a week.
- Occupational therapy and physiotherapy were available seven days a week
- The trigger and response team (TART) were covering 8.00am to 11.00pm seven days a week as part of a pilot project.
- A physician of the day was available at weekends from 2pm-9.30pm. A chest consultant, stroke consultant and discharge consultant were also available in the morning at weekends from 9am-12pm.
- The cardiology department supplied variable weekend cover. For all out of hour's cardiac angiography or pacing emergencies patients would be transferred to Basildon Cardiothoracic Centre.

Access to information

- Patients we spoke with told us they had no concerns regarding access to information relating to their care or treatment.
- Changes in the way "do not attempt cardio pulmonary resuscitation (DNACPR) forms" were stored in patients notes have made it easier to find the necessary information quicker. The DNACPR forms were now filed on the inside cover of the patient's notes rather than further in where they become "lost" among other information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies and procedures relating to consent and the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards 2009 (DoLS).
- There were clear directions for staff if they needed to make an application to deprive a patient of their liberty, which included who to send the application to and how to access an independent mental capacity advocate (IMCA) if required.
- Mental Capacity and DoLs is part of the trust mandatory training. The trust target for completion of the training is 95%. 67.95% of medical staff and 86.7% of nursing staff had completed the training.
- Staff we spoke with were aware of consent, Mental Capacity Act and Deprivation of Liberty Safeguards requirements. Staff explained the systems for assessing people's mental capacity and giving consent regarding treatment.
- We viewed six sets of records in regard to assessments under MCA and DoLS Four were fully documented and correctly completed. One DoLS application was awaiting an external assessment and one had expired, but there was no evidence that an extension had been requested
- Patients informed us that they were asked for their verbal consent before staff helped them, and before any procedures were undertaken. .

Are medical care services caring?

Good

We rated medical services as good for caring because:

Medical care (including older people's care)

· Feedback from people who use the service and those close to them was consistently positive about the way staff treated patients.

· Staff treated people with dignity, respect and kindness and staff spent time talking to people to make sure they received information in a way they could understand.

· The chaplaincy service offered counselling services and these were available to staff patients and their family.

However:

· Medical wards scored 90% (on average) in the Friends and Family test (FFT) between March 2015 and February 2016. This was worse than the England average of 95% during the same period, meaning less patients would recommend the ward to their friends and family than in other areas of England. The FFT result for Goldhanger Ward for in June 2016 was 67%, which is significantly worse than the England average.

· We observed poor communication by staff whilst on Goldhanger ward with patients and relatives.

· Relatives and patients gave us mixed feedback regarding care planning. Some patients and relatives told us that they had been included in making care plans and some had not.

Compassionate care

- Patients consistently spoke positively about staff attitudes and behaviours.
- Patients, their relatives and friends told us that staff were always cheerful, helpful, thoughtful, kind and had a good attitude. One patient said, "They're a nice bunch."
- We saw nursing staff sharing appropriate humour with a patient and a nurse gently stroking a patients hand to comfort and reassure them.
- Patients told us that they were happy with the care they received, one patient said, "The care I receive is second to none".
- Patients told us that staff were always polite and introduced themselves and we heard staff introducing themselves to patients in a polite way.
- Patients told us that at the beginning of every shift a nurse would introduce themselves and explain they are the nurse taking care of them. We saw the nurse's name recorded above each patient's bed.
- We saw nursing staff respecting patients privacy and dignity by closing curtains when delivering personal care. Staff politely asked visitors that were not family, to leave before discussions with doctors and nurses. When curtains were closed, we saw nursing staff identify themselves through the curtain and ask permission to come in so that they could assist with the care being provided.
- Patient call bells were within patient reach in 21out of 23 patients we checked. Patients told us that nurses came immediately when called, and we saw patient call bells answered promptly during our visit.
- The Patient Council conducted their questionnaire on Baddow, Braxted, Danbury, Felsted and Goldhanger wards between December 2015 and March 2016. Patients gave positive feedback about the wards and said that staff were welcoming and the wards felt calm. Patients said the night times could be noisy due to patients being admitted.
- During our inspection, all the patients we spoke with said they would very happily recommend the hospital despite the FFT results of March 2015 to February 2016 not reflecting this.
- Relatives told us that visiting hours were flexible. .
- On Goldhanger Ward, we observed a relative asking the senior nurse for a vomit bowl for a patient. A senior nurse brought the bowl and gave it to the relative but did not enquire after the patient or show any concern to the lady regarding her husband.
- We heard a nurse on Goldhanger Ward speak very abruptly to a patient and to a caller on the telephone.

Understanding and involvement of patients and those close to them

- Patients told us that doctors and nurses had time to answer their questions. One patient said, "The Doctor explains everything to me". We saw a nurse explaining a blood pressure reading to a patient when they asked about it and reassuring them that it was ok. On another occasion, we saw a nurse answering a patient's questions about diabetes.
- Patients told us that they had enough information about their condition through discussions with doctors and from information leaflets.
- One patient told us "staff keep me informed, tell me what is going on. It is nice to have people who give you confidence in what they are doing".

Medical care (including older people's care)

- Patients told us that doctors and nurses had explained their medications and why they were taking them.
- The wards had cards for friends and relatives to take and fill in called, "I am an essential partner," which allowed them greater access to the wards outside of visiting hours and overnight.

Emotional support

- The trust chaplaincy service provided a 24/7 multifaith service for patients and their families. This was via requested bedside visits, weekly ward visits by chaplaincy volunteers or attendance at the Multi Faith room. Patients told us that they were aware of the chaplains and several patients had spent time with them.
- The occupational health department offered a counselling service for staff, and staff could self-refer. The chaplaincy service also offered counselling services and these were available to staff, patients and their family. A patient told us they had attended counselling, and follow up advice had been provided for once the patient was discharged home.
- A stroke specific counselling service was available to support patients and relatives affected by stroke. A relative told us they had been offered this service.

Are medical care services responsive?

Good

We rated medical care services good for responsive because:

- Staff had developed ways of providing information in a range of formats for patients who had communication difficulties.
- Patients found it easy to complain, their complaints were taken seriously, responded to appropriately and learning shared to help prevent reoccurrences.
- Staff had developed ways to make the hospital stay more comfortable for patients with dementia and confusion.
- Referral to treatment times (RTT) from June 2015 to February 2016 were better than the England average

However:

- Four patients told us that they had been moved ward during the night. One patient had been moved wards twice and taken for an X-ray in the middle of the night.

Service planning and delivery to meet the needs of local people

- The trust acting chief operating officer was looking at ways of working differently to reduce the number of admissions, improve capacity and improve the discharge process within medicine.

Access and flow

- Referral to treatment times (RTT) for incomplete pathways from June 2015 to February 2016 were consistently above the England average. Incomplete pathways are times for patients waiting to start treatment. 99.3% of general medicine patients, and 100% of geriatric and thoracic patients started treatment within 18 weeks.
- The trust was in the process of developing a frailty service, which would operate in the ED department. The service would be available 9am -5pm Monday to Friday with cover provided at weekends. The service aims to alleviate some of the pressures on the ED and help patients get the right care quickly.
- Admission to a medical ward was via one of two routes, general practitioner referrals went straight to emergency assessment unit (EAU) or the emergency short stay (ESS) unit then to a ward. Patients attending via ED went direct to ward or EAU/ ESS if there were no medical beds available at that time.
- On day one of our inspection there were 16 medical outliers (a medical outlier is defined as a patient admitted to a ward different from the Internal Medicine wards) rising to 25 on day two. Staff told us that the medical outliers were medically stable patients and had been assessed against a set criteria to ensure that there clinical needs could be met.. Outliers were visited by the l 'Matron Of The Day' daily. Each ward had a dedicated medical consultant responsible for reviewing the outliers on that ward.
- Discharge planning started as soon as the patient arrived on the ward. The trust had introduced a red and green day scheme to help identify those patients who were following a discharge plan.Staff told us they aim to complete discharges by 11am and that delays in transfer of care (DTOC) are usually due to difficulties restarting care at home.

Medical care (including older people's care)

- We observed two ward board rounds. Ward areas carried out morning and afternoon board rounds, which were attended by a multidisciplinary team (MDT). They are a means of assisting patients discharge pathways and managing any delays in that process. The MDT consisted of doctors, matrons, medical teams, nursing staff, therapy and social care colleagues. Twice daily board rounds had been introduced to wards as part of the NHS England SAFER Patient Flow bundle (which includes expected date of discharge and length of stay reviews). The intention is that board rounds will contribute to increasing flow of patients throughout the hospital.
- Medical bed occupancy was at 100% and had been for the previous eight months. There was one protected stroke bed. Bed occupancy was reviewed at 9am and 12 mid-day as part of the bed meeting.
- The discharge lounge could accommodate up to 14 patients. The lounge was open from 8am-8.30pm seven days per week and was staffed by two health care assistants (HCA) and one Registered Nurse (RN). Volunteers come in during the week to offer support to patients and staff by collecting pieces of equipment and transporting patients

Meeting people's individual needs

- Dementia boxes, which contained items, such as cards, dominoes, colouring books, puzzles and fiddle mitts were available in ward areas. These provided patients with tactile stimulation and we saw the boxes in use.
- The trust had appointed dementia champions on each ward. Dementia champions were nurses who provided information and support to carers and families of patients living with dementia and the nurses caring for them. All the nurses we spoke with on the medical wards had received dementia awareness training.
- Patients living with dementia who may have wandered around the ward or who were anxious about being alone, had one to one nursing staff support at all times, this kept them safe and minimised harm from falls or absconding.
- Dementia packs, which contained information and advice for relatives of patients living with dementia were available. A dementia carers questionnaire and a visitor pass for open visiting were included in the pack. The dementia nurse specialist audited the response rate for the questionnaire monthly.
- Dementia friendly ward spaces included the use of pictures of historic icons, for example famous film stars or sporting legends above patient beds to help them locate their bed space.
- Different ward areas were painted in different colours to help patient orientation and toilet doors had pictures of toilets on them to remind patients where the toilets were.
- Staff gave patients living with dementia a magazine called the Daily Sparkle, which contained puzzles and "news" from this day in history. The trust provided the magazine and it was well received and enjoyed by patients.
- "This is me" booklets were used for patients living with dementia. These booklets were completed by the patient's family or carers and used by nursing staff to help provide personalised care for patients with dementia. We saw a nurse supporting a relative to complete the booklet and explaining its importance.
- We looked at the records of six patients who were living with dementia and who had received the "this is me" booklet. Three were completed and three were awaiting completion by family or carers.
- Communication aids used to help with people who had communication difficulties, included picture books depicting images of people in pain, thirsty, cold, hot, happy or sad.
- Staff could access Language Line, which is an interpretation service by telephone for people whose first language is not English.
- We saw a patient who was hearing impaired writing in a notebook to communicate with staff.
- Pets as therapy (PAT) dogs, came onto the wards on Thursday mornings. Patients enjoyed the interaction with the dogs and this brought them comfort and happiness.
- There were posters and leaflets displayed in wards providing information to patients and their relatives about accessing dementia care nurses for advice and support around dementia related issues, falls, blood clots and stroke.
- On one ward we visited, we heard a nurse offering a relative a "pass word." The relative would say this word to the staff member who answered the telephone when they telephoned the ward for updates on the patient.
- Dementia care advice leaflets for friends and relatives were available on the wards.

- Terling ward had advice leaflets available for the public to take on wall of the ward regarding living with heart failure, heart valve disease, pacemakers, blood pressure, diabetes and your heart, atrial fibrillation, angina and heart attacks.

Learning from complaints and concerns

- The trust received 434 written complaints between April 2015 and March 2016, 10% of these related to medical care.
- The trust partially upheld 40 complaints and three complaints were not upheld. Danbury ward received the most complaints, followed by Terling, Braxted and Felsted.
- The highest number of complaints by subject within the medical wards was ten, in relation to poor care received on the wards followed by seven complaints relating to discharge. Attitudes of doctors and medication issues received six complaints each and the remainder of complaints related to communication at the end of life and cancelled procedures.
- Staff told us that they discussed complaints and fed back at ward meetings and daily safety huddles we saw meeting minutes that confirmed this.
- Staff had arranged face to face meeting with a patients relatives to discuss concerns and complaints.We saw feedback from this discussed on a ward meeting agenda.
- We saw leaflets in the wards on how to raise a complaint. All the patients we spoke with were aware of how to raise a complaint but they all said they had no reason to complain.

Are medical care services well-led?

Good

We rated well led for medical care services good because:

· Staff felt well supported by local leaders, peers and senior management.There was good communication between all staff grades and senior management.

· There was evidence of good governance arrangements including the management of risk registers and reporting of quality concerns. Incidents were managed through governance meetings.

· There was a clear focus on improving quality across medicine and this was reflected in the quality improvements plans, which included developments in the service to improve patients care.

· There was evidence of patient engagement through patient surveys, and how results from the surveys were acted upon and new initiatives implemented.

· The culture with in the hospital was friendly and the trust values were being upheld.

Vision and strategy for this service

- From July 2016, the trust was in the process of changing the structure of its leadership teams and moving from 11 directorates to four divisions to create more central accountability and increase leadership support. Medicine and emergency care will be joining to form one division
- Staff were not aware of any specific vision for the medicine division but told us they were aiming to work more closely with community partners to help improve flow through the medical wards and would be engaging with the Essex Success Regime (The Success Regime is part of the NHS Five Year Forward View, which is a blueprint for the NHS to take decisive steps to secure high quality, joined-up care).

Governance, risk management and quality measurement

- The department of medicine risk register was discussed at the governance meetings and updated on a monthly basis.There was a designated owner, clear timelines and review dates. The trust had identified numerous risk areas including, emergency flow, finance and recruitment
- There was a ward improvement plan for Goldhanger. 44% of tasks were completed and 56% were on track to be completed by 1 July 2016 with no anticipated risks to delivery of the plan.
- We reviewed four quality improvements plans which included patient discharge, reduction of pressure ulcers and management of stroke. Examples of actions included education packages for staff in pressure area care and a gap analysis of the speech and language team to move to a seven day service.
- Staff knew how to escalate concerns relating to risk and clinical governance. Concerns and risks were discussed at the ward safety huddle. These were escalated to the

'Matron of the Day' who attended a daily meeting with a senior nurse, medical director and governance representatives where plans were made to tackle the risks identified.

- The medical directorate reported quality concerns to the clinical governance group who in turn reported issues to the patient safety and quality committee on a monthly basis.
- Monthly governance meetings had resulted in a reduced number of outstanding Datix reports. We saw minutes of monthly medical governance meetings documenting the incidents reviewed, the actions to be completed and the person responsible for completing them before the investigation could be closed.
- Nursing staff said they felt daily safety huddles held on the wards had led to better sharing and learning around incidents and complaints on the wards.
- Staff carried out audits routinely looking at patient notes, infection prevention and would be auditing red-green days once they had become more established.

Leadership of service

- The medical division senior team consisted of a clinical director and lead nurse.
- All the nursing staff we spoke with spoke positively about leadership locally and trust wide.
- All the staff we spoke with held the Chief Nurse in high regard and spoke positively about her presence on the wards and her "hands on" approach.
- Staff told us the culture with in the hospital was friendly.
- All the staff we spoke with knew the trust values and felt they were being upheld.
- Staff said there was good communication from the senior executives and showed us updates from them on the hospital website. Staff said that the executives are more visible on the wards now than they used to be.

Culture within the service

- Staff we spoke with were willing to speak to inspectors honestly and frankly during the visit.
- Nurses and HCAs told us they felt valued and respected by colleagues and management.
- There was an open culture of sharing and learning around complaints and incidents, meeting minutes showed this learning and sharing.
- Staff we spoke with said it was a very friendly hospital. All the staff we passed in the corridors greeted us and made sure we knew how to get to where we wanted to go.

Public engagement

- Members of the patient council carried out monthly patient surveys. Results would be fed back to the nurse in charge with recommendations and areas of good practice.
- The trust ran a dementia carers survey between April 2015 to December 2015.Following the results the trust became one of the first 100 hospital to sign up to 'Johns Campaign' offering the right to stay with a patient with dementia day and night and introduced the Carers Pass' reinforcing right to open visiting.

Staff engagement

- Staff awards included "Time to Shine" and "terrific ticket", which were awarded to staff that that had gone above and beyond expected levels. Colleagues or members of the public could nominate staff for the awards. Staff spoke positively about the "Time to Shine" award and appreciated the letter of recognition, which they received as part of the award. Staff told us the "terrific ticket" award was a nice idea and one staff member who had received the award said it had made them feel proud and appreciated.

Innovation, improvement and sustainability

- There was an increase in the number of permanent doctors and nurses employed by the trust since our last visit. There were seven more consultant physicians, 44 more nurses and four more HCA. We saw a reduction in the number of agency staff employed.
- Danbury ward was introducing a 6pm-2am shift to help alleviate the pressure on staff during the evening medication rounds and help get patients settled down for sleep in a more timely way.

Surgery

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

Information about the service

Mid Essex Hospital Services NHS Trust (MEHT) provides a comprehensive range of acute and community based services.

MEHT is the Essex and Suffolk county centre for gastric cancer and the national centre for gastric patients for all of the UK. The service has identified it is number one in the United Kingdom for gastric pacing and the first UK accredited Upper gastrointestinal robotic centre, where robots are used to aid procedures such as robotic gastric pacing and robotic 'Heller's myotomy'.

Additional services include a national profile plastics service, regional head and neck services and a supra regional burns service (St Andrew's centre for plastic surgery and burns) to a population of 9.8million. Surgical services also include 3D laparoscopic surgery and access to a pain clinic.

The trust, based in the heart of Essex, employs over 3,800 staff and provides services from five sites in and around Witham, Chelmsford, Braintree and Maldon. The main site is Broomfield Hospital in Chelmsford, which were redeveloped as part of a £148m Private Finance Initiative (PFI).

Broomfield Hospital has 642 beds hospital wide of these 164 are surgical beds. a surgical day unit and day surgery theatres and 19 theatres.

During the inspection, we visited the anaesthetic assessment unit, theatre suites, day surgery unit, Surgical emergency unit, Lister, Rayne, Notley, John Ray and Heybridge wards.

We spoke with 16 medical staff, 44 nursing staff including managers, three members of the multi-disciplinary team and 19 patients.

Surgery

Summary of findings

Overall, surgical services were rated as good because:

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incident management was in line with 'being open' and the duty of candour. Staff were caring, compassionate and respectful and were positive about working in the service. Medical staffing levels and skill mix were recognised as being satisfactory within the service.
- Trust wide monitoring of staffing against acuity had taken place bi-annually to determine whether current staffing levels and skill mix were appropriate for the acuity of patients who used the service. Shortfalls in trained nurse levels were identified on the surgical risk register. Nursing staff spoke positively of the staffing escalation process used to communicate and address staffing shortfalls.
- The training information provided by the trust showed that staff attendance at mandatory training was above the trusts target of 80%.
- We observed good infection prevention practices by staff. Clinical equipment was serviced and daily checks had taken place on equipment.Daily monitoring of resuscitation equipment had taken place.
- Care was provided in line with National Institue of Clinical Effectiveness guidance (NICE CG50) in respect of recognising and responding to deteriorating patients. Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time. Consent processes were robust and documentation associated with these processes was adapted to the individual patient's needs and understanding.
- Patients received evidenced based care and treatment and patient outcomes had improved. Good multi-disciplinary working existed between the trust, local clinical commissioning groups and community services.
- Service planning and delivery considered patients' needs, which meant changes to the service and how it was delivered benefited the patient. Support was in place for those patients and their families who had either learning disabilities or living with dementia. The trust had identified a lead nurse for dementia who was also a 'Dementia Friends Champion.'
- The service was well led and a clear leadership structure in place. Individual management of the different areas were well led. Cultural work had taken place to strengthen the multi-disciplinary teams. Feedback from staff and patients had resulted in changes to aspects within the service.

However

- The safeguarding level 2 training target was 95% and we observed that staff attendance fell below that at times with attendance in some specialties as low as 44%. The target rate for this training was only met by allied healthcare professionals and professional scientific and technical staff.
- Operating theatres were established against the 'Association for Perioperative Practice (AfPP staffing recommendations). Theatres had a vacancy rate of 62 whole time equivalent (wte) which included 42 trained nurses at band 5 and 6 and 20 theatre assistants at bands 2 and 3. The reason for the high vacancy rate was due to an increase in theatre lists.
- Training in resuscitation was not meeting the targets set by the trust. The resuscitation team had no one who had European Peaditatric Life Support training.
- Medical outliers were located throughout the service. Outliers relate to patients who were situated away from the speciality they should have been admitted to. There had also been 182 incidences of surgical patient outlying on menical wards over the previous 12 months.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. Incident management was in line with 'being open' and the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents', and provide reasonable support to that person.
- Clinical equipment was serviced and generally daily monitoring checks had taken place on equipment which required them. We observed good infection prevention practices by staff.
- The surgical department had sufficient numbers of medical staff with the appropriate skills.
- Shortfalls in trained nurse levels were identified on the surgical risk register. Trust wide monitoring of staffing against acuity took place bi-annually to determine whether current staffing levels and skill mix were appropriate for the acuity of patients who used the service. Nursing staff spoke positively of the staffing escalation process used to communicate and address staffing shortfalls. Some staff had raised some concerns about the length of shifts in surgery, for example, shift times were identified as from 7am to 9.30pm.
- Ongoing recruitment and the introduction of new ways of working ensured sufficient staff worked within the service. Not all of the new nurses had started at the trust; however, we were told that their start dates were identified up to September 2016.
- Operating theatres were established against the 'Association for Perioperative Practice (AfPP staffing recommendations). The theatre vacancy rate was 62 whole time equivalent (WTE) and was due to theatres being tasked to increase theatre lists. To assist recruitment an additional budget of 100,000 pounds was secured and we observed ongoing recruitment taking place during the inspection.
- Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time.
- Systems were in place to ensure that risks to elective and emergency patient groups were identified pre-operatively, for example, venothromboembolism (VTE) assessment was completed for all hospitalised patients within 24 hours of admission
- Systems were in place to ensure that the '5 steps to Safer Surgery - World Health organisation' (WHO) surgical safety checklist was completed for patients prior to and following surgical intervention. The trust monitored completion of the WHO checklists and took action where checklists were not fully completed.

However :

- Training in resuscitation was not meeting the targets set by the trust. The resuscitation team had no one who had European Peaditatric Life Support training.
- Two glucometer machines on Lister ward weekend checks were not completed. Daily monitoring of resuscitation equipment had taken place. However, in the pre-assessment unit we observed that expiry dates were missing from packaged Callisto laryngoscopes blades, sizes three and four. We asked the staff member to confirm to us when the blades were due to expire as no piece of equipment has an indefinite shelf life.
- Patients' venous thromboembolism (VTE) assessment status were not always reassessed after 24 hours of the initial assessment-taking place.
- We found gaps in recording keeping on the Surgical Emergency ward and Heybridge ward.
- On Notley ward, the medicine storage room felt very warm however, there were no temperature records available to ensure medicines were stored within a safe temperature range.
- On Heybridge, John Ray and Notley wards, we found issues in the safe prescribing of the pain killer paracetamol. Paracetamol can be prescribed to be given intravenously (IV) or orally (o), however we noted that doctors prescribed both 'IV' and 'o' on the same prescription with no clear distinction between the two.

Incidents

- Reporting systems were in place to ensure incidents were investigated and lessons learnt. Staff told us that

they had received training in root cause analysis, which formed part of the incident investigation process. Medical and nursing staff said they knew how to report incidents and had received feedback.

- Incident feedback was cascaded through email, staff meetings and during ward daily safety huddles (safety huddles are where staff gather to receiveand share information) to ward staff. Other forums included, the sisters daily safety huddle meeting and at the general surgery and specialist surgery governance groups where findings were presented through an 'Incidents & Clinical Effectiveness Report'.
- We reviewed three incidents submitted by the trust and saw that learning and changes were identified to improve practice. However, the action plans did not confirm whether all the proposed actions were achieved. Apologies were given to the families for two incidents; the third incident identified 'Falls Practitioner to share Panel review with patient on 27/04/15'. Further information was not provided by the trust to confirm this had taken place.
- Feedback on one never event was given to all staff through 'the working together to improve' newsletter (undated).' The newsletter included a summary of the never event and learning.
- Staff received serious incident feedback through the 'Bi-weekly Focus' newsletter.
- There were 2 never events recorded for surgery between March 2015 and March 2016 A never event has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event. 47 serious incidents were reported during this period.
- Monthly mortality and morbidity (M&M) meetings took place. We saw a selection of minuted speciality mortality and morbidity meetings dated between February and April 2016. The trust provided two examples of learning and changes to practice in the urology (February 2016) and burns (March 2016) specialities as a result of these meetings.. We saw the respective teams were provided with guidance and direction for both areas and where specific processes were involved these amended accordingly.
- Staff followed the trust 'Appendix 6 – Duty of Candour Actions Flow Chart' when incidents occurred. Incident reporting was in line with 'being open' and the 'duty of candour.' The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents', and provide reasonable support to that person. We reviewed one incident where this had occurred and saw that recommendations and shared learning were identified. Staff had received feedback at a ward meeting on the 25 April 2016.

Safety thermometer

- The NHS safety thermometer is a local improvement tool used to measure, monitor and analyse patient harm, and harm free care. Data from the 'Health and Social Care Information Centre' (HSCIC) confirmed the trust had reported 20 pressure ulcers, six falls with harm and 14 new catheter urinary tract infections between February 2015 to January 2016.
- Safety thermometer data included data collected for falls, which had resulted in injury and grade two, and grade three pressure ulcers. The statistics for Lister ward dated from April 2015 to February 2016 identified there had been no pressure ulcers and one fall, which had resulted in injury. Staff identified a falls practitioner was available for advice and support and that staff were being trained in the use of a new hoist, which should reduce patient falls.
- Venous thromboembolism (VTE) assessment screening was undertaken and compliance levels reported to the trust assurance committee. In addition, VTE assessment screening compliance was monitored through each directorate's monthly performance report. The surgical directorate's performance from July 2015 to December 2015 ranged from 89.5% to 94.5%, below the trust target of 95%.

Cleanliness, infection control and hygiene

- Staff told us they could easily contact the infection control team, which meant appropriate professional advice was available. Clinical areas had individual infection control (IC) link nurses; for example, on Lister ward two band six junior sisters were the identified IC link leads.
- Staff throughout surgical wards and theatres observed good infection control practices. We observed staff use personal protective equipment and hand sanitiser. Patients also confirmed that staff used hand sanitiser

before attending to them. Hand sanitiser was located on entry to each clinical area and within clinical areas. Clinical staff was seen to be 'bare below the elbows' in clinical areas.

- Staff received infection prevention and control training as part of their induction and at yearly mandatory training. The surgical directorates training statistics (2015 – 2016) confirmed medical and nursing attendance rates at infection, prevention and control training to be between 88% to 100%.
- Cleaning schedules and hand washing guidance were in place. The cleaning schedules identified the tasks and frequency of cleaning in each area. Colour coded systems were applied to cleaning equipment used in different areas. Clean labels identified equipment, which were cleaned so staff knew they were ready for use.
- Bi-annual deep cleans of theatre areas took place.
- Patient's pre-operative screening assessments prior to surgery included MRSA screening. We reviewed 17 patients' notes and observed that four of the patient's records did not identify the MRSA result.
- Performance tables for different surgical specialities from March 2015 to February 2016 showed MRSA screening levels for elective and non-elective patients ranged from 62.5% (lowest surgery rating) to 100% (highest surgery rating).
- From April 2015 to March 2016, the trust confirmed 23 inpatient / readmission infections. The infections included 12 deep incisional infections, two superficial and nine organ / space infections (infections in the anatomy of organ spaces as opposed to the incision).
- Ward performance dashboards displayed the levels of infection if any, for each clinical area. For example on the Surgical Emergency ward (SEW) and Lister ward (LW) from April 2015 to February 2016, no MRSA or Clostridium Difficille infections were reported.
- Hand hygiene audit results from September 2015 to February 2016 identified between 92% to 100% compliance for anaesthetics and critical care, surgery and endoscopy and specialist surgery.
- The personal protective equipment (PPE) audit for gloves use commenced in February 2016 and identified between 97% to 100% compliance for surgery and endoscopy, specialist surgery and anaesthetics and critical care. The PPE audit for aprons for the same period identified 100% compliance.
- Cleaning audits were undertaken, for example, theatre 1-6 audits for the 27 March 2016 identified the overall percentage score as 99%.

Environment and equipment

- On Lister ward, we observed two glucometers (equipment used to check blod glucose levels), were checked on 29 occasions in six weeks. The checks were completed on weekdays but not at weekends.
- Maintenance stickers were observed on equiment with dates confirming maintenance checks.
- Resuscitation equipment on the surgical wards and theatres were in date and monitored.
- We checked the resuscitation trolley with a staff member on the pre-assessment unit. We observed that the callisto laryngoscopes blades, sizes three and four, although packaged had no expiry dates.We rasied this with a member of staff who sought to replace these pieces of equipment. .
- The 'Association of Anaesthetists of Great Britain and Ireland' (AAGBI) guidelines for checking anaesthetic equipment were followed. We checked random anaesthetic equipment checklists in main theatres which were completed.,An anaesthetist confirmed they completed their own equipment checks prior to each theatre list. The operating department practitioner in the day surgery theatres had completed daily equipment checks.
- Measures were in place to maintain security. Security cameras were located throughout the building and people either had to ring a bell to enter the clinical environment or use password access.
- The hospital clinical sterile service department (CSSD) moved into a purpose built building in January 2016. The service had received the necessary accreditation so that it could provide equipment cleaning and sterilisation services.
- All theatre equipment sets containing sterile equipment were traceable as an allocated number identified each piece of equipment. The scan track system used in association with this numbering system immediately identified whether a number had been used, therefore, ensuring that the number was not reused.
- We saw a selection of equipment check logs for the CSSD and noted that daily, weekly and quarterly checks had taken place. However, it was not clear on the checking lists what the daily tolerance levels of these

checks would be. Staff told us that should equipment be out of range it would automatically alarm to alert them. This would then be refered to the maintenance department.

Medicines

- A pharmacy team provided clinical pharmacy services to ensure medicines were handled safely. The pharmacy was open seven days a week for in-patients including bank holidays. An emergency cupboard for medicines was available out of hours as well as an on call clinical pharmacist to respond to any queries.
- We reviewed medicines management at six surgical locations and noted it was in line with trust policy, for example, medicines were locked in cupboards and drugs trolleys. Trained nursing staff carried the controlled drug keys. Patients' drug charts throughout surgery were reviewed and no gaps seen against the entries.
- We reviewed the controlled drug (CD) books in theatres and the surgical wards and saw that when CDs were administered two trained staff signed to say they had performed the necessary checks and had administered the CD.
- Drug fridge checks and monitoring records were completed throughout the service.
- On Heybridge, John Ray and Notley wards, we found issues with regard to the safe prescribing of the pain killer paracetamol. Paracetamol can be prescribed to be given intravenously (IV) or orally (o), however we noted that doctors prescribed both 'IV' and 'o' on the same prescription with no clear distinction between the two. We looked at four prescription charts and found three charts with a prescription for paracetamol 'o/iv'. There is a difference in the prescribed dose for 'IV' and oral based on a patients weight, which should not be interchangeable. We found that the patients' weight was not always documented on the prescription chart. It was also not always clear from the medicine records whether a patient had been given the paracetamol orally or intravenously.
- On Notley ward, the medicine storage room was very warm however, there were no temperature records available to ensure medicines were stored within a safe temperature range. Medicines should be stored under 25 degrees Celsius to ensure efficacy. However, we could not be sure that the room was below this temperature. , The medicine refrigerator was locked with daily temperature records available, which showed medicines were stored safely. We found loose strips of medicines inside a medicine trolley and not in their orginal container.
- Nursing and medical staff received medicines training at induction. Trust medication management training statistics identified attendance at this training ranged from 83% to 98% for nurses and 20% to 50% for doctors for 2015 - 2016.
- The pharmacy team completed monthly CD and storage audits to ensure that approrpaite controls were in place.

Records

- We reviewed a mixture of 23 sets of medical and nursing notes. The types of documentation seen included completed pre-operative assessments, pre-operative checklists, risk assessments, care plans and consent documentation.
- On the Surgical emergency ward, we observed some shortfalls in documentation as not all areas within six patients assessments notes were fully completed. For example, in one patient's admission assessment, the pre-surgical assessment did not identify the outcome of the MRSA screening, the safeguarding adult question was incomplete and patient wishes were not identified. The patient had a selection of care plans, which were not completed, signed or dated by the nurse. Evidence of discharge planning from admission were not documented..
- On Heybridge ward in three patients' notes, we found some gaps in their records. One patients malnutrition universal screening tool (MUST) score, mobility plan and waterlow score (pressure ulcer risk assessment tool) were not completed, whilst a second patients falls care plan was not fully completed.
- Patients' records confirmed evidence of ongoing care and treatment reviews documented by doctors' daily written notes. Evidence of physiotherapy and occupational therapist involvements in patients care from admission were documented in one of the patients records we reviewed.
- Risk assessments were fully completed in 16 patient's records we reviewed. The types of assessments included: Venous thromboembolism (VTE), pressure ulcer, falls, MUST. Patients care plans reflected their needs, were reviewed and seen to link with the patients risk assessments.

- In line with the Royal College of Surgeons 'Good Surgical Practice (2014)' staff told us that pre-operatively patient concerns and / or needs were discussed within the multi-disciplinary team at the patient's pre-admission visit. For example, support for a patient with safeguarding needs or complex needs was identified prior to surgery.
- One surgical matron said they had implemented a check system whereby they checked patients do not resuscitate records daily to ensure they were appropriately completed and reviewed when necessary.

Safeguarding

- The safeguarding adult lead, clinical nurse specialist for adult safeguarding, learning disabilities lead and the elderly assessment team (EAT) worked with hospital staff to monitor vulnerable patients such as older adults or adults with learning disabilities.
- Adult safeguarding lead nurses met with social services and the tissue viability team weekly.
- Safeguarding reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.
- Staff said the safeguarding team could be accessed by telephone for advice and described effective working relationships with the local adult safeguarding teams and other healthcare professionals such as social workers and community nursing staff.
- Staff said that a new safeguarding app had just been released by the safeguarding team, which advised the reader what to do in specific situations. We did not see this app in practice.
- Staff demonstrated knowledge of the safeguarding guidance to follow, what to do and who to contact should a concern be raised.
- Staff told us that concerns about safeguarding issues were also recorded on daily safety huddle documentation so that staff were informed of current issues.
- Adult safeguarding training was completed at trust induction and yearly online mandatory training sessions. The trust-training target for safeguarding training attendances was 95%. Surgical training statistics for level two safeguarding training (training which should be given to all staff involved in clinical care) for 2015 – 2016 confirmed medical and nursing attendance rates were from 64% to 92%. Completion of level one safeguarding training for medical and nursing staff ranged from 85% to 97%. These training figures showed that the training target of 95% was not fully met in all surgical specialities.

Mandatory training

- Staff of all grades confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, resuscitation, manual handling, infection control, and safeguarding.
- The trust target for mandatory training compliance was 80%.Training records provided by the trust stated that medical staff attendance at mandatory training was identified between 88% to 93%, whilst nursing staff attendance was between 88% to 96%. The reporting unit with the highest levels of training non-compliance were the anaesthetics & theatres directorate.
- We were told there was always a healthcare professional on duty with advanced life support (ALS) training in the surgical wards and operating theatres. The theatre matron was a designated ALS trainer and operating department practitioners (ODPs) who carried the cardiac arrest / trauma bleep were ALS trained.
- Training statistics provided by the trust confirmed that 85% of ward nursing staff had completed basic life support training. In addition,79% of nurses in theatres had completed adult advanced life support training. However training rates amongst medical staff for basic life support were as low as 21% in orthopaedics.
- Nursing staff told us they had completed intermediate life support training on induction. Records supplied by the trust showed that in theatre only 16% of theatre staff and 80% of ward nursing staff had completed this training. In the theatre recovery only 28.5% of staff had intermediate life support training. Only five out of seven memebers of the resuscitation team had completed training in advanced life support and no one had completed European paediatric life support training.

Assessing and responding to patient risk

- All patients saw their named consultant at each stage of their journey. Anaesthetists calculated the patient's American Society of Anaesthesiologists (ASA) grade as part of the assessment of a patient about to undergo a general anaesthetic. The ASA was used for assessing the fitness of a patient before surgery. Five of the eleven patients' records we reviewed had the patietns ASA status documented pre-operatively.

- The ASA grading was discussed at daily briefing sessions and a summary of the ASA grade information were circulated weekly to the surgical and anaesthetic team.
- An extended recovery service for patients requiring an extended period of care but not full critical care facilities was provided. During the previous 12 months (June 2015 –May2016), 15 patients had stayed overnight in recovery. When level three patients (Patients needing advanced respiratory support and / or therapeutic support of multiple organs).required a critical care and no bed was available, an anaesthetist was allocated to stay with them to maintain patient safety.
- Elective cases were pre-assessed in clinic, and high-risk operations or high-risk patients were flagged for a dedicated consultant delivered pre-assessment. Following this, all high-risk operations and patients were discussed every Thursday with the lead intensive care consultant and theatre coordinator to determine clinical management and post-operative need.
- The emergency list was a consultant delivered service; a dedicated consultant surgeon and anaesthetist were on every emergency list. At 8am every morning the emergency team, which included emergency consultant teams (anaesthetist and surgeons) met to discuss all cases booked (priority, acuity, list order and need for post op care). Twenty-four hour emergency surgical services were provided with consultants available by phone at home and who would return to site when required. During the inspection we observed an emergency list safety huddle led by an anaesthetist. The discussions related to patients on the theatre list and included discussions of patients' needs and pain medication requirements. Patient flow and potential movements were also discussed. In addition, a daily bed management meeting took place 2.30pm to discuss and review the next day's theatre list.
- We observed an 8:30am daily theatre safety huddle, which involved all members of the multi-disciplinary team (MDT). The theatre safety huddle had operated for a year; however, staff told us that although issues were reported they were not always solved. We also observed a safety huddle in theatre six and saw that all the necessary checks and discussions took place so that the safety of the patient was ensured throughout their operation.
- The trust had a designated trigger and response team (TART), which responded to requests from the ward to assess patietns who were at risk of deterioration.
- The National Early Warning Score (NEWS) is a toolto track patient deterioration. . We reviewed two patients NEWS scores histories and supporting documentation, which confirmed escalation had taken place.
- Staff used Vital PAC when monitoring patients NEWS.This software system assists staff to quickly and accurately check and record a patient's vital signs.The system immediately highlights any patient who is deteriorating.This was not, at least at the time of the inspection, connected to the critical care outreach team to alert the team of a deteriorating patient although there were plans for this to be introduced.
- On the Surgical Emergency unit, we observed that patients' venous thromboembolism (VTE) assessments were completed. However, we did not see evidence of two patients VTE status being reassessed after 24 hours of the initial assessment-taking place. This meant the National Institute of Care Excellence (NICE) guidance (CG92) was not followed..
- Staff completed the '5 steps to Safer Surgery - World Health organisation' (WHO) surgical safety checklist for patients prior to and following surgical intervention. During our theatre observations, we observed that staff completed four patients' surgical safety checklists thoroughly. These checklists were documented on-line and on the theatre white board.
- The WHO checklist were completed and showed compliance to be 98%. An observational audit of practice at Broomfield Hospital which included 68 patients details was completed in November 2015 and showed good compliance overall. The outcome identified 100% compliance with allergies documentation, 97% WHO checklist completion.
- Interventional radiology services were easily accessed and a dedicated theatre was identified within the main theatre complex for this work.
- One staff member confirmed that they completed annual online 'sepsis six' training and were able to describe what six actions were included in the treatment of patients who required this treatment. Information provided by the trust identified that an overall total of 79% of nursing and medical staff had completed sepsis six training. Sepsis is a potentially life-threatening response to an infection. Early identification and specific treatment is essential to reduce the risk to patients.

Nursing staffing

- Senior staff told us that the staffing followed guidance on theatre staffing as directed by the AfPP (Association for peri-operative practice) guidelines and NICE guidelines SG1.
- Ward acuity review documentation for December and June 2015 demonstrated that surgical wards acuity and staffing levels were close to those anticipated by the trust . The results were subsequently presented at board level meetings. We saw and staff confirmed where shortfalls wereidentified these posts were recruited to.
- Staffing escalation guidance ensured safe staffing levels. Staff described the staffing escalation route taken from ward level, to 24-hour hospital co-ordinator support and out of hours hospital management support.
- Staffing was identified in the risk registers for wards within surgery. We asked 15 staff about staffing levels and skill mix within the surgical department. Staff said that although there were some areas where nursing shortfalls existed they felt that current staffing levels and skill mix were appropriate for patient caseload.
- Staff told us that where shortfalls existed or where staff worked 14-hour shifts such as on the Surgical Emergency ward (SEW) a staff consultation was to be launched in two weeks to gain staff feedback.
- Staff confirmed that staffing rotas were completed by band seven nursing staff using an electronic rota system. Where staffing shortfalls existed bank nurse shifts were identified on the nurse rota to replace the staffing shortfalls. For example, staff on Rayne ward said their agency / bank nurse use was highest at night when up to 50% of the night shift would comprise of temporary staff.
- The increase in operating lists by consultants which amounted to approximately 600 extra lists created a high vacancy rate within the theatre department. To assist recruitment an additional budget of 100,000 pounds was secured. An additional recruitment event was planned for the 20 June 2016. This ran alongside ongoing recruitment. The trust anticipated a that this would mean the need for 62 extra staff including 42 trained nurses at band five and six and 20 theatre assistants at bands two and three.
- Meetings took place at a number of forums at department and trust level where staffing levels and patient acuity were discussed. Staff said that safety was maintained by flexing staff and the cancellation of operations if required. However, we were told that surgery which involved children and patients with oncology type conditions was not cancelled.
- All staff including temporary staff completed inductions to the clinical areas. We saw nine competency check forms completed for agency staff on Heybridge ward and saw that temporary staff had signed to say they had read the appropriate policies.
- Nursing sickness rates within the surgical areas were identified by trust data as 4% for each of the surgical specialities. Whilst medical sickness rates across surgery were reported as 1%.
- Nursing vacancy rates ranged from 11 %(19.6 wte - surgery) to 22 %(85.1wte - theatres).

Surgical staffing

- The surgical department had sufficient numbers of medical staff with appropriate skill's to ensure that patients received safe care.
- There was appropriate medical escalation procedures in place where shortfalls were identified.
- We saw documentation, which confirmed that the trust reviewed services to ensure appropriate medical staff were in place to continue services.
- Discussions with one consultant confirmed that the current consultant on-call arrangement of seven days and nights in a row would discontinue in July 2016. Consultant on call arrangements would revert to four days and three nights from July 2016.
- The service was consultant led 24 hours / seven days a week as this ensured continuity of patient care. Surgical services were supported by a mixture of consultant on-site emergency cover freed from elective duties and out-of-hours by phone as required. The on-call frequency and requirement of consultant staff varied across the directorates. As part of the network for services such as ear, nose and throat, some off-site on-call consultant cover was provided by consultants who worked in other local trusts to maximise cover and the efficiency of rotas. Junior and middle grade and training grade doctors on-site supported each speciality.
- Health and Social Care Information Centres (Hscic) statistical data from September 2004 to September 2014 confirmed 263 whole time equivalent (wte) medical staff were in post. Of these 38% were consultants compared to the England average of 41%, 12 % were middle career doctors compared to the England average of 11%. The

registrar group was 43% compared to an England average of 37%, whilst the proportion of junior doctors at the trust was 7% compared to an England average of 12%. The trust identified there had been difficulties recruiting junior medical staff, which led to some difficulties staffing rotas. This shortfall had meant that second year foundation doctors were rostered onto these rotas.

- On call surgeons met at 8am on the Surgical Emergency Unit (SEW) for a medical handover session. The team comprised of those doctors who would be on call for the week. We observed the 8am handover for general surgery attended by day and night doctors, the consultant on call and the day nurse in charge. The handover was comprehensive and detailed each patient's needs. The theatre list was also completed and the order of the list agreed. Additional scans and referrals to other services were arranged. Following this handover the ward round took place.
- We observed cohesive discussions took place on the surgical ward round. Patients were fully assessed and their status updated with the addition of information provided by nursing staff and allied health professionals.

Major incident awareness and training

- MEHT business continuity strategy and plans were used in conjunction with the major incident plan to ensure that services continued to be provided. The policy set out the principles and processes for the creation and revision of business continuity and emergency planning management for MEHT as required under the Civil Contingencies Act (CCA) 2004 as a statutory duty of a Category 1 responder.
- The trust 'Emergency Preparedness & Resilience Group' membership included a broad range of internal and co-opted external stakeholders. The major incident plan, internal incident plan, specific emergency plans, business continuity plan and emergency planning activities were covered by this group, who were responsible for the development and revision of such plans. The group is led by a lead Executive Director for Emergency Planning.
- The CBRN(E) (Chemical, Biological, Radiological, Nuclear, Explosives) HAZMAT (Hazardous Materials) incident decontamination plan detailed the procedures should an incident occur.
- Major incident clinical guidelines for adults and children were also available for staff use.

Are surgery services effective?

Good

We rated the effectiveness of the surgical service as good.

- The service provided evidenced based care as identified within evidenced based clinical guidelines. Monitoring of clinical guidelines had taken place.
- Care was provided in line with National Institute for Health and Care Excellence (NICE) guidance.
- The trust identified that they met the majority of the 'Core Standards for Pain Management, Faculty of Pain Medicine'. However, there was a need to increase the availability of training sessions in pain management for staff.
- Patient's surgical outcomes were monitored and reviewed through formal national and local audit. Auditing systems had informed practice, introduced changes and lessons learnt to improve outcomes for people.
- Patients received care and treatment by trained, competent staff.
- Corporate and local induction processes were in place for new staff.
- Evidence of multi-disciplinary team working was observed.

However :

- Outliers were located throughout the service. Outliers relate to patients who were situated away from the speciality they should have been admitted to. Staff identified concerns relating to frequent patient moves throughout the service and patient outcomes including care being affected. Concerns were also identified that patients placed on general surgical wards or outliers were not reviewed daily.
- The trust confirmed that surgical services do not currently monitor against the 'NHS England seven day services priority standards' around 'Time to first Consultant review.'

- Some audits appeared to be past their completion dates and action plans were not identified as having been submitted for the majority of audits identified as being in progress.
- Staff on Rayne ward said they experienced difficulties obtaining hot meals for patients in out of hour's periods

Evidence-based care and treatment

- Guidance from the 'Royal College of Surgeons' and the 'National Institute for Health and Care Excellence' (NICE) informed care, for example when treating a patient with a venothromboembolism, pressure ulcers and when considering patients nutritional needs.
- Care was provided in line with NICE CG50. This guideline identified measures staff took to recognise and respond to deterioration in patient's conditions. We saw staff monitored the patient's progress throughout their journey from pre-assessment to the post-operative stage. Baseline physiological observations including respiratory rate, heart rate and temperature were taken at pre-assessment followed by agreed frequencies of physiological observations at the patient's admission through to discharge home. The 'national early warning score' was used to detect deteriorating patients and escalated deteriorating patients through the escalation framework.
- Nursing staff told us that policies and procedures reflected national guidance and could be accessed on the trust intranet site. We saw that local policies were written in line with national guidelines.
- Evidence-based standards, which build on the World Health Organisation Surgical Safety Checklist approach, were developed and tested by clinical experts. The standards, named 'National Safety Standards for Invasive Procedures (NatSSIPs)' were formally endorsed by a number of organisations. Senior staff told us that guidance, which related to invasive procedures and standards, was in implementation stage at the trust. They said they were working with the Clinical Commissioning Group and the multi-disciplinary team to develop these standards. An action plan was in place and the focus group representatives remit was to communicate progress to other staff groups regarding the implementation of these standards.
- The surgical phase three audit plan identified audits the surgical department participated in. The audit data identified dates of proposed completion. However, some audits appeared to be past their completion dates and action plans were not identified as having been submitted for the majority of audits identified as being in progress.
- Quarterly 'Adult patient observations audits' had taken place and were reported against in March and December 2015. The audit confirmed assurance of sustained improvement in patient observations documented and the management of patients at risk of deteriorating. Although, the audit was trust wide, four and then six surgical areas were included during each audit. The conclusions from both audits confirmed improvement in documentation of patient observations. For example, national early warning scoring had improved from 94% to 99% over the course of both audits.

Pain relief

- A pain team whose remit included paediatric and adult services provided the 24 hour integrated inpatient and outpatient pain management service. The team comprised of five consultants, a designated paediatric anaesthetist lead, six nurses, two physiotherapists and psychologists. In addition, four pain link nurses provided staff with additional support, education and information to ensure that pain was managed effectively. Ward nurses who had undertaken the pain link role had received additional education to enable them to carry out this function. Staff reported good support from the pain team. Following referral patients were seen by the pain team within 24 hours.
- The 'enhanced recovery programme' was introduced six years ago as part of the pain management process to prepare and educate patients pre-operatively prior to their surgery.
- Pre-assessment nurses identified patients who required additional pain management support.
- To ensure that patients pain needs were met the pain team met and discussed patients who required their support twice daily. In addition, two consultant led ward rounds took place weekly and the nurses who worked within the pain team attended the 8am surgical team handover and ward rounds. Therefore relationships with other services were developed. One patient from Notley ward described staff as 'amazing, they answer my bell and give me my pain relief.'

- A pain reduction action plan had been drafted as part of the on-going culture work streams and friends and family test feedback.
- Staff said the service had mostly met the 'Core Standards for Pain Management' as identified by the Faculty of Pain Medicine'. The shortfalls identified relate to staff training in relation to pain management. The pain team identified that current pain management training provision consisted of a one-hour pain management training on induction and eight training sessions are available to staff, however, these training sessions are often poorly attended.
- Anaesthetic medical staff complete competency assessments and new surgeons had completed one week with the anaesthetic team. Their learning included pain management and intravenous fluid management.
- We tracked two surgical patient's pathways as part of the pathway related to pain management. We observed pain management discussions took place with the patient prior to and post-surgery. Patients told us their pain was well controlled post operatively.
- Nursing staff on Heybridge and Rayne wards have received training in the use of epidural medication.
- The pain team used a software system when monitoring patients pain levels. This software system assisted staff to quickly and accurately check and record a patients pain levels and observations ush as blood pressure and pulse.

Nutrition and hydration

- All patients had access to a dietician pre and post operatively depending on their needs. Staff could refer patients to the dietetics service and all wards had a linked dietician that gave advice either during the inpatient spell or in a post-discharge outpatient appointment. Specific examples included the upper gastro intestinal service where a dietician attended clinics.
- A malnutrition universal screening tool was completed within 12 hours of admission.
- Staff told us that blue jugs and cups were given to patients living with dementia. Coloured plates and snack boxes were also available. This served as an indicator of patient risk and informed staff that assistance may be required with meals and drinks.
- A variety of food choices was available to patients. Staff on Rayne ward said they experienced difficulties obtaining hot meals for patients in out of hour's periods, although sandwiches were available. Special diets, for example diabetic, gluten free, textured and allergy diets were available. Staff said that patients who required gluten free meals had complained about the lack of variety offered. This and other issues had been raised with the catering team in an attempt to improve patient choice. The outcome of this meeting was an increased variety of sandwiches.
- We spoke with two patients about the food provided at the hospital. One patient told us that the hot food was not great and therefore this person would purchase a sandwich. The other patient described the food as 'awful'.
- Staff told us that 'protected mealtimes' had been introduced, however, meal times were not always protected. For example, should a patient be called to attend a scan and it fell at lunch / meal times they would go for their scan. Protected mealtimes are periods on a hospital ward when all non-urgent clinical activity stops. During these times, patients are able to eat without being interrupted and staff can offer assistance.

Patient outcomes

- The trust said they were working towards the Anaesthesia Clinical Services Accreditation Scheme (ACSA) and were on the next phase to be accredited.
- Trust feedback from the 2014 / 2015 national vascular registry (NVR) showed the trust had excellent outcome figures for abdominal aortic aneurysm repairs. The standardised mortality ratio was 0.7 (national average 1) which meant that survival was more likely at the trust compared to the national average. Data for carotid endarterectomy outcomes showed that the trust was at the national average for this procedure.
- Bowel cancer audit results (2015) against 11 indicators confirmed the trust performed well, with the exception of the data completeness indicator for patients having major surgery. This indicator scored 39% against the East England average of 62% and England average of 80%. We asked the trust what actions had been identified to improve this shortfall. We were told that a senior service manager in general surgery would support this review and deliver the action plan it generated. A multi-disciplinary team co-ordinator team

was now in place. Reviews of the team structure, workload and the workflow around the data quality, sign off and uploading of bowel cancer patient information were taking place.

- The 2015 National Emergency Laparotomy Audit (NELA) identified a mixed result with two out of 11 indicators achieving 70 – 100%. Three indicators achieved a red status 0 to 49%, whilst six indicators achieved an amber status 50-69%. Discussions regarding the NELA audit and its progress took place at a trust audit meeting on the 11 May 2016. The trust had appointed an anaesthetic fellow to lead on data entry, completion and quality. In terms of changes in response to the audit, the following examples of changes were implemented: Formal handover time in shifts for other anaesthetists and a policy was implemented to ensure that consultant surgeons formally hand over in person. Fully staffed operating theatres available to emergency general surgery (EGS) patients 24/7, emergency surgical unit opened and a bi-monthly (or more frequent) review of all EGS deaths.
- The Hip Fracture Audit (2014 - 2015) showed that the hospital had performed better than the England average against eight indicators.
- Hospital episode statistics (HES) data (August 2014 to July 2015) confirmed emergency readmission for elective admissions in the top three specialities, plastic surgery, urology and ear, nose and throat (ENT) surgery were between eight to 11 readmissions higher than the England average of 100.
- HES data (August 2014 to July 2015) confirmed general surgery, trauma and orthopaedics and plastic surgery non-elective readmissions were below the England average of 100. A score below 100 indicates a positive finding, whilst a score above 100 represents the opposite.

Competent staff

- Staff confirmed they were trained in the speciality of the ward they worked on and competencies completed at ward level. The staff we spoke with said they felt their training needs were met.
- Within each orthopaedic ward, the senior sister and junior sisters/charge nurses hold the orthopaedic qualification with other band five staff nurses who also hold this qualification (nine staff in total). The orthopaedic unit had a bleep system in operation so there was an experienced orthopaedic nurse available to advice on orthopaedic issues as required.
- The surgical unit was supported by three matrons and an associate chief nurse who provided clinical support as required. Within the surgery wards, 11 staff were graduates, and seven staff had care specific courses including leg ulcer management, infection prevention, acute care and advanced assessment.
- All areas caring for patients with a tracheostomy arranged for their staff to attend face-to-face training in tracheostomy care provided by the consultant physiotherapist and the head and neck clinical nurse specialist. Staff completed tracheostomy competencies and were signed off once competent.
- Staff enhanced their skills through rotation between different areas within the theatre department. This was supported by the completion of competencies. Senior staff said that all band six nurses including recovery nurses had completed intensive care competencies and had supervised practice in the intensive care unit.
- Day surgery staff had completed three months competency based recovery training and objectives completed before the nurse could work in the day surgery recovery. We did not see these completed objectives and competency assessments for these staff whilst on site. However, we did review some recovery staff training files to confirm what training they had attended and what competency assessments they had completed.
- The trust identified there was always a theatre nurse or operating department practitioner on-call from home to provide level three critical care cover. The senior house officer in anaesthetics was resident in recovery and the anaesthetist could be called in from home overnight if patient's volumes exceed capacity.
- Staff told us that new staff completed inductions at a corporate and local level. One example given by staff on Rayne ward included a one-week corporate induction and a one-week preceptorship programme if the nurse was newly qualified. This was followed by a two-week supernummary period with a designated mentor and completion of competencies over a two-month period. Two other staff identified satisfaction with their recently completed inductions to the service.
- Staff confirmed completion of yearly appraisals and confirmed appraisal time was rostered into the duty

rota. Staff identified their appraisal experiences were good and for continuity they remained with the same appraiser for appraisal completion. The 2015/2016 trust appraisal data for the surgical areas confirmed between 71% to 100% of nursing staff on the surgical wards and in the theatre, areas had an appraisal. Medical staff appraisal rates for the same period ranged between 67% to 100%.

- Junior medical staff (x1) identified good support was provided from their educational supervisor.
- Staff told us clinical supervision was available to nursing staff, however electronic records were not kept of supervision sessions attended. Nursing supervision took place through forums such as the newly qualified nurse preceptorship programme and competency package, staff received supervision when taking on extended roles and in safeguarding situations.
- Senior staff said new medical staff attended the corporate induction and completed mandatory training. We were told that 65% of doctors had direct supervision, whilst all non-consultant grade doctors had a clinical supervisor, with clinical supervision built in to consultant job plans and consultants were trained to deliver this role.
- Middle grade and junior doctors were allocated clinical and educational supervisors.

Multidisciplinary working

- Staff told us that good multi-disciplinary working existed between the health care professionals working within surgery. For example, a 9am meeting took place on Lister ward which involved the multi-disciplinary team (MDT) where discussions about patients included their needs and impending discharge arrangements. Information about each patient was summarised on the 'Red / Green days Board', which was implemented two months ago. On a red day, the patient had no identified intervention, whilst on a green day individual patients tests took place. Staff described this system as useful as it identified priorities, helped with patient discharge planning including estimated discharge dates.
- Daily MDT meetings took place on Notley ward at 8.30am which involved therapy staff and social service staff. These meetings included discussions about patients discharge needs, safeguarding issues and whether social worker involvement was required. The information and issues from the meeting were captured on a handover sheet.
- The pain team described good MDT working between themselves and the surgeons.
- Staff identified that physiotherapists, occupational therapists and pharmacy staff rotated around the wards and that there was effective MDT working amongst all the healthcare professionals.
- The newly configured discharge team had identified a senior patient flow coordinator to assist designated surgical wards with patients discharge arrangements and to identify what equipment if any the patient required at home.
- Staff identified they were able to access the dementia team and elderly care team for advice and support.
- Patients records identified their care was reviewed daily by senior clinicians at the daily ward round and that the multi-disciplinary team (MDT) were actively involved in patients care and treatment plans.
- Ward nurses worked closely with the end of life care team and chaplaincy to ensure that patients at end of life received the necessary support and care they required.

Seven-day services

- The trust confirmed that Mid Essex Hospital Services NHS Trust (MEHT) surgical services do not currently monitor against the 'NHS England seven day services priority standards' around 'Time to first Consultant review. 'However, they said they had been reviewing this in terms of delivering the 'SAFER' patient care bundle which would be a manual paper notes audit. No further information was provided by the trust in relation to this standard.
- Theatres, including anaesthetics and recovery had staff on duty out of hours to cover emergencies.
- The majority of wards had designated physiotherapy and occupational therapy staff based locally to assist patients along their treatment pathway. A physiotherapy assistant was also based on Lister ward. A physiotherapist was on site from 8am to 8pm Monday to Friday. At weekends, service provision was provided from 8am to 8pm; in addition, an on-call service was available for respiratory patients.
- Staff confirmed effective multi-disciplinary team (MDT) working throughout the service and with external stakeholders. Doctors, pharmacy support and radiographers were easily accessed out of hours.

- Staff said that they had experienced difficulties at times accessing computerised tomography scans for patients after 5pm.
- Trust chaplains provide a trust wide presence and a 24-hour on call service.

Access to information

- Staff identified examples of how information was shared amongst the multi-disciplinary team (MDT). For example, morning meetings had taken place with social workers, physiotherapy and nursing staff to discuss patients' needs in hospital and in preparation for discharge home or to another care provider.
- Patient investigation results were easily accessible, for example, the online patient x-ray (PACs) system provided staff with details of the patients x-rays pre-operatively.
- Patients GP's received email notification, which detailed information about the patient's procedure and treatment.
- Physiotherapy and occupational referrals informed specialists of patients' needs in hospital and prior to discharge. Staff said that nurse-led referrals were initiated to identify patients' needs and support requirements. These referrals assisted the patient's recovery through the involvement of physiotherapists and occupational therapists in their care package.
- Physiotherapy staff said that patients were referred to intermediate care services to ensure that they were assessed as being suitable for treatment at a cottage hospital site. The original concept of a cottage hospital was a small rural building having several beds.
- Physiotherapy staff said they attended the Friday morning trauma meetings to ensure they received updates on patients who required physiotherapy support.
- We observed good examples of MDT discussions between the clinical director for anaesthesia and the lead intensivist during their weekly theatre list meeting, which took place in the intensive care unit. Some of the information shared related to patient risk levels and postoperative care requirements.
- The discharge team worked closely with other health care professionals. This was to ensure the patient's discharge support needs were met prior to their discharge home or to another healthcare provider.
- Senior staff attended the daily safety meeting in main theatres where they reported any patient falls and / or overnight issues. Staff said that information sharing between healthcare professionals and departments was good.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff identified different consent forms were used to obtain patient consent. The consent forms used were dependent on the following factors: the type of procedure, the patient's ability to consent, for example, patients with dementia type conditions or learning disabilities and for patients whose consciousness was not impaired.
- Staff said patients with dementia type conditions were generally supported through the consent process by their relatives.
- Occupational and physiotherapy staff said they attended patient's best interest meetings with families present.
- Whilst on the surgical emergency ward, we reviewed one patient's do not attempt resuscitation (DNAR) documentation. We noted that patient and relative discussions were not recorded on the form but were documented as having been discussed with the family in the patient's notes. The reason for the DNAR was not documented. These observations were brought to the senior nurse's attention so that the documentation could be corrected by the addition of the missing information.
- A senior staff member told us they had recently implemented daily checks of DNACPR documentation to ensure that these documents were completed correctly and reviewed.
- Discussions with four post-operative patients confirmed they had signed a consent form and were informed of what to expect during the preoperative period and following surgery. We reviewed two patients consent documentation and saw that it was signed and dated and the risks explained prior to surgery. We also observed from other patients records that consent documentation was signed for their respective surgery.
- During discussion, we observed that two members of trained nursing staff and junior medical staff had a good understanding of the Mental Capacity Act. On the day

surgery unit, we observed that a capacity assessment had been appropriately completed for a patient to ensure that they had the capacity to make decisions and understand what was happening.

- The trust identified that 82% to 93% of nursing staff had completed three yearly MCA training; theatres and anaesthetic were identified as the least compliant at 82%. Separate compliance data was provided for recovery staff dated 12 July 2016. This data confirmed 80.8% nursing staff attendance at MCA training and 76.6% nursing staff attendance at the three yearly deprivation of liberty safeguards training.
- Medical staff MCA training figures identified attendance between 79% to 90%. All high dependency unit staff had completed restraint, breakaway and conflict resolution as an action from an incident, this was being rolled out across the intensive care unit.

Are surgery services caring?

Good

We rated caring as good because:

- Patients received compassionate care with good emotional support. We witnessed several positive interactions between staff and patients, their carer's, and relatives.
- Patients were fully informed and involved in decisions relating to their treatment and care.
- The multi-disciplinary team provided support during the patient's admission, stay and in preparation for their discharge home.
- Patient's emotional needs were supported throughout their surgical experience.
- Patients were overwhelmingly positive about the care they received and said they were treated with dignity and respect.

Compassionate care

- We spoke with 19 patients who spoke highly of the care provided by the nursing staff, however, one patient identified they felt that communication between the medical staff and nursing staff could be improved. This was because the medical staff did not always communicate everything and / or the nursing staff were not always informed of the changes to patient treatment pathways.
- One patient on the day surgery ward told us that they had experienced nothing but excellent care on a number of visits to the unit.
- A patient on the surgical emergency ward told us "all staff are happy to help, I feel that staff are invested in my care and nothing is too much trouble"
- Throughout our inspection, we observed members of medical and nursing staff provide compassionate and sensitive care that met the needs of patients. Staff had a positive and friendly approach and explained what they were doing.
- Staff were observed to place themselves in front of a patient who lip-red.
- Patients we spoke to said that staff treated them with dignity and respect. We saw that curtains were pulled around patient bays and staff in theatres covered patients throughout their surgery to protect their dignity.
- We observed that the day surgical unit had a small recovery area, which meant that patient's privacy and dignity could be impacted. For example, other patients could hear a patients recovery and experiences.
- Feedback cards and comment boxes were available throughout the service. We saw patients had given positive feedback about their experiences on the cards displayed in ward areas. One patient said they had completed patient surveys in the past.
- We saw patient information 'Your views are important to us' and a 'compliment, complain and comment poster' displayed in each bay on Lister ward to encourage patient feedback about their experiences.
- Guidance was also available for staff on how they could improve the patient experience, for example, 'Shhh… Make night time a quiet time on the ward' poster.
- Surgical wards response scores performed well, above 90% in the 'Friends and Family Test' (FFT) between April 2015 and February 2016. The 12-month response rate for these wards ranged from 87% to 100%. Previously, at Broomfield Hospital the average response rate from August 2014 to July 2015 was 43.2% (5,414 people) against the England average of 35.5% (696,897 people).
- A number of changes took place following feedback from the friends and family test 2015-2016. These included: The creation of a male / female split in the day surgery unit; the endoscopy recovery was moved out of the day surgery unit into a dedicated area and "clinical

Tuesdays" were introduced where senior nursing staff (chief nurse, deputies and associates) work clinically alongside ward staff to provide supervision, leadership and support.

Understanding and involvement of patients and those close to them

- Patients and their families were involved in discussions about their care and treatment. Four patients told us that staff were very informative and had given them full explanations of what to expect. Two patients said they felt confident questioning the medical and nursing teams where necessary so that they were fully informed in all aspects of the treatment and care. One patient said that they felt the doctors were not approachable.
- Physiotherapy staff said that families were involved in discharge planning processes. One example, involved families measuring home furniture to ascertain suitability. Where necessary additional equipment was provided to raise home furniture prior to the patients discharge.
- Physiotherapy and occupational therapy staff told us that they had participated in home visits with families prior to the patients discharge to ensure the home environment was suitable for the patient. These home visits were more likely to take place when a large piece of equipment was proposed for use by the patient in their home environment.
- We observed an anaesthetist speak with a patient in the anaesthetic room. The anaesthetist confirmed with the patient their understanding of the surgical procedure to be carried out and explained the procedure so that the patient understood what was going to happen.
- We observed staff informing a patient with learning disabilities where they would come to for their outpatient's appointment.
- Interpreting services were available for patients to ensure that they were involved and understood their care.
- Staff took time to speak with patients and encourage patients to use appropriate forms of support. For example, an elderly patient with hearing impairment was treated kindly by a doctor who suggested to the patient that they replaced their hearing aids as lip reading may be challenging with complicated information. The doctor suggested they speak in the patient's cubicle to maintain privacy.
- Throughout our inspection, we witnessed staff giving patients information about their care. We saw staff giving a patient on the surgical admissions ward information about their surgery. The nurse dealt with the patient's questions kindly and considerately.
- Patients we spoke to said that staff had kept them informed about their care. This was supported by the patient survey, which showed that 85% of patient questioned were happy with the information they received about their care. A patient on Heybridge ward told us that staff always explained a procedure and asked for consent before any care is given.
- The stoma nurses and colorectal clinical nurse specialists' office was located by Heybridge ward. Their location meant they were nearby to offer specialist support and encouragement and give patients information about their care.

Emotional support

- Dementia champions were identified on clinical areas whose training and experience ensured that those patients with dementia type conditions had their emotional and physical needs fulfilled.
- In theatres, we observed theatre staff welcomed patients into the anaesthetic room, put patients at ease and answered patient's questions.
- Staff showed a good awareness of patient's with complex needs and / or those patients with a learning disability. Staff told us during the patients initial pre-assessment staff determined what immediate support the patient required to aid them in their hospital admission and subsequent discharge.
- Where patients required mental health support, referrals were made so that staff could ensure their mental health needs were met.
- On the surgical day unit, we witnessed the carer and relative of a patient with learning difficulties given access to the ward to give support despite relatives not usually being admitted.
- We witnessed kind and caring staff interactions with patients in all areas we inspected. We saw a nurse on Lister ward with a patient very anxious about going home. The nurse sat with patient and kindly explained their care plan.
- The Trust had established a number of patient support forums within the surgery directorate. This included The Bra Club, a patient led support group offering support to patients undergoing breast surgery and a knee and hip

club for patients undergoing knee and hip replacements. These forums gave the opportunity for patients to share their experiences and offer support to other patients with similar conditions.

Are surgery services responsive?

Good

We rated responsive as good because:

- The surgical service had good support internally and from other tertiary centres.
- Service planning and delivery considered the patients' needs, which meant changes to the service and how it was delivered benefited the patient.
- Support was in place for patients with learning disabilities or dementia type conditions and their families. The trust had identified a lead nurse for dementia who was also a 'Dementia Friends Champion.'
- Patients knew how to complain and we saw examples of lessons learned from complaints

However we also found:

- Staff identified concerns that patients who required social care referrals were not seen quickly, therefore delaying their discharge.
- Outliers were located throughout the service. Outliers relate to patients who were situated away from the speciality they should have been admitted to.

Service planning and delivery to meet the needs of local people

- The stoma service led by a clinical nurse specialist was accessed by patients in the community.
- Patient and staff feedback had been collected as part of the current upper GI cancer quality improvement project. This process engaged all staff involved in a patients pathway, from the GP to the ward staff and built a new way of working in relation to patient values and staff values.
- The glaucoma support group linked with the national glaucoma group. Improvements were made to patient's information by the group working with a patient who had lost sight.
- Staff were involved in the recent 'phase two' development of the Surgical Emergency ward to improve its effectiveness and develop surgical ambulatory care. This group comprised of multiple clinicians, led by the clinical director of surgery and co-chaired by the surgical matron.

Access and flow

- Hospital episode statistic (HES) data identified admissions to the surgical service as 35,610 from September 2014 to August 2015. Of these 39% were day case admissions, 24% elective admissions and 37% emergency admissions.
- Admissions by speciality as identified by HES data (September 2014 to August 2015) were general surgery (11%), trauma and orthopaedics (13%), plastic surgery (38%) and other (38%).
- Theatres at Broomfield Hospital had a 96% utilisation. Monthly theatre utilisation varied between 53% and 96% from December 2015 to February 2016.
- Surgical admissions followed surgical pathways, which started at pre-admission clinics and the anaesthetic assessment unit following the patient's referral for treatment.
- Following a review of surgical services, a 19-bedded surgical emergency ward (SEW) opened in April 2015 whose remit was to admit emergency surgical patients.There was a formalised admissions policy. Staff told us that this ward had initially relieved bed pressures on the two-inpatient surgical wards as patients were initially admitted to SEW before transfer to their specialist surgical ward.
- The SEW had a dedicated area where GP and emergency department referrals were seen which was supported by a nurse and doctor.
- An elective day surgery unit, which comprised of ten cubicles operated Monday to Friday, 7am – 9pm, with an occasional Saturday plastic surgery list. Patients stayed between two to six hours dependent on their needs and were then discharged home.
- We observed that discussions took place about patient access, flow, needs, risk levels and support requirements. Some of the forums where this took place included the 9:30am theatre bed management meeting and at the weekly theatre list discussion by the clinical director for anaesthetics and the lead intensivist. Staff identified that the biggest challenge was maintaining bed flow throughout surgery.
- A nurse led discharge team operated in surgery. The current lead nurse took over the team in October 2015

and had since March 2016 reviewed patient flow and team roles. Currently, the team's actual establishment comprised of one band 8b nurse, 5.2 whole time equivalent (WTE) band six nurses (funded 5.6WTE), three patient flow coordinators and one senior patient flow coordinator. We were told that the senior patient flow coordinator was due to start on the surgical wards. This person would assist ward staff with patients discharge assessments and identify what equipment if any the patient required at home. A five-day service would be provided, Monday to Friday. This person would assist staff on the surgical emergency ward, Rayne and Haybridge wards.

- Staff identified concerns that patients who required social care referrals were not seen quickly, therefore delaying their discharge. These delays were escalated to the matron, the discharge team and the clinical commissioning group (CCG) daily. In addition, 'Multi-agency Discharge Events'(MADE) had taken place alternate weeks where staff from the CCG, social care, healthcare and allied healthcare professionals met to discuss patients ready for discharge.
- The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.The data provided by NHS England (September 2014 – February 2016) confirmed RTT times were in line with the England average. For general surgery 82.2% of patients were seen within 18 weeks of referral, Ear,nose and throat (ENT) 91.4%, Urology 93%, oral surgery 90.6% trauma and orthopaedics 79.6%, ophthalmology 77.8% and plastic surgery 88.8%.
- Following the inspection we reviewed the RTT data from March to May 2016 The data showed an improvement in RTT performance in three specialities. These were ENT (93.4%) urology (94.2%) and oral surgery (97%). General surgery (53.6%) trauma and orthopaedics (47.5%), ophthalmology (77.4%) and plastic surgery (71%) had seen a decline in RTT performance. However this was reflective of a national trend and the figures were still in line with the national average
- The trust had commenced twice-weekly elective care meetings, introduced a theatre utilization group and revised the trust access policy to try to improve the RTT targets. To support this, additional clinics commenced and theatre lists were changed. Three locum consultants in surgery and ophthalmology and two substantive consultants to the trauma and orthopaedic specialities were employed.
- In addition, a demand and capacity review of the specialties was to be completed so that gaps were identified and filled. In the interim the trust identified it would continue to outsource suitable patients to manage the waiting lists. Since the beginning of April, they had outsourced almost 700 patients.
- Outliers were located throughout the service and relate to patients who were situated away from the speciality they should have been admitted to. Senior staff said that in the last six weeks four medical outliers had been admitted to the surgical emergency ward (SEW) and a weekly average of four medical outliers were admitted to Rayne ward (the vascular & urology ward). Staff said that the medical outliers on Rayne ward were seen daily by their medical teams.
- Throughout the inspection we observed medical outliers on some surgical wards, for example on the 15 June 2016 four medical outliers were on Heybridge ward, whilst, on the 16 June 2016 five medical outliers were on Notley ward.
- Over the past 12 months, there had been 182 instances of a surgical patient outlying on a medical ward. The trust identified that every patient moved to an outlying ward is assessed for suitability as outlined in the 'Clinical Operations Service Policy' . Outlying patients were seen daily by their specialty team, discussed in key specialty meetings and at every bed management meeting (four times per day).
- A bed management team was onsite, which senior nurses reported to. During the inspection, we observed a bed management meeting attended by senior nurses from across the hospital and observed that all issues, including beds were discussed. These meetings took place four times daily.
- The trust had identified a cancer recovery plan to improve cancer 31 day referral targets. The challenging areas related to high volumes of skin and urology cancers.
- Hospital episode statistics (HES) data (September 2014 to August 2015) confirmed the average length of stay for elective plastic surgery (2.3 days) and urology (1.3 days) was lower than the England averages for these specialities.
- HES data (September 2014 to August 2015) confirmed the average length of stay for the top three specialities plastic surgery (1.9) and trauma and orthopaedics (9.1) was slightly higher than the England average for each speciality. Whilst general surgery was, lower at 4 days

against an England average of 4.2 days. In the majority of elective and non-elective services, the average length of stay has been similar to or lower than the England average

- NHS England data (Quarter (Q) one 2013/14 to Q3 2015/16 identified that numbers of cancelled operations remained steady since Q1 2014/15, and declined in 2015/16. The percentage not treated within 28 days was similar to the England average during this time.

Meeting people's individual needs

- Single sex accommodation was provided in clinical areas.
- People could access verbal and written language interpretation services through the trust. Telephone interpretation services were provided were there was a need, for example, during consultations or appointments.
- Visually impaired patients could access braille or large text documents.
- The spiritual needs of patients, staff and visitors were supported by the spiritual care and chaplaincy department.
- Designated disabled spaces were provided around the hospital.
- The hospital electronic flagging system identified when a patient with learning disabilities or autism was to be admitted / attend hospital. The learning disability specialist nurse had supported families and staff to ensure patient's needs were met and reasonable adjustments made, for example, easy-read information, longer appointments and home visits. Patients also completed a care passport to enable staff to learn about their individual needs prior to admission.
- We observed a patient with learning disabilities receive additional support in the day surgery unit. This person was being supported by their carer and a designated nurse. We observed that this patient's cognitive impairment assessment was not fully completed and identified this with staff. We returned to the ward later and saw that the document was completed.
- Two dementia specialists, one nurse and one occupational therapist provided support and advice for families and staff. Dementia champions had received specific training to enable them to support the patient and their family. Staff made referrals to the dementia team. All patients over the age of 75 years were screened for dementia following emergency admission.
- For those patient's living with dementia either the patient and / or their family were asked to complete the 'This is me' tool. This tool informed staff of the patient's needs, preferences, likes, dislikes and interests so that the patient's care was tailored to their needs. Open visiting was also available for relatives and / carers.
- The 'Patient Experience and Engagement Group (PEG)' meeting (4 March 2016) identified 100% of staff had completed level one dementia training. Since April 419, staff had completed Level 2 and 189 staff had completed Level 3 training. The first level three dementia training session was completed by doctors in January.
- Physiotherapy staff said they worked closely with the trust dementia team to support patients who were living with dementia so that their needs were met.
- The trust dementia booklet 'A guide for patients and their relatives' (May 2014) and a hospital newsletter 'Daily Sparkle' were available for patients and their families to access. We observed the dementia booklet was provided in different formats and languages on request through the patient advisory liaison team.
- Notley ward had developed a 'dementia friendly' day room for patients with dementia type conditions. The room was set up to reflect the Queen's birthday.

Learning from complaints and concerns

- Complaints were discussed at trust board and the patient safety and quality committee. We saw that complaints themes formed part of the patient experience paper reported at the trust board since January 2014. Weekly directorate complaint meetings were held between associate chief nurses, matrons and any other appropriate staff within directorates. A member of the patient advice and liaison team (PALS) and complaints team attended to discuss all active PALS and complaints cases and highlight any areas of concern.
- Key themes from complaints, compliments and feedback were discussed at the patient engagement group and relevant service user groups.
- Communication was one theme identified within surgical patient's complaints. The trust identified that to improve communication customer care development work was in progress. This included the 'Hello, my name is' campaign, values and culture work. To improve staff communication the corporate induction now included

customer service training. Family and friends results were discussed at ward meetings. Staff said they had received feedback about complaints at weekly meetings and through monthly newsletters.
- An easy-read leaflet available for patients was written in word and pictorial format. Additional information about the 'Independent Complaints Advocacy Service' (ICAS) was also identified.
- How to complain leaflets were displayed in all areas to assist a patient, carer or relative if they wished to complain.
- The surgical service received 64 written complaints from 2 April 2015 to 31 March 2016. Four complaints were upheld, whilst, 28 complaints were partially upheld. The two main complaint themes related to all aspects of treatment (24) and clinical treatment – surgical group (20). The clinical area, which had with most (x5) complaints, was John Ray ward.

Are surgery services well-led?

Good

We rated the leadership of surgical services as good because:

- Governance, risk and quality measurement processes were in place. Staff received updates through the governance, risk and quality frameworks. Risk registers were in place, which identified areas of risk across the service.
- The surgical service had high nursing vacancy rates and to mitigate risk across the service measures were put in place. These included staffing escalation processes, continuous nursing recruitment and new ways of working. The introduction of the safety huddle was one forum where nursing shortfalls were discussed and appropriate actions taken to ensure safe staffing levels and skill mix.
- Some staff we spoke with identified knowledge of the trust core values and what they involved.
- Clearly defined management and clinical leadership structures were in place. A new leadership structure was introduced on the 1 April 2015 which comprised of a directorate triumvirate team. The team included a clinical director, associate chief nurse and associate director of operations.
- Individual management of the different areas within the surgical service were well led.
- Public and staff engagement processes captured feedback from both groups, which was generally positive.

However we also found:

- Some staff had a limited knowledge of the 'duty of candour.'

Vision and strategy for this service

- The Trust is part of the 'Essex Success Regime (ESR)' with two other NHS Trust's. The ESR is a newly established model and will be the mechanism for responding to the changing healthcare landscape including commissioning. The clinical strategy for surgery is being developed through this process with full clinical, patient and public engagement across the three organisations.
- The ESR programme comprised of four workstreams: medicine, surgery and women's and children's services. It is anticipated that patient and public consultation will commence from autumn 2016. Work would commence in developing strategic and clinical pathway options to support the consultation process. It had been agreed that all work at individual trust level would be driven by and influenced by the outcomes of the ESR strategic programme. This has meant that information related to local strategic plans cannot be currently provided until the future configuration and patient pathways are agreed.
- Staff identified involvement in the development of the trust values and vision. Two staff we spoke with identified that the vision included being the best and the values included patient centred care and teamwork. Five other staff said the values were launched in 2016 but were unable to recall them.

Governance, risk management and quality measurement

- Performance dashboards were used to communicate performance for specific areas. Each clinical areas performance dashboard identified performance levels against named criteria; for example, statistics for the Surgical Emergency ward (SEW) and Lister ward (LW). Year to date mandatory training attendance (93% (SEW) and 96 %(LW) against a target of 75%), completed staff appraisals (78% (SEW) and 86% (LW) - target 80%) and

staff hand hygiene levels (100%). These statistics were mostly met with the exception of the staff appraisal target on the SEW as compliance was identified as 2% below target.

- Surgery had an identified governance framework which was led by a designated consultant and had a matron in attendance. In total, there were three governance directorates. Following this, the trust provided a copy of the surgical governance framework displayed in flowchart format. The framework provided identified the governance structure.
- We discussed the governance frameworks with two consultant staff who identified that each directorate had their own governance framework led by an identified governance lead. In surgery governance, half days took place to discuss and learn from governance issues. However, some of these were cancelled because of the doctors' strikes and financial pressures.
- We spoke with the surgical governance lead who was new to the role. They confirmed governance meetings took place and discussions included serious incidents, complaints and risks. Each directorate produced quarterly governance reports. In addition, Information from governance meetings were cascaded to surgical audit meetings. Challenges were identified in getting people to attend these meetings.
- Surgery governance meeting minutes (13 November 2015) confirmed that discussions involved the health and safety report findings, training and health and safety, risk frameworks, staffing and sickness on surgical wards, complaints, serious incidents updates and clinical incident activity. An action log was produced from this meeting; however, the responsible, due and completed columns were not completed for all actions. Therefore, it was difficult to ascertain who took responsibility for each action and whether the actions were now completed.
- We saw governance meeting action logs identified for the muscular skeletal governance meeting (6 January 2016 and 2 March 2016) and noted that both action logs were not fully completed to indicate whether actions were completed or when they were due for completion.
- Staff told us that monthly risk and governance meetings took place. Monthly surgical and anaesthesia, critical care and theatre staff newsletters were circulated to staff. Staff said the surgical newsletter, which was introduced in June 2016, included information on the three top risks and what was happening, incidents feedback and learning and general information about appraisals, sickness and mandatory training.
- Staff said that safety and governance issues were highlighted to staff groups through the monthly team brief, at sisters and team meetings and by email. We also saw a 'patient safety and quality priorities ' poster displayed on Lister ward which identified care priorities such as effective care, improving the patient experience and safe and harm free care. This showed the importance the service placed on the provision of safe and effective care.
- The surgical service had high nursing vacancy rates and to mitigate risk across the service measures were put in place. These measures included staffing escalation processes, continuous nursing recruitment and new ways of working. The introduction of the safety huddle was one forum where nursing shortfalls were discussed and staff said that actions were taken to ensure safe staffing levels and skill mix.
- Trust board involvement was evident in relation to risks such as serious incidents.
- Risk registers were in place at trust, divisional and ward level.
- We observed that the risk register had identified a large number of ophthalmology risks. We asked the senior surgical team to explain this. We were told the increase had been due to a higher number of older patients and changes to the 'National Institute of Clinical Excellence' guidance. We were told this was recognised as a national problem. In response, some nurse led clinics had been introduced.

Leadership of service

- A leadership structure introduced on the 1 April 2015 which comprised of a directorate triumvirate team. This team included a clinical director, associate chief nurse and associate director of operations.
- The structure was further supported by teams of clinical directors, matron's, service managers, allied health professionals, senior sisters and charge nurses.
- The executive team were described by senior staff as supportive and approachable. However, not all staff groups were aware of who the executive team were.

- We saw that band six staff were given opportunities to act up into a senior role. One band six nurse we spoke with was currently acting into a band seven role. This person had no leadership training to-date but this training had since been offered.
- Staff said that the ward sister from Notley ward was nominated for an 'Inspirational Leadership' award and was a runner up in this category.

Culture within the service

- Staff told us that staff at all levels were supportive, approachable and friendly.
- Following the 2015 – 2016 'Friends and Family Test' the trust implemented a trust wide culture programme that had developed trust values and what is expected of staff to be at their best. The trust identified this was being built into recruitment processes and training.
- We asked 10 staff about their understanding of the 'duty of candour' regulation. The 'duty of candour' is a regulatory duty that required providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This included giving them details of the enquiries made, as well as offering an apology. When asked three staff members were unable to explain the regulation. Whilst, seven staff demonstrated some awareness of the duty of candour, regulation and what it involved.
- The trust identified that they had just started to introduce the 'National Safety Standards for Invasive Procedures (NatSSIPs) 2015. They said they were working with the clinical commissioning group and the multi-disciplinary team to develop these standards. An action plan was in place and the focus group representatives remit was to communicate progress to other staff groups regarding the implementation of these standards.

Public and staff engagement

- The trust has held patient listening events. The last listening event took place in 2015 and was attended by 353 patients. A trust action plan resulted which identified 10 themes of work. We were told of one initiative a preoperative 'Hip / Knee Club', which had received good patient feedback and had improved the patient information provided following patient feedback.
- Patient council meetings took place every four to six weeks. The biggest complaint identified by patients was noise. Staff were tasked to try to reduce noise levels and to explain to patients when noise levels may be expected to rise, for example, when moving patients.
- Meeting minutes from three 'Patient Experience and Engagement Group (PEG)' meetings confirmed patients feedback was acted upon and service improvements implemented. For example, a carer's pass was implemented for carers/ relatives of patients with dementia, cognitive impairment and end of life patients.
- A plastic surgery trauma listening event was held on Monday 6 June where ex and current patients attended an evening with the trauma clinical and management team to discuss their experiences.
- The upper gastro-intestinal clinical nurse specialist team run monthly patient forums to engage and support ex-patients.
- The 2015 NHS Staff Survey involved 297 NHS organisations in England. Over 741,000 NHS staff were invited to participate using a self-completion postal questionnaire survey or online. The key findings were presented either as a percentage or as scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score was always one and the maximum score was five.
- Staff received bi-monthly newsletters to inform them of the latest news.
- Staff said they had received good support and regular communications from their line manager and that team meetings took place. On Heybridge, ward monthly team meetings took place.

Innovation, improvement and sustainability

- The trust identified that upper gastro-intestinal (UGI) surgery was internationally recognised and had recently introduced leading edge robotic technology. The trust identified the workforce had a very good relationship with the partner organisation.
- The Trust has launched a culture improvement programme, which set the vision, and values that it operated within.
- A consultant nurse operated weekly in urology theatres.
- Nurse led urodynamics were about to be introduced.
- An orthopaedic home support service was in place.
- The monthly surgical management group (SMG) was a non-minuted action learning set for the surgical team

and all band 8a staff were invited to this forum. The SMG debated a key issue or topic, which was supported by data and / or a relevant journal article. This was to build trust, develop an open culture and support staff in their professional development.

- A leadership / management journal club was developed to enable staff to debate a relevant journal and encourage reflection on individual leadership and management styles and practices.

Specialist burns and plastic services

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

Information about the service

Specialist burns and plastic surgery services were provided from The St Andrew's Centre, within Broomfield Hospital. Both services were managed as one directorate and were led by the same senior management team. The burns service was a supra-regional burns unit for major paediatric and adult burns in the South East of England. It served a population of approximately 9.8 million, and was part of the London and South East of England Burn Network (LSEBN), an operation delivery network for specialised burns treatment. Services included emergency treatment, reconstructive treatment, revision treatment, multidisciplinary pre-surgery assessment, post-operative assessment, hospital and community care, therapy and psychosocial specialist burns care. The unit consisted of a six bedded burns intensive care unit (ITU), which provided care for adults and children, from six months of age, an emergency admission room, an operating theatre, an adult burns rehabilitation ward and children's burns ward, and a dedicated burns outpatient department, which had an outreach team providing clinics throughout the region.

The plastic surgery service served a population of 3.2 million and provided comprehensive head and neck, hand, burns, skin, abdominal wall, lymphedema, vascular, and cleft lip and palate plastic surgery. This included emergency treatment, reconstructive and revision treatment, multidisciplinary pre-surgery assessment, post-operative assessment, hospital and outpatient care, therapy and psychosocial care. There were three plastic surgery wards: Stock ward, which specialised in breast reconstruction, head and neck, and free-flap surgery; Billericay ward, which had 6 plastic surgery beds for head and neck patients who required airway support, and Mayflower ward which specialised in hand trauma and consisted of 12 inpatient beds and 2 patient bays with four patient trolleys for elective admissions, and a trauma assessment area for trauma admissions. There was also a plastics outpatient department within the centre, and outpatient services were further available from alternative locations including Braintree Community Hospital, and other NHS trusts in Essex and East London.

During our inspection we visited all of the burns and plastic surgery areas within the St Andrew's centre. We spoke with 16 people who used the service, 32 members of staff including service leads, managers, nurses, anaesthetists, doctors, domestics, support workers, physiotherapists and occupational therapists, healthcare assistants and student nurses. We also reviewed 15 patient records and analysed data we requested from the trust.

Specialist burns and plastic services

Summary of findings

Specialist burns and plastics surgery services have been rated as outstanding overall. The Safety,Effective and Responsive domain has been rated as good, and the caring and well-led domains have been rated as outstanding. The rating of outstanding has been given because two domains of five clearly demonstrated outstanding practice.

We found that safety performance since our last visit in 2014 had improved significantly in the plastic's trauma service, and performance remained outstanding in the burns service.

- Documentation within patient records was clear, accurate and legible. Compliance with mandatory training for all staff was 86% which was well above the trust average, and there was always a sufficient number of staff on duty to meet the needs of people who used the service.
- Lessons were learnt following incidents and appropriate action taken to improve safety beyond the affected team.
- There was an abundance of service specific policies and procedures available, which was developed by the directorate as an MDT, reflected evidence-based national best practice. There was dedicated research team for the directorate, and audit results showed that outcomes for people using the burns service were the best in England and were comparable with the best in the world.
- Pain management was effective and an MDT approach was taken. All nursing and support staff had either completed or were working through service specific competencies, which had been developed by managers. This demonstrated high levels of competence related to burns and specialist plastics care.
- The Friends and Family Test (FFT) results for the directorate were consistently high and the best in the trust. Feedback from people who used the service was consistently and overwhelmingly positive. We observed that people were treated with dignity and respect at all times, and that the service was innovative in ensuring patients understood and were involved in their care. This included a "case manager" for all burns rehabilitation patients and close working with a legal firm specialising in burns, which incorporated the legal element of patient's needs in their patient care. Emotional support available was extensive and tailored to individual need.
- Services were planned and delivered to meet the needs of people using the service, and they were constantly evolving to improve continuity, flexibility and choice of care. The needs of different people where always taken into account and we saw excellent examples of such care delivery. Formal complaints were low and managed effectively.
- Access and flow throughout the burns service was seamless, and in the plastic surgery service significant improvement and action had taken to enhance seamlessness. we found that leaders were quick to respond to concerns, were visible and approachable, and staff could not speak more highly of them. We found an extensive amount of examples which demonstrated the directorate was innovative, made improvements where needed and ensured sustainability of service provision. Throughout services staff were extremely positive; energised, passionate about their role and felt involved in exciting service developments arising.

However:

- The Friends and Family Test (FFT) wasnot being used on Mayflower ward.
- MRSA screening was significantly below the trust target and needed improving, however, necessary action was being taken to improve this.
- Four out of 12 junior doctor's post were vacant for the plastic surgery service, we found that the service was taking appropriate action and mitigating risk where necessary.
- The plastic service was not monitoring cancellation rates for trauma patients. However, the directorate was aware of these concerns and had appropriate plans in place to address them. It was also recognised that the opening of the new trauma assessment unit, due to open early 2017, would significantly improve access and flow of the plastic service

Specialist burns and plastic services

Are specialist burns and plastic services safe?

Good

We rated the safety of burns and plastics services as good because:

- Safety performance since our last visit in 2014 had improved significantly in the plastic's trauma service, and performance remained very good in the burns service.
- Documentation within patient records was clear, accurate and legible.
- Throughout the directorate 86% of all staff were compliant with mandatory training.
- There were sufficient numbers of middle grade doctors and nursing staff available to meet the needs of people who used the service.
- Lessons were learnt following incidents and appropriate action taken to improve safety beyond the affected team.
- The directorate regularly reviewed mortality and morbidity for burns and plastic services.
- Infection control procedures were practised in line with the trust's policy, and the burns unit demonstrated outstanding practice in relation to an infection control incident.

However we also found:

- MRSA screening was significantly below the trust target and needed improving.
- Four out of 12 junior doctors post were vacant for the plastic surgery service. Although there was a regional shortage of specialist trainees in this service, and the trust was working to mitigate the risks of doctor shortages where possible by training physician assistants and using locum doctors to cover vacant shifts.

Incidents

- There had been no never events reported for burns and plastic services during April 2015 to March 2016. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. At our last visit in 2014 we had serious concerns regarding never events, however, at this inspection in June 2016 we found that lessons had been learnt which were embedded into practice. This related to previous wrong site surgery and we found that there were now aprioriate and multiple checks taking place before surgery, including skin markings, which all staff were familiar with and to prevent reoccurrence.
- At our last visit in 2014 we had serious concerns regarding never events, however, at this inspection in June 2016 we found that lessons had been learnt which were embedded into practice. This related to previous wrong site surgery and we found that there were now aprioriate and multiple checks taking place before surgery, including skin markings, which all staff were familiar with and to prevent reoccurrence.
- One serious incident which related to a pressure ulcer, and 722 incidents of which 590 were classified as no harm incidents, had been reported between April 2015 and March 2016.
- The trust had an electronic incident reporting system in place. Staff were able to tell us what constituted an incident and knew how to correctly report one. Staff told us that they were reporting more incidents since our last visit and records we looked at confirmed this.
- Following the reporting of incidents, we saw that thorough and robust investigations were carried out where necessary, with lessons learnt identified. Lessons learnt were then shared throughout the directorate which ensured that action was taken to improve safety beyond the affected team or service.
- For example, we found that staff across the directorate were reminded that intravenous medicines must be checked by two nurses prior to administering to a patient, this was following an incident reported in another area where this practice had not happened.
- The directorate regularly reviewed mortality and morbidity for burns and plastic services. Review occurred at a number of monthly meetings including the "Safety and quality" and "Burns mortality and morbidity" meetings, both of which were minuted. We checked the last two meeting minutes for both meetings.
- Managers were aware of the principles of Duty of Candour (Duty of Candour is a legal duty on hospitals, to inform and apologise to patients if there have been mistakes in their care that have led to significant harm),

and we were shown an example where duty of candour had been applied. This related to a pressure ulcer and we saw the trust response letter to the service user which was appropriate.

Safety thermometer/dashboard

- The NHS Safety Thermometer was used trust-wide to determine safe care for all wards. Trust wide results showed that harm free care was improving from January 2015 (91.42%) to January 2016 (94.7%). The NHS Safety Thermometer is a national tool which records the presence or absence of four harms: pressure ulcers, falls, urine tract infections in patients with a catheter and new venous thromboembolisms and is used to determine "harm free care". This information was not displayed for the public. We requested a breakdown of information per directorate, however, this information was not provided.
- The directorate did use and display a dashboard at the entrance of every ward area. The dashboard was easy to understand and contained information about how each ward area was performing in relation to staffing levels, mandatory training, infection control, incidents, falls, pressure ulcers, complaints and compliments.
- Overall this information demonstrated that the performance of each area was improving with the exception of screening for Methicillin-resistant Staphylococcus Aureus (MRSA) and medicine related incidents, which we have reported on below in this section.

Cleanliness, infection control and hygiene

- There had been no cases of hospital acquired MRSA and one episode of hospital acquired Clostridium Difficile (C.difficiile) reported by the directorate between June 2015 to May 2016.
- There were robust cleaning schedules for each area of the directorate. Every area we visited was visibly clean and well organised.
- Staff demonstrated that they adhered to universal infection control principles. We saw that staff practised good hand hygiene, and all staff used personal protective equipment appropriately, wore their uniforms bare below the elbows and disposed of waste products appropriately.
- Each area conducted hand hygiene audits regularly. This showed that good hand hygiene standards were maintained overall. On Burns Adult Rehabilitation ward the service had scored 100% compliance with their hand hygiene audit from February 2015 to January 2016. However on Mayflower ward there were five occasions where the ward did not submit their hand hygiene audit data during this period.
- MRSA screening across the directorate required improvement. For example, on Stock ward in March (88.2%), April (90.9%) and May 2016 (88.2%) screening was below the trusts target of 100%. Mayflower, Billericay and Burns Rehabilitation ward had similar results during this same period. We discussed this issue with two senior managers who were aware of the problem and told us that the issue was stemming from emergency admissions in the plastics service, and that they were reinforcing the issue to all areas. Records also confirmed that appropriate action was being taken to address this.
- Staff told us that in the last year there had been a patient diagnosed with a Carbapenemase Producing Enterobacteriaceae (CPE) infection, which led to the temporary closure of the Children's Burns Unit for a period to deal with and contain the infection. CPE are bacteria which usually live harmlessly in the gut of humans. This is called "colonisation" and a person is said to be a "carrier". A person who is a carrier can put other patients at risk of developing an infection unless strict precautions are taken, or they could go on to develop an infection themselves. Records showed that the burns unit contained the infection and the exercise was recognised as being a credit to the unit. Senior nurses presented this case success at the trust's annual "Nurses' Day", which ensured learning was shared with other directorates.
- The domestic team on Burns ITU was recently awarded an OSCA award (a hospital incentive to celebrate staff success) for their dedication and effective specialist working on the unit. All domestic staff were trained in infection control procedures necessary for the unit.

Environment and equipment

- Resuscitation equipment was checked regularly in line with national guidance throughout the directorate. Records from the past three months confirmed that the matron for each service visited ward areas daily to ensure that this equipment had been checked.

- Each area we visited was bright, clear of clutter and well organised. There were adequate storage facilities and suitable levels of equipment for safe monitoring and effective treatment.
- Records confirmed that equipment had been serviced recently, and equipment checked appeared visibly clean.
- There was no dedicated plastics outpatient department for children. This meant that children waited and were seen in the same place as adults. However there was a separated children's play area in the corner of the department, and children were seen in specific outpatient rooms which were child friendly.
- A manager confirmed that there had been no business case or plans to improve this issue. This meant that children waited and were seen in the same place as adults, and that the service was not meeting national standards for children and young people. A number of professional bodies, including The Royal College of Surgeons (2007), state that wherever possible children should be seen in designated children's outpatient departments. This issue was not on the directorates risk register, and we raised this same concern at our visit in 2014.
- We saw that recent improvements had been made to the operating of Mayflower ward. Since our last visit the ward had decommissioned the contingency beds on the ward, and had changed operating procedures to be open 24 hours a day 7 days per week. The ward had 12 beds dedicated to plastics inpatients. The trauma service and elective admissions also were managed from the two patient bays and day room. Staff throughout the plastic service told us that this had improved patient safety.
- There had been an approved business case for a new dedicated hand trauma and assessment unit. This meant that the trauma service workflow would be relocated from Mayflower ward to a different part of the hospital. We saw structural plans for the new unit which included six consulting rooms, a minor operating suite, recovery, reception and waiting area. This unit was planned to be open Monday to Sunday between the hours of 07:00 and 20:30.
- Patients referred to the trauma service outside these hours were to be assessed and either asked to attend Mayflower ward or return to the assessment unit the next day. We observed that building work had commenced for the new unit and expected completion was early 2017.

Medicines

- Records confirmed that controlled drugs, such as Morphine, were checked daily. Medications for resuscitation were also checked daily with the emergency equipment.
- On Mayflower ward, we found one controlled drug, Temazepam, which was out of date by three months. This was despite daily checks which had taken place every day since then. We informed a senior manager and asked them to take action. At our unannounced inspection on 30 June 2016 we found that the service had taken appropriate action to address our concerns.
- Medicines were stored securely throughout the directorate, with the exception of Mayflower ward. On this ward we found that the medicines rooms, where controlled drugs were stored, had a key code restriction in place. However we found that a member of staff had written the code for the keypad on the door, which was visible for patients and visitors. We raised our concerns to a senior nurse who took immediate action to resolve this issue.
- Fridge temperatures were checked and we were assured that they were being monitored appropriately, and that medicine was being stored safely.
- We checked 16 patient's medicine charts and found that medicines were prescribed appropriately.
- There had been a high number of medicine incidents reported for the directorate which largely related to the plastics service. In December 2015 records confirmed that there had been three incidents reported and the month prior to this there had been four.
- We saw that these incidents had been reported, investigated and managed appropriately, with lessons learnt shared across the directorate. Records confirmed that regular monitoring of medicine errors continued and incidents were reducing significantly. For example there had been one medicine error reported in February 2016 which was significantly lower than previous months we have mentioned.

Records

- Records were stored securely throughout the directorate. On the plastic surgery wards there were key-coded patient record cabinets in use which were locked, and computers were password protected and locked throughout the directorate.
- In the plastics service, paper patient records were in use, and in the burns service there was a mixture of paper patient records and an electronic patient record system called 'MetaVision' in Burns ITU, which was password protected.
- Documentation was clear, accurate and legible in patient records. Where a concern had been identified action was taken as a result and then recorded. For example, one patient was living with dementia. The patient had received further assessment, and care had been tailored to their individual needs.
- Burns and plastic services both used trust-wide inpatient and day case patient care records. These were booklets consisting of numerous holistic patient assessments with supporting care plans.
- Relevant risk assessments, pre-operative checks and care plans were fully completed in the patient records we reviewed. Assessments included moving and handling, pain, skin integrity and medical history.

Safeguarding

- Staff had access to the trust's safeguarding policies and procedures via the intranet.
- Staff were knowledgeable as to what constituted a safeguarding concern, how to raise matters appropriately and who the safeguarding leads for the trust were.
- There were notices throughout the service which informed staff, patients and visitors about relevant safeguarding topics and how they could get further support and advice.
- The burns service had a dedicated adult and children's safeguarding nurse who worked three days a week, and out of these hours staff had access to the trust wide safeguarding team.
- There are three levels of safeguarding children training. Level 1 provides a baseline understanding, Level 2 provides greater knowledge for those working regularly with children and Level 3 provides high level of knowledge for staff working in complex situations and who have to assess, plan, intervene and evaluate needs of children (Working together to safeguard children: HM Gov 2015. Adult safeguarding training and level one and two children's safeguarding was part of mandatory training for staff. Records confirmed that 85.6% of staff were compliant with their mandatory training.
- The majority of nurses (39) had completed level 3 children's safeguarding training out of those recognised as required to be level 3 trained (47) across the directorate. A further five nurses of these 47 had training dates booked.
- During our visit we observed an incident where a member of staff acted appropriately to safeguard a patient who was at risk of harm. This person was referred to social services by the member of staff and we saw that they later received the help and support they needed to make sure they were safe and protected.
- Staff confirmed that there was regular safeguarding supervision for registered nurses in the burns service, which provided additional support and advice for staff in relation to safeguarding practice.

Mandatory training

- Staff told us that they were compliant with mandatory training across the directorate and records confirmed that 85.6% of staff had completed their training, which was above the trusts target of 75%.
- On the Children's Burns ward 98.6% of staff were up-to-date with this training.
- Mandatory training consisted of subjects such as basic life support, safeguarding adults and children,, fire awareness, information governance and health and safety.

Assessing and responding to patient risk

- Throughout the directorate the national early warning tool called NEWS (national early warning score) was in place. For areas that provided paediatric care, 'children's early warning tools' (CEWT) were in use. When completed, early warning tools generate a score through the combination of a selection of routine patient observations, such as heart rate. These tools were developed and introduced nationally to standardise the assessment of illness severity and determine the need for escalation.
- We checked 10 patient records and saw that early warning charts were completed and scores were accurately calculated in all of the records. Staff knew when to escalate concerns if a patient scored high.

There were directions for escalation printed on the reverse of these observation charts, and notices throughout the wards reminding staff about when and how to escalate concerns.

- On the Adult Burns Rehabilitation ward we observed that patient's NEWS (scores) were recorded on the patient board behind the staff desk; this was so that the nurse in charge was constantly aware and had an overview of patient's wellbeing.
- There was a trust-wide trigger and response team (TART), who attended the ward when alerted by staff about high NEWS (scores). Staff told us that they knew how to contact the team when required.
- Staff had access to trust policies about the deteriorating patient and transfers of care to other hospitals via the intranet. Local criteria had also been developed to support admission to appropriate services. For example, neonates were directed to an alternative NHS service with Paediatric Intensive Care Unit (PICU) facilities as required.
- The 'WHO Surgical Checklist, Five Steps to Safer Surgery' was in place and used in the plastics theatres and outpatient department, where minor procedures were carried out. We looked in seven patient records and found that this checklist had been completed.
- The emergency call bell system in Burns ITU had been upgraded in 2013 so that in in the event of an emergency anywhere within the burns service the emergency call is heard in burns ITU. This alerted anaesthetists and burns surgeons who attend immediately, ahead of the trust crash team.
- Local admission criteria had been developed to either accept or re-direct children who did not meet the criteria, for example neonates with major trauma would be redirected to a service with PICU based on a provisional pathway which was followed.
- All children were reviewed daily using a paediatric trigger tool to assess whether the child had deteriorated and therefore transfer would be considered.

Nursing staffing

- The 'Safer Nursing Care Tool' had recently been completed to determine safe staffing levels in each clinical area. A senior manager told us that this was conducted every three months.
- Staff we spoke with confirmed that nursing staffing levels were safe. For example, on Mayflower ward levels of staffing (average fill rate) for November 2015 (99%), December 2015 (105%) and January 2016 (103%) were above planned numbers most times.
- Staffing numbers, both actual and established, were written on boards in every ward area, and were in public view. We looked at staffing rotas and found that actual staffing levels correlated with planned levels at most times. Where shifts were not filled, we saw that these were filled with regular bank and where applicable, agency staff.
- Bank and agency staff equated to 10.8% of staffing which was higher than the trust expectation (10%). However, the directorate's divisional report dated December 2016 stated that the use of bank and agency had almost halved since May 2015 with a continuous downward trend, and that the higher than expected rate was attributable to vacancy rates on the plastic surgery wards.
- Bank and agency staff were provided with orientation of the area they would be working on prior to working. Records confirmed that orientation was happening . Records confirmed that there were always two Registered Nurses (child branch) on duty on the Children's Burns ward.
- Burns ITU employed two adult nurses who were trained in paediatric intensive care, and all nursing staff had completed paediatric basic and advanced life support training.
- A paediatric trained nurse was allocated to care for a child when they were admitted to burns ITU. When this was not possible due to there not being a sufficient number of paediatric staff employed by the service to provide this care, a registered nurse who had undertaken additional training in paediatric ITU care looked after the child with the support from a band 7 nurse. Whilst this meant at times,the burns service was not always meeting national paediatric ITU standards, which stipulate that, "Nurses working with children and young people should be trained in children's nursing with additional training for specialist services or roles" (The Royal College of Nursing; Defining staffing levels for children and young people's services, 2013), we found that the service was mitigating this risk because of the staff arrangement described. Further more, paediatric nursing competencies had been introduced for all nursing staff, and Band 7 nursing staff were rotating to

another NHS trust which had a Paediatric Intensive Care Unit (PICU) to support completion of competencies. There was also an internal nursing rotation programme whereby RNs (child branch), from the Children's Burns Ward took turns to work on Burns ITU and vice versa.
- Staffing records demonstrated that there was a good skill mix of staff on duty at all times. There was always a senior staff nurse on duty for each area.
- Staff sickness rates (4.4%) were slightly higher than the trust expectation (3.5%).
- Different areas within the directorate had varying methods for handover of patient care to the next shift. Throughout the service we observed that handover was effective because communication was clear and information was well structured.

Medical staffing

- There were always three junior doctors, two senior doctors and an anaesthetist on site for the directorate. In addition to this two consultants were on call 24/7 and an additional paediatric consultant from the trust was always on call as well.
- The directorate employed 20 consultants, and all anaesthetists were paediatric trained.
- There was not a dedicated paediatrician for burns; however the team of paediatricians at the hospital supported the burns team. This meant that the service was not fully meeting the burns care standards for children requiring intensive care. However, this risk was on the directorates risk register and the burns service was taking appropriate action to mitigate associated risk.
- Two Paediatric Intensive Care Unit consultants were appointed to work with the burns service from another NHS trust. These consultants attended the St Andrews Centre twice weekly, and reviewed patients daily as part of a multidisciplinary (MDT) review, and as required, via video link.
- Staff raised concerns with us that the amount of junior doctors employed for the plastics service was poor, which sometimes meant medicine prescriptions and patient discharges were delayed. We saw that this issue was on the directorates risk register, which stated, "Insufficient staff to maintain 48 hours European Working Time Directives and sustain service activity at 100%".
- A senior manager for the directorate told us that four of the 12 junior doctor posts were vacant, and that whilst these were posts were being advertised, the service was struggling to recruit.
- The service was is the process of training and recruiting physician assistants (Physician assistants are health professionals with a postgraduate qualification who can work in a variety of healthcare settings under the supervision of a trained doctor), to support care delivery and free up junior doctors for clinic and theatres. This included senior managers working with a group of nurses from the services to determine where further support was required and why.
- The risk register stated that it was recognised that it would be 18-24 months before the physician assistants were able to contribute to the workforce. During this period the service was still actively recruiting to fill the four junior doctor posts which were vacant. However in the interim period records confirmed that this risk was mitigated by using locum doctors to cover shifts.
- Locum staff were used as required to fill vacant shifts. Staff confirmed that these were largely substantive doctors who were doing shifts as locums.
- Handover was well attended, and discussion between medical staff was structured and clear.

Major incident awareness and training

- The directorate had a 'Burns Unit Major Incident Plan; in place, which staff were aware of. This detailed a clear operational protocol in the event of a major incident. This was accessible and available to all staff electronically.
- This major incident plan was used in conjunction with the trust's 'Major Incident Plan' and 'Critical Care Surge Plan', all of which were available for all staff to access via the trust's intranet.
- The burns service linked with the London and South East of England Burn Network (LSEBN), whose purpose it is "to provide a framework to ensure there is a co-ordinated approach to burn care in London and the South East". St Andrew's had regular contact with LSEBN, and were alerted promptly if there was a major burns incident requiring an admission.
- The plastics service followed the trusts 'Major Incident Plan' and this was available through the trust's intranet.

Specialist burns and plastic services

Are specialist burns and plastic services effective?

Good

We rated effectiveness as outstanding for the burns and plastics services because:

- Service specific policies and procedures developed by the directorate as an MDT reflected evidence-based national best practice.
- Audit results showed that outcomes for people using the burns service were good.
- The management of pain was exceptionally good with an MDT approach. An anaesthetist for the directorate was on duty at all times, and six nurses had obtained non-medical prescribing qualifications to ensure that patients received pain relief in a timely way.
- All nursing and support staff had either completed or were working through service specific competencies, which had been developed by managers. This demonstrated high levels of competence related to burns and specialist plastics care.
- Training opportunities for staff across the burns and plastic services was excellent. Staff were well supported to develop professionally and academically in their specialist area.
- The directorate had recently introduced an electronic live trauma database. This meant that staff had up-to-date information about the trauma service, which meant that care and treatment was more effective, because patients were given updates regularly about waiting times. This system adjusted their food and fluid options based on live waiting times for operations.

Evidence-based care and treatment

- Relevant trust policies and care records showed that patients' needs were assessed and care was planned and delivered in line with recognised guidance, legislation and best practice standards. For example the trust followed "National Institute of Health and Clinical Excellence" (NICE) guidelines in relation to the prevention and management of pressure ulcers (NICE, 2014; Pressure Ulcers: prevention and management CG179).
- New evidence-based care and treatments were identified by individual staff or the directorate's research team, and bought to the governance meetings to discuss suitability to the service and how it can be used. We saw an example of this process where a member of staff had learnt about a new skin treatment for superficial burns following attendance at a British Burn Association (BBA) study day. This had initiated an audit of facial burns in the children's burn service to determine whether changes in practice should occur. This audit was taking place during our visit and all staff from the ward where participating in this audit at some point.
- There were numerous burns-specific policies that had been developed within the burns service and with MDT team input. This represented outstanding practice. These were based on evidence-based practice that was issued by relevant organisations such as the BBA and the National Network for Burn Care (NNBC). All service specific policies were ratified appropriately, up-to-date and accessible to all staff within the service.
- The plastic surgery service had an abundance of policies and guidance in place that had been developed within the team. For example, the hand therapy team had developed extensive guidance for hand care that reflected each consultant's choice in treatment and preferred regime. This included "Extensor tendon repairs mallet injury" and "Radial nerve injury" guidance.
- The breast team had developed policies and guidance on breast care for the service, such as "Deep Inferior Epigastric Perforator Flap (DIEP Flap)" guidelines, and patient information leaflets which reflected up-to-date evidence-based practice. This equally demonstrated outstanding practice.
- There was a dedicated research and development (R&D) department within the trust. The trust stated that the St Andrew's Centre was, "providing a cutting edge environment to support pioneering research" led by this team. The team consisted of two co-directors, a specialist nurse and consultant, a chief research officer and research coordinator. Their aim was, "to provide excellent healthcare delivery and identify effective treatments and cures through research and development underpinned by good research practice and governance". Records showed that the team had ground breaking success in terms of their research, including research outcomes which led to the development of the trusts on-site, "Helen Rollason Research Unit".

- In addition to this the directorate had developed its own research unit called the, "St Andrews Anglia Ruskin Burns and Plastic Surgery Research Unit" (StAARS), in partnership with the local Anglia Ruskin University in Chelmsford. The aim of StAAR was to, "to restore wounds, promote healing and allow the body to regenerate new tissue instead of scarring; better understand scar modulation and design new pathways of rehabilitation (physical therapies); and develop cost-effective, reproducible techniques based on existing technology that can be disseminated as common practice in modern regenerative medicine and surgery". The team consisted of three research fellows, as well as many overseas consultants. The StAAR team had published over 20 papers in peer-reviewed journals, presented over 100 papers at national and international scientific meetings and given 20 invited lectures at scientific meetings.
- There were a number of local audits that took place. This included audits of documentation, dementia screening, medication storage, hand hygiene, emergency equipment, paediatric observations, duty of candour and recognition and management of sepsis audits.
- Records showed that audit results were disseminated to all staff and that action was taken to make improvements where required. For example, we saw that there was a recent audit for dementia screening which showed that compliance continued to improve as compliance was averaging 90%. Staff were encouraged, through team meetings to make a, "Conscious effort to push it further to get to 100%".

Pain and itch management

- We asked 15 patient's about their pain management whilst admitted. All of these patients confirmed that they were regularly assessed for any pain they may be experiencing, and that nurses were prompt and effective at managing their pain.
- Medication charts that we looked at showed that pain relieving medication was given as prescribed and in a timely way.
- We saw that pain assessments happened regularly for patients for admitted and those waiting to be seen in the hand trauma clinic.
- Six nurses within the directorate had obtained non-medical prescribing qualifications. This meant that these nurses could prescribe pain relieving medicine which in turn reduced the time patients waited for medicine.
- On the burns wards there was twice daily multidisciplinary (MDT) ward rounds where each inpatient was reviewed. The anaesthetist took the lead during this time to review current medication the patient was on, their pain and itch scores, and prescribed analgesia and anti-itch medication as required.
- There was an anaesthetist available for the directorate at all times, and during the day there was a pain team within the trust available. Staff told us that the pain team was responsive and that they knew how to contact them for advice and support.
- On the Children's Burns ward there was a child-friendly pain scoring system which supported staff to determine pain experienced.

Nutrition and hydration

- On admission patient's nutritional and hydration needs were assessed. Malnutrition Universal Screening Tool (MUST) assessments were undertaken in all the patient records we looked at. This tool identifies patients at risk of malnutrition.
- Food and fluid charts were accurately completed, as required, in the patient records we looked at. On Burns ITU the electronic patient records that were in place were monitored closely by staff and updated as needed to reflect fluid balance.
- Patients that could drink had filled water jugs by their bedside, and each ward area provided regular hot drink rounds during the day and evening. There were also regular meal times on the ward areas with a variety of food choices. Patients told us that the drink and food choices were good.
- Patients on the trauma list having procedures under local anaesthetic told us that they had been offered food and drinks throughout their wait for the treatment. They had access to water in the waiting area through the day.
- For those patients on the trauma list awaiting an operation under general anaesthetic, we saw that that the trauma nurse regularly checked for updates as to

how long the patient would be waiting. If the delay in treatment was longer than anticipated then the nurse spoke with the anaesthetist who confirmed the patient could have a drink or food if allowed.
- In the plastics outpatient department there were water facilities for people waiting, and a café bar where people could purchase food and drink.
- In the burns service there was a designated dietician who was available during the week days and attended the daily MDT ward rounds.

Patient outcomes

- We did not identify any outliers relating to burns or plastic surgery care. An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care that people receive.
- The standardised risk for elective readmission rate for plastic surgery (106) was higher than expected. A figure greater than 100 represents that there were more than expected and it is above the England average.
- The standardised risk for non-elective readmission rate for plastic surgery (85) was lower than expected. A figure lower than 100 represents that there were less than expected and it is below the England average.
- According to trust figures, the mortality rate for those operated upon within 24 hours had been reduced by 20% for 2003-07 from 1998-2002. These outcomes were outstanding. Staff told us that they were in proud of their accomplishments within St Andrew's.
- Burns ITU did not submit Intensive Care National Audit and Research Centre (ICNARC) data. Senior leads for the service told us that they had been in discussion with ICNARC, and they had been advised that due to low admissions of Burns ITU patients, this would displace confidence intervals in terms of statistical analysis and therefore participation was not recommended.
- However, Burns ITU did use and analyse cumulative sum analysis (CUSUM) techniques, which is a tool to monitor the rates of adverse mortality. We reviewed the CUSUM data since September 2012 which demonstrated that this service performed at a level comparable which was equal or better than most burns services in the world.
- The St Andrew's Centre was part of the first study to develop and implement real-time outcome monitoring for mortality in burns using CUSUM techniques. This was following the service leading an eight year retrospective study of mortality, which was performed on all admissions to the St Andrew's Burns ITU service. The study described a successful design of an early warning system to monitor outcomes in burns intensive care settings. The study was undertaken in partnership with several organisations and was published in 2013. Records we reviewed also confirmed that CUSUM mortality rates continued to be consistently better than expected against the national average and world comparisons for adult patients.
- The directorate regularly participated in numerous national audits for burns and plastics services. In the past year this included evaluation of patient requests for risk reducing mastectomy and influence of multidisciplinary team meetings in managing referrals, national audit of the practice and outcome of implant breast reconstruction and of current practice in managing open flexor tendon injuries and open hand fractures.
- Audit results were presented at national and international meetings and where applicable audit resulted in changes to practice. For example, there had been a recent audit of "preoperative imaging prior to free flap breast reconstruction" which demonstrated the value of pre-op CT scanning prior to surgery. These audit results were presented at The Belgian Plastic society meeting and the St Andrew's centre now completed pre-op CT scans on all patients undergoing free flap breast reconstruction (DIEP) surgery subsequently.
- Records confirmed that the average length of stay (LoS) was regularly monitored for both plastics and burns services. In the plastics service LoS on average was 2.45 days for elective patients and 1.64 days for emergency patients in May 2016. We looked at data from the past 6 months and found that these results were similar.
- In burns rehab a recent enhanced rehabilitation project had been undertaken which had led to a 35% reduction in LoS for burns patients. This project had recently been presented by the team, led by a physiotherapist, at a "British Burns Association" (BBA) annual event.
- Young adults aged between 18-24 years had the additional option to join the Young Adult Children's Burns Club, which demonstrated that were transition arrangements in place for children and young people to adult services.

- There were many examples whereby professionals employed by the centre had published burns specific research papers in national and international healthcare journals.
- The hand therapy team, which consisted of physiotherapists and occupational therapists, had regular meetings, whereby if one of the team had recently attended training or read a new research article that was useful, they shared this information with their colleagues.

Competent staff

- Staff appraisal rates across the directorate required improvement. Appraisal rates were particularly low on Burns Children's ward (72.2%); Mayflower (64%) and Stock ward (45.2%). However, managers we spoke with were aware of this and were taking appropriate action to improve compliance.
- Staff confirmed that they had either been revalidated in terms of their professional registration, or were working through this process. On individual wards we saw that progress was being monitored. For example, on Mayflower ward the manager had an up-to-date list of nurses who required revalidation and when they had either completed this or when it was due by.
- There were specific burns and plastics competencies for newly qualified nurses and new starters. Records confirmed that all staff either had completed these or were working through these.
- All newly qualified nurses also undertook thorough preceptorship packs with trust wide and specialist competency frameworks. Newly qualified staff confirmed this they had undergone this process.
- Staff reported that newly qualified nurses were well supported and that the skill mix met the needs of the patients and the wards.
- We saw evidence of healthcare support workers undertaking further training and being supported to achieve healthcare qualifications including degrees in adult nursing. For example one healthcare support worker had completed associate practitioner training and was in the process of completing their degree in adult nursing, which was funded by the trust. There were plans for a further two health care support workers to undertake associate practitioner training.
- We spoke to a student nurse who reported that they felt well supported during their clinical placement. We reviewed data sent to us from students that had been on placement on the burns unit, the feedback they sent was immensely positive and demonstrated outstanding practice in relation to supporting and teaching student nurses.
- Across the plastics service 18 nurses had completed the accredited Burns and Plastics course. Staff were supported to develop their skills through other accredited specialist training too: three nurses had undertaken a hand course, four had completed training in head and neck plastic surgery, 12 had completed mentorship training, and 20 were deemed competent in airway management.
- In the Burns service a large proportion of staff had undertaken specialist burns training. In Burns ITU 26 registered nurses had obtained post-registration ITU courses, and 17 had achieved HDU course accreditation.
- On the Adult Burns Ward two nurses had been funded and completed Burns Rehabilitation courses, six had undertaken the Burns and Plastics postgraduate courses, and three nurses had achieved accredited training in emergency burns paediatric care.
- Staff told us across the directorate said that training opportunities were very good.
- Junior anaesthetists and surgeons, who typically came from plastic surgery backgrounds, participated in the twice daily patient ward rounds in the burns service. Junior doctors were responsible for presenting the progress of the low dependency patients at the ward rounds within the team, which in turn provided learning opportunities and the time to ask senior colleagues questions.
- There was a three day burns course that was available to all staff, which was delivered "in-house" by the burns service which was available to all staff.

Multidisciplinary working

- MDT working between specialities and allied health professionals, such as hand therapists, was truly outstanding across the directorate. For example, on the burns unit there were twice daily MDT rounds for all admitted patients. This was well attended by the burns anaesthetist and burns consultants, as well as anaesthetics, clinical fellows, senior nursing staff, junior medical staff, physiotherapists, dieticians and clinical psychologists.
- The entire multidisciplinary team also met to discuss the patients in more detail on a weekly basis.

- On Mayflower ward the hand patients were also seen daily by a consultant, with an MDT including hand therapists and the lead nurse for the ward attending.
- There were dedicated leads for specialities who coordinated MDT working to ensure seamlessness of service. This included an allocated trauma nurse who oversaw the care of all trauma patients waiting to go to theatre or who were waiting to be reviewed. Also, on Burns rehab there was a dedicated senior nurse who was a "case manager" whose job it was to oversee patients on the unit from admission to discharge and post discharge.
- There were arrangements in place for working with social care partners in safeguarding investigations.
- There were systems in place for district nurse referral arrangements, and discharge summaries were sent to patient's GPs routinely at discharge via an electronic system. We case tracked two patients and found that these arrangements were effective.
- On Burns ITU there were Service Level Agreements (SLAs) in place whereby paediatric intensivists participated in daily paediatric burn ward rounds. This occurred on site every Monday and Friday and remotely via video-link on every other day and additionally where required.
- Patients that were "stepped-down" from Burns ITU benefited from follow-up and continuity of care from the same team because of the MDT model of care in place. We saw that when a person was discharged, or transferred, from the burns to the plastic surgery wards, then one of the burns nurses regularly visited the patient, and the same surgical and anaesthetic team were constantly involved in the patient's ongoing care.
- The burns team worked with other providers locally to improve local burns services to patients. For example, the directorate delivered annual paramedic training days to teach paramedics about burns management.

Seven-day services

- There were at least two consultants on call, and two middle grade and three junior doctors for the directorate onsite at all times. Nursing staff told us that these medics responded in a timely way when needed, particularly in more urgent situations.
- Patients were seen by a consultant daily during the week as required, or out of hours by the on call consultant for the service if necessary.
- An SLA that was in place with another trust which ensured that there was always access to a paediatric intensivist via video link.
- Occupational therapy, physiotherapy, speech and language therapy (SALT) and pharmacy support was available Monday to Friday 9-5pm. Out of these hours there was an on call physiotherapist and pharmacist available at all times.
- There was also access to trust-wide imaging services at all times.

Access to information

- All staff we spoke with, including bank staff, confirmed they had access to patient records in both electronic and paper format as necessary, and access to relevant computer systems including pathology.
- We asked staff what they would do if a patient requested a copy of their own medical notes. Staff were familiar with the principles of the "Freedom of Information Act" (2000) and told us that they would escalate any request to a manager who would then take appropriate action in line with trust policy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on consent, the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLs) was part of mandatory training for all staff. Records confirmed that on average across the directorate 85.6% of staff had completed their training, which was above the trusts target of 75%.
- Staff demonstrated good knowledge and practice of the need for consent, how to correctly assess mental capacity in line with the Mental Capacity Act (2005), and when and how DOLs is applied.
- Trust policies regarding consent, the Mental Capacity Act and DOLs, were accessible to staff via the intranet and staff confirmed they could access these.
- Patient records we checked showed that appropriate consent forms were in place, and these were fully completed for patients undergoing surgery and invasive procedures.
- The burns service also had a dedicated mental health nurse who worked within the burns MDT who worked part time over three days. Staff told us that this member

of staff supported them with MCA and DOL applications as required. Outside of these working hours there was a safeguarding team who could also provide specialist knowledge and support.
- Staff demonstrated appropriate knowledge about Gillick competency and Fraser guidelines. These guidelines are tools used to assist professionals in determining whether a child is mature enough to make their own decisions about care and treatment.

Are specialist burns and plastic services caring?

Outstanding ☆

We have rated caring as outstanding for burns and plastic surgery services because:

- The Friends and Family Test (FFT) results for the majority of the directorate was consistently high, if not 100%, and the best in the trust.
- Feedback from patients, who used the service, showed that at all times people were treated with kindness, dignity, respect and compassion whilst receiving care and treatment. This feedback was overwhelmingly positive.
- People who used the service and those close to them were encouraged to be involved as partners in their care. One of the many examples included; on Adult Burns Rehabilitation ward where we saw that there was a dedicated "case manager" who oversaw patient care from admission to after discharge. This ensured that this patient had continuity of care, and this member of staff regularly checked that this patients' needs were being met and that they were involved and understood their care.
- Support was available to those who required this. For example, on the burns unit we saw that legal services were advertised and that the "case manager" would support patients through this process by getting them in touch with a specialist legal department in relation to their injury. St Andrew's was the first burns unit in the county to work in partnership with a legal firm specialising in burns, and incorporate the legal element of patient's needs in their patient care. This supported the emotional wellbeing of the patient and their families.
- Emotional support available to patients and people who cared for them was extensive. This included a psychologist for the directorate. Two play specialists were employed for children's burns services. There were numerous clinical nurse specialist employed who provided nurse-led care, and or, specialist tailored support for patients.

Compassionate care

- Staff consistently acted in a friendly and caring manner with people who used the service and those close to them.
- Staff responded to patient needs promptly and always knocked before entering patient rooms throughout the service.
- In outpatient areas there were engaged/vacant signs on doors of consultation rooms which were in use, and where patients were seen in a multi-patient rooms there were curtains that had recently been put in place to ensure privacy and dignity was maintained.
- Patient's personal, cultural, social and religious needs were taken into account when plans of care we decided. Records confirmed that assessments of these needs took place on admission. This was also confirmed to us by staff we spoke with.
- Friends and Family test (FFT) results showed that most patients were extremely likely to recommend the hospital to friends of family based upon the service they received. The results from across the wards that used the FFT was outstanding in most areas.
- The trust acknowledged that the FFT for both burns and plastic services were often the best results in the trust. Records showed that plastic surgery ward results were steadily improving. For example, on Billericay ward from January 2016 (89%) to May 2016 (96%).
- On the Children's Burns and Adult Burns Rehab wards the FFT results were outstanding. We looked at data between January 2016 and May 2016 which showed 100% of patients would recommend the service.
- Senior staff confirmed that Mayflower ward were not completing the FFT despite this being an inpatient ward. A manager recognised that the FFT should be in place and told us that it was being looked into. Records from senior manager meetings confirmed that this was being discussed.
- On the Burns Children's ward we saw that a notice board displayed children and their parents/carers recent comments about their stay. There were

numerous comments which were overwhelmingly positive and demonstrated that caring was outstanding. This included, "Your staff are out of this world and thank you for all you have done" and, "You all go above and beyond here and it is recognised – thanks for everything".

- We observed numerous examples of compassionate care where staff went above and beyond to be kind. This included one episode of care we observed on Burns ITU whereby a patient living with a mental health condition, was allocated the same registered nurse per shift where possible. We observed good rapport between the patient and staff member allocated to them because of this, they were laughing and calling one another by their first name. This member of staff knew the patients likes and dislikes and ensured that care was delivered to make the patient as comfortable as possible. For example, the patient liked the door open and didn't like people they didn't know well to enter the room without a member of staff being present.
- Also, on one of the plastic surgery ward wards we saw a patient go to the ward manager and shake their hand telling them, "You and your staff are truly amazing, I cannot speak more highly of you all for your kindness and all you have done".

Understanding and involvement of patients and those close to them

- People who used the service told us that they felt involved in their care. On the Adult Burns Rehab ward "adult ward in-patient care records" were used and had boxes which the registered nurses completed when they spoke with a patient. These boxes were used to record a summary of conversation. It also prompted the nurse to ask whether there was anything else the patient wanted to discuss.
- Throughout the services there were numerous notices visible informing patients and those close to them about the service offered. For example, on the Burns Adult Rehabilitation ward there were posters regarding what local legal advice and support there was available to them, in relation to the injury the patient was being treated for.
- On Billericay ward we saw many notices which outlined the additional care and services patients were offered in relation to those living with dementia, learning disability or vulnerable elderly patients.
- In Burns rehab there was a dedicated senior nurse who was titled "case manager" whose job it was to oversee patients on the unit from admission to discharge. This ensured continuity of care.
- We reviewed one patient's set of records where we found that they had received extensive support from the psychotherapist and the case manager on Burns Rehab, due to their mental health needs. We found that they were followed up after discharge by the case manager who continued to offer them support following their burn injury.
- We spoke with a patient and their relative in the outpatient department who told us that they felt involved and understood their care and treatment fully. The patient confirmed that they were offered choice in treatment in relation to their skin condition

Emotional support

- The plastics service employed eight clinical nurse specialists(CNS). This included a CNS for head and neck, two skin CNSs, four breast CNSs and two Cleft CNSs. These nurses managed their own nurse-led clinics and fulfilled a number of additional roles. For example, the breast CNS provided a nipple tattooing service following breast reconstruction and one of these nurses was based on Stock Ward and provided specialist care during admission for patients undergoing elective breast reconstruction surgery.
- There was a range of emotional support available for people who used the service. There were two nursery nurses employed per day shift, one allocated to the children's ward and one for outpatient clinic for children's appointments.
- There were also four play specialists employed, who worked across the children's burns service, and endeavoured to ensure that children were supported with psychologically-grounded play, to prepare and distract them during care and treatment. Their aim was to alleviate children's anxieties.
- The twice daily ward rounds included the presence of the burns clinical psychologist, and therefore mental health needs of patients were assessed at every round.
- Patients that were "stepped-down" from Burns ITU benefited from follow-up and continuity of care from the same team because of the multidisciplinary team

model of care in place. This meant that if patients returned for burns reconstruction care over several years they received care and treatment from the same team who knew them well.

- The St Andrew's Centre jointly worked with the London Burns Support Group. This group is for people over 16 years of age who have experienced a burn of any size that have been treated at St Andrew's. It offered meetings four times a year, which include social events and speakers. Family and friends were welcome. This group offered support, but also provided an opportunity for patients to support other burns victims.
- The service also provided the Children's Burn Club, which is a registered charity under the umbrella of the Mid Essex Health Trust, which was funded by the London and South East of England Burn Network. The club was open to any child or young person under the age of 18 years old that had a burn injury.
- The club offered support to young burn survivors and their families to help them come to terms with burn trauma and altered body image, and included fun activities like residential camps, days out, workshops and parties, and peer support amongst members was encouraged. This support helped people rebuild self-esteem, confidence and expectations after a burn injury.
- On Burns Rehab we spoke with one patient and their relative. The patient had recently been stepped down from Burns ITU. The relative told us that Burns ITU staff had, "Supported me every step of the way through such a difficult and hard time and now [patient] has been transferred to this ward [Burns Rehab] yes I am still involved and supported without douby. I can't thank staff enough".
- We spoke with a parent on the Burns Children's ward whose child who was admitted for a burns injury. The parent told us that staff were, "Incredibly supportive and very kind" and that she had stayed with her child the entire time.

Are specialist burns and plastic services responsive?

Good

We rated responsiveness as good because:

- The directorate planned and delivered services to meet the needs of people, including an approved business case for a new trauma unit with extensive funding which had recently been secured.
- Services provided were constantly evolving to improve continuity, flexibility and choice of care.
- The needs of different people were always taken in to account and services were planned, delivered and coordinated accordingly.
- Formal complaints were low, and where received these were investigated thoroughly, an apology sent and action taken as a result with learning disseminated throughout the directorate.
- Access and flow throughout the burns service was seamless, and in the plastic surgery service significant improvement had been made and action taken to improve access and flow.

However we also found:

- There had been 795 plastics operations cancelled by the hospital in the last 12 months. Whilst there were suitable plans in place which were being actioned to address this we found thatcancellation rates for trauma patients specifcally were not being monitored robustly.

Service planning and delivery to meet the needs of local people

- The burns service had clear plans in place which set out how it planned to meet the needs of the people within its service provision boundaries. There was involvement with other organisations such as the London and South East of England Burns Network (LSEBN), whose purpose it is to "provide a framework to ensure there is a co-ordinated approach to burn care in London and the South East, and that patients have access to the best possible services". St Andrew's had regular contact with LSEBN and followed the guidelines and protocols issued by this organisation.
- Equally in the plastics service we found that information about the needs of the local people and service demand had recently been analysed and was used to inform how services were planned and delivered. This included input from commissioners and other stakeholders. For example, records confirmed that concise service planning had taken place, with a supporting business case to relocate the trauma service within the hospital in response to increased service demand.

- Services were also planned and delivered to ensure flexibility, choice and continuity of care for people who used the service. For example, the burns outreach team continued to expand and improve their services, this included a weekly nurse and therapy led clinic which was to be held in another NHS hospital in Cambridgeshire. This commenced in June 2016 and the aim was to help reduce the travel time and distance for people who used the service who lived in the North of the geographical area such as Peterborough and Kings Lyn.
- We were assured that facilities and premises were appropriate for the services that were planned and delivered. We also recognised that the new facilities that were being developed, the trauma unit, would further improve this.

Access and flow

- Patient flow into the burns service worked well. Admissions were accepted through burns consultants, and following discussion with the senior nurse lead. There were also admission guidelines in place which were followed by the service and used by the LSEBN to direct care to the centre. There was a Burns ITU admission room which had been situated purposefully and in close proximity to A&E and the Burns service entrance, which was used for transfers in.
- When adults or children were "stepped down" from ITU, they were transferred to either the Children's Burns ward or the Adult Burns Rehab ward for further care and treatment.
- Following discharge from hospital there was a dedicated burns outpatient service which was situated within the hospital close to Burns ITU.
- The burns outpatient department offered a nurse-led clinic, led by a senior sister and six registered nurses, who ran daily clinics Monday to Saturday. A consultant clinic was also run once a week on a Tuesday morning, where patients attended to discuss future plans and where burns scars were reviewed.
- There was a paediatric consultant outpatient clinic which ran on two Tuesdays each month. In order to ensure that children were treated separately from adults, as per national children's service standards, burns outpatient clinics for children were delivered from the Children's Burns ward.
- The burns outpatient department accepted new referrals of wound size 5% or less, and followed the St Andrew's "taking of new referral" guidelines.
- The burns service recognised that travelling to Chelmsford from the outskirts of the London and South East area could be lengthy for some patients. Consequently, in November 2013 the service developed a Burns Outreach service, to enable outpatients who had used the service, to be treated closer to home. This was under continuous development and recently the service had extended to provide local care in Ely, Cambridgeshire. Outreach guidance and criteria had been developed to support this system.
- There were six ITU/HDU beds used flexibly according to patient dependency in the Burns ITU department for a population of approximately 9.8 million. There were also a further two Burns HDU beds available, but these were not commissioned.
- The plastics surgery trauma service received on average 10 referrals a day. However, this could rise to 20 during busiest periods.
- Trauma patients accessed the plastics service through referral from A&Es, Minor Injury Units and GPs across the region. Records confirmed that referred patients needing treatment had risen significantly in the past five years. In early 2010 the service treated 685 cases, which rose to 1270 cases in the first quarter of 2015.
- An approved business case to develop the trauma service was in the process of being actioned, to relocate the trauma service to a dedicated trauma unit.
- The service had also improved the operation of Mayflower ward. The contingency part of the ward that was operating at our last visit in 2014 had be decommissioned, and the ward was since open as a 24 hour 7 days a week admission ward with 12 admission beds. The trauma service was run from one of the patient bays, a clinical room and a waiting room. These temporary changes to the way Mayflower operated, and the long-term plan to relocate the trauma service meant that people could access and care and treatment in a timely way. We observed this had made a significant improvement to the service, and all staff we spoke with confirmed our observations.
- Mayflower ward also ran an elective admission plastic surgery service from the ward, where all elective

admission were seen except patients admitted for free-flap surgery. Mayflower Ward consisted of two bays of four beds, four side rooms and a bay with four theatre trolleys.

- On Stock Ward we saw outstanding examples of admission processes, and good access and flow for breast patients. Patients were pre-assessed and provided with pre-operative and post-operative care, in a dedicated breast bay on Stock ward by the same nurse specialist.
- Discharge arrangements were recognised as an ongoing concern for the service. 11 out of 32 members of staff told us that this was because junior doctors were too busy to complete discharge summaries which were required prior to a patient going home.
- Senior managers confirmed that these delays were not monitored, however told us that when junior doctor posts are filled following successful recruitment and when physician's assistance were in post this would improve.
- Records confirmed that discharge summary completion had improved from 27% in February 2015 to 89.3% in January 2016.
- 15 members of staff told us that outliers (patients who were admitted under a different speciality but nursed on the ward) had greatly improved in plastic surgery. In May 2016 the average number of outliers for Billericay ward was 3.1 patients, Mayflower ward 0.7 and Stock ward 2.9. At our last inspection in 2014 we found that on some days up to 50% of patients on these wards were outliers and there these recent results showed that significant progress had been made to resolve this long-term issue.
- 80.8% of the time plastic surgey admitted patients recived their treatment within 18 weeks of referral time. This was highlighted on the services "Accountability and Performance" report dated February 2016, which stated that theatre capacity and bed capacity issues are resulting in cancellations of operations, and therefore overall performance is affected. This included 26 patients who had delays in Lymph Node biopsies. However we saw that the trust had a detailed RTT (referral to treatment time) improvement plan in place which had objectives with required by dates, and the plan was up-to-date and being monitored.
- We saw that the concern about RTTs for admitted patients was on the directorates risk register and that a business case had been submitted to improve the service provision. Senior managers were aware of the issue when we spoke with them and told us that the new trauma unit, when running, will reduce theatre use and bed occupancy. They also told us that the cancelled operations were usually owing to a lack of theatre staff being available. Records confirmed that the directorate was having daily meetings with the surgical directorate, who staffed theatres, in attempt to resolve the issue
- 93.3% of the time plastic surgey non admitted patients recived their treatment within 18 weeks of their referral.
- In the past 12 months there had been 795 plastics operations cancelled by the trust. This issue was on the service's risk register and the service was taking appropriate action to address this. This included the new hand trauma unit commissioned and due to open in autumn 2017, consultant led clinical redesign of hand trauma pathway, plastics lists were being reviewed a week ahead to review which lists can run and which patients can be treated to avoid last minute cancellations, daily theatre meetings were being held and a consultancy team were working together to support theatre redesign, including pre assessment, scheduling, booking and maximising theatre capacity.
- Senior managers told us that cancelled operations for trauma patients were not being monitored because although this data was captured through the trauma electronic system, there wasn't staff availability to collect this and analyse it. This meant we were not sure how many patients had their operations cancelled and when. Although 14 members of staff we asked told us that cancellations for trauma had improved since our last visit in 2014.

Meeting people's individual needs

- Staff confirmed that translation services were available, and could give examples when they had used them. On the Children's Burns ward there were welcome signs saying "Welcome" in many languages.
- There was good flexibility in supporting people, such as vulnerable patients with complex needs. Patients who were identified as being vulnerable in any way, such as frail, confused or with learning disabilities, had specific attention paid through the use of assessments, to determine capacity and patient's understanding.
- Additional support was considered and planned at the pre-assessment stage with the patient and relatives where appropriate. For example, if a patient had

dementia they were given a pass card, which allowed their significant other to stay with them during their entire hospital admission. This meant that the service was tailoring care to individual need.

- There was a learning disability nurse specialist for the trust. Staff we spoke with were aware of the support this nurse specialist offered, and knew how to access their contact details. Staff were also knowledgeable about the trust's safeguarding team and the dementia nurse specialist.
- There was a school teacher who was part of the children's burns service, who provided educational support to children and liaised with the child's school as required.
- On every shift there was a play specialist and nursery nurse/health care assistant on duty who were based on the Children's Burns Ward, but also offered support in Burns ITU as required.
- The Adult Burns Rehab Ward contained a gym with extensive modern rehabilitation equipment. Staff told us and we observed that the gym was well used and opened as required. There was a dedicated burns physiotherapist team and an occupational therapist to support rehabilitation.
- The trust offered special diets which met people's individual needs, such as vegetarian, vegan, gluten-free and halal meals.
- On the Children's Burns Ward environments were designed to purposefully distract and entertain children during their stay, through bright walls and colourful decoration. Children's movies were provided on bedside televisions. Children had access to play rooms which were filled with age-appropriate toys for all ages of children admitted. Throughout the service child areas were child friendly.
- The children's burns service encouraged parents to stay the night with their child, and there were enough fold-up beds for each admission. There were two relative's' rooms on the Adult Burns Rehab Ward that could be used for relatives of adult patients, so they could stay over if their loved one was admitted to Burns ITU.
- Burns ITU provided patient diaries, which are used when a patient has been sedated for some time whilst they are mechanically ventilated. After discharge from ITU, patients often report having gaps in their memory from their condition or they may remember nightmares and hallucinations. A patient diary is written by healthcare staff and those close to the patient, and includes daily entries about the patient's condition in everyday language.
- Staff confirmed that translation, advocate and specialist advice (for example legal or mental health support from local specialists) was available for all patients dependent on need. This ensured that all patients and their careers were helped to be involved and understand there are and treatment. We saw posters throughout wards which promoted these services.

Learning from complaints and concerns

- Information for people about how to make a complaint, raise concerns or compliment the service, was displayed where visitors would see it. The information included details of the Patient Advice and Liaison Service (PALS).
- Staff described the value of dealing with a person's concerns straight away before it developed into a more significant complaint. Staff said that when a concern was raised with a member of staff this would be referred to the most senior nurse on duty who would either manage the issue or escalate it to their senior. We observed this happen during our inspection.
- The directorate had received a total of 21 complaints between June 2015 to May 2016
- We reviewed three complaint responses and found that concerns and complaints were regularly reviewed by senior managers, listened and responded to, and used to improve the quality of care.
- One complaint investigation we looked at was regarding cancellation of an operation and lessons learnt were discussed at the sister's meeting and feedback to all ward staff was delivered to reduce the likelihood of reoccurrence.

Are specialist burns and plastic services well-led?

Outstanding ☆

We rated well-led as outstanding in the specialist burns and plastics services because:

- There was a clear service vision and strategy, with supporting objectives which were challenging and innovative while remaining achievable. All managers we

spoke with told us they had received training in management and leadership, and more junior staff were often given the opportunity to "step-up" and take lead of the ward or unit with support, to encourage their development.

- Leaders were visible, approachable and had a wealth of expertise in relation to their role. Staff could not speak more highly of their seniors across all wards and units and told us that leaders strived to deliver and motivate them to succeed.
- Since our last visit in 2014 the scale of improvement in leadership and shift to a positive culture was extensive, Staff were energised, passionate about their role and worked effectively as a team.
- Staff and people who used the service were engaged with the service and we saw that their views assisted service development. There were high levels of staff satisfaction and staff were proud of the organisation as a place of work. Staff at all levels were actively encouraged to raise concerns.
- There were robust systems in place to identify, analyse and manage risk, and we saw that appropriate action was taken to mitigate risk. There was plentiful evidence of continuous learning, improvement and innovation throughout services.
- Leaders were successful in the development and approval of business cases to aid service development. This included the recent Trauma Assessment Unit business case which had recently been approved with £850, 000 of funding allocated. This showed that leaders drived continuous improvement and that staff were accountable for delivery change. This was also one example of many to show that there was a clear proactive approach to seeking out and embedding new and more sustainable models of care.
- Where we identified concerns, or where the service had known concerns, we found that managers took immediate action to resolve the issues. This included the concerns we have addressed under the safety and responsive domain relating to; junior doctor shortages, low rates of MRSA screening, referral to treatment times and high rates of cancelled surgery.

Vision and strategy for this service

- The trust vision and set of values was visible throughout the wards and corridors. Staff knew and could quote these.
- The directorate was part of the trust's 2011-2016 trust-wide clinical strategy, and with the Essex Success Regime being developed, the directorate recognised that the creation of the next strategy, 2017-2022 would not be formed until after these changes have occurred. Informal discussions, which were recorded, had already begun for the directorate which showed the direction and improvements the services were heading toward.
- On the Children's Burns Ward there was a specific philosophy that had been developed and recorded, with a clear vision and strategy for that specific area. This was an example of outstanding practice.
- New set objectives since our last visit in 2014 included the development of the new hand trauma unit and expantion of the burns outpatient outreach service.

Governance, risk management and quality measurement

- The service had systems in place to identify, monitor and manage risk effectively. Incidents, serious untoward incidents, complaints and audits were analysed and reported to the governance team. This system was robust and effective.
- This included a risk register which was up-to-date with clear lines of accountability, regular meetings to review burns and plastic surgery performance and strong leadership of the individual areas and directorate as a whole.
- The service measured service quality through an indicator dashboard. There was one dashboard for each inpatient area and these indicated elements of risk within the service. The dashboard was colour coded (green, amber and red). If an area was highlighted "at risk" it was presented in red, which alerted those scanning the dashboard.
- The dashboard contained information such as patient falls, pressure ulcers acquired, MRSA incidences and staff sickness rates. Managers were aware of the areas that were "red" on the dashboard from their clinical area and had plans in place to address these issues. For example, in Burns ITU appraisal rates were flagging as red as they were lower than the trust expected and managers were taking appropriate action to improve this.

- CUSUM data was used to measure service quality in terms of mortality rates (as previously described thoroughly under the "Effective" section of this report).
- The directorate held regular governance, clinical MDT, sisters, local ward and quality and safety meetings. This was an opportunity to identify risk and drive improvement across the service. All these meetings were well attended and minuted.
- Each area undertook a safety huddle daily, which included the nurse in charge of the clinical areas and a senior manager, to determine risk and plan service arrangements accordingly. For example, if shifts were left vacant or there was a high risk patient on the ward.
- Staff had access to a folder on each area, which included risk assessments undertaken of the local environments and copies of the trust's risk management policy.
- Where we identified concerns, or where the service had known concerns, we found that managers took immediate action to resolve the issues. This included the concerns we have reported on under the "safety" and "responsive" domain relating to; junior doctor shortages, low rates of MRSA screening, referral to treatment times and high rates of cancelled surgery.

Leadership of service

- The directorate was led by a head of nursing and a clinical director, who was the lead burns consultant. There was a matron for both burns and plastics services.
- There were display boards within each area which had photos of the staff employed, their names and job roles. This meant that leaders were easily identified by patients and visitors.
- Senior ward managers were dedicated, enthusiastic and inspiring. The managers of each unit demonstrated clear leadership principles and the trust values. Staff spoke highly of their seniors. They said that they felt respected, valued , well-supported and driven to strive by managers. Each inpatient area had a regular team meeting, and we saw that minutes of these meetings were communicated to each member of staff. Staff we spoke with were able to give us examples of what they had learnt from attending or reading meeting minutes.
- Ward managers were offered to attend, and many had achieved training in leadership and management.
- In Burns ITU junior nursing staff were offered the opportunity to act-up as band 7 (sister level) nurses with support, to encourage their development and team cohesion.
- There had recently been a trauma consultant appointed, who staff spoke highly of the service and leadership, and told us that this role had driven significant improvements in the trauma service. In addition there was an allocated trauma nurse at all times, and a trauma coordinator available Monday-Friday.
- When we spoke with senior staff there was a clear alignment between the recorded risk and what these members of staff told us was on their "worry list". These members of staff also recognised that that action was already being taken to address these concerns.
- We noted that there had been significant improvement in relation to safety and effectiveness of the service since our last visit in 2014. Managers were taking necessary steps to action known risk. This included the staffing issue in Surgery which impacted on the staffing of plastics theatres leading to cancelled operations. We have reported on this further under the responsive section of this report. However we also recognise that there is still some improvement required including; the need to monitor the number of cancelled operations for trauma patients.

Culture within the service

- Staff were very open and honest with inspectors. They said what worked well and what did not work as well.
- Staff said they would raise concerns with managers if necessary, in line with the trust's whistleblowing policy and they felt that they would be listened to. Staff gave examples of when they had done this and how managers had taken appropriate action. They also told us that managers encouraged them to raise any concerns they had.
- Across the directorate there was a positive ethos, immense pride in service quality, and mutual respect between colleagues. In plastic surgery we noted that staff were energised and excited about the new changes to the plastic surgery service that were in progress.
- Staff throughout the service said that they were passionate about their job, felt respected by peers, and were well support by their seniors. They also told us that there had been immense improvement in relation to all the domains we inspect to since our last visit in 2014.

Specialist burns and plastic services

Public and staff engagement

- Staff from the burns service told us that they were encouraged to be involved in service development and that the regular team meetings were an opportunity to raise ideas. Managers from the plastic surgery wards told us that they have been heavily involved in the service design of the new trauma unit.
- The Children's Burns Ward was purpose built in 2010. Staff told us that they were involved in the design, and that they regularly attend other burns units to get new ideas for their area.
- Staff also confirmed that they are actively involved in leading, planning and delivering the trust's Children's Burns Club. Staff spoke passionately about the positive impact this club had in supporting children as they grew up with their burns.
- An inpatient survey, in the form of the Friends and Family Test, was conducted monthly in each ward area except Mayflower ward.
- Senior managers that we spoke with visited clinical areas daily to assess risk and see whether further support was required. These managers demonstrated the value of staff raising a concern and we saw that action was taken as a result.

Innovation, improvement and sustainability

- Local managers had formed a business case which had been approved and subsequently the plastics service had been allocated £850,000 of additional funding to develop and maintain a new trauma assessment department.
- Twice daily multidisciplinary (MDT) ward rounds had been developed by the service, which meant that patients across all areas were reviewed at least twice daily by the entire team, which in turn improved MDT working relationships and continuity of care.
- A Children's Burns Club had been developed for children who had sustained a burn and used the service. There was also clubs for young adults and adults offered regionally.
- On the Burns Rehabilitation ward, a recent enhanced rehabilitation project had been undertaken which had led to a 35% reduction in LoS for burns patients. This project had recently been presented by the team, led by a physiotherapist, at a "British Burns Association" (BBA) annual event, and led to improvements in rehabilitation services provided within the service.
- The trust also supported nurse-led treatment. The breast care nurses offered a nipple-tattooing service to patients who had undergone extensive breast surgery.
- On-going charity work, led by the service, occurred, which in turn was used to improve the club and the burns service provision. For example, charity funding was used to buy clothing for patients who could not afford them.
- The service had developed an intense three day burns training programme, which was available in-house, but was also available for other organisations and professionals to attend via the British Burn Association (BBA) website.
- The St Andrew's Centre was part of the first study to develop and implement real-time outcome monitoring for mortality in burns using CUSUM techniques. The study described a successful early warning system to monitor outcomes in burns intensive care settings.
- The trust told us that 60-70% of plastic surgeons across the UK had trained and worked at St Andrew's.
- The directorate had developed its own research unit called the, "St Andrews Anglia Ruskin Burns and Plastic Surgery Research Unit" (StAARS), in partnership with the local Anglia Ruskin University in Chelmsford. The aim of StAAR was to, "to restore wounds, promote healing and allow the body to regenerate new tissue instead of scarring; better understand scar modulation and design new pathways of rehabilitation (physical therapies); and develop cost-effective, reproducible techniques based on existing technology that can be disseminated as common practice in modern regenerative medicine and surgery". The StAAR team had published over 20 papers in peer-reviewed journals, presented over 100 papers at national and international scientific meetings and given 20 invited lectures at scientific meetings.
- The trust and breast reconstruction nurses had set up a 'Breast Reconstruction Awareness' (BRA) group, which was a registered charity. We found that the money raised through this scheme had been used to make various improvements within the breast service. We observed outstanding breast reconstruction pathways, and numerous applicable patient information booklets, which had also been funded by the BRA charity.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology includes all services provided to women that relate to pregnancy, including antenatal, day assessment unit, labour and birth, and postnatal care. Broomfield Hospital has 56 beds, providing all levels of maternity care, and Mid Essex is part of the Midlands and East Local Supervising Authority.

There were 4,436 deliveries by Mid Essex NHS Trust between July 2014 and June 2015.Between January 2016 and June 2016 there were 2204 deliveries.

The inspection team visited antenatal and postnatal services, as well as the labour ward, and theatres providing obstetric-related surgery. We observed care on Gosfield (gynaecology) Ward, and visited the midwifery-led birthing unit located within labour ward. We did not visit the maternity services at Braintree or Maldon during this inspection.

We received comments from people who contacted us to tell us about their experiences. We used information provided by the organisation and information that we requested, which included feedback from women using the service about their experiences.

We spoke with 10 people who used the service and over 30 members of staff including senior managers and service leads, managers, midwives, consultants, doctors, nurses, anaesthetists, support workers, administrators and domestics. We also reviewed 15 sets of care records

Summary of findings

- There was good evidence of incident reporting and learning from incidents with examples of how practice had been changed. Investigations reviewed demonstrated that there was a clear process in place including the discharge of duty of candour.
- Patient risk assessments such venous thromboembolism (vte) were completed.
- There was a good compliance of mandatory and specialist training amongst midwifery, gynaecology and medical staff, including Cardiotocograpghy (CTG – machine to record babys heart rate and contractions in the womb). There was 100% compliance with skills and drills training in midwifery and medical staffing, which ensured that staff has the required level of competency to attend to emergency situations.
- The trust had successfully recruited midwives, and had introduced a dedicated ward coordinator role which ensured that capacity in the maternity unit, clinical need and staffing was consistently monitored throughout the 24 hour period to ensure women's safety.
- There was good evidence of engagement with national and local audits and self-assessment to benchmark against recommendations. The trust had responded to the high level of caesarean rates,

through a dedicated project to reduce the number and increase natural births. This project was known as “project 2%, which had shown a reduction in caesarean sections.
- Women were treated with dignity, kindness and respect throughout the service and were given information about their care so that they could make informed choices.
- There was a process in place for the monitoring and management of delayed inductions. There was evidence of innovation such as the introduction of the telephone triage system in maternity. This ensured that women were referred to the most appropriate pathway for their clinical need
- There were excellent examples of leadership at unit level and directorate level. There was clear direction and commitment from the Head of Midwifery and clinical directorate in ensuring the best service for women across maternity and gynaecology. Managers at unit level were engaged and passionate with good examples of how they were driving change to improve womens care

However:

- Staff were not recording Modified Early Warning Scores (MEOWS) in line with guidelines. The trust had an action plan in place to address this and had reviewed the number of times staff were having to write MEOWS scores on different charts. This had led to the streamlining of documentation and improved compliance.
- Screening for elective and non-elective women was consistently below target of 98% target from February 2015 to January 2016 ranging from 75% to 97%.
- The Maternity safety thermometer data was not available at the time of inspection as data collection had commenced in April 2016.
- The ratio of Supervisor of Midwives to midwives was below the recommended 1:15 ratio. The ratio of Supervisor of Midwives (SoM) to midwives was 1:17 from January 2015 to February 2016.
- There was no fast track dedicated pathway for women admitted with gynaecology problems through the emergency department. Although this was being addressed, this had been identified in the previous inspection in 2014.
- HSA4 forms (used to notify government in termination of pregnancies carried out) were sent to the Chief Medical Office, within the 14 days in line with the Abortion Act 1967. This is a breech of Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

We rated this service as good for safe because:

- There was good evidence of incident report and learning from incidents.
- The environment and equipment was found to be clean, in good working order and compliant with regular checking.
- There was a dedicated team who managed womens notes and ensured that these were kept contemporaneously and accessible. It was acknowledged during the inspection that the trust would be moving to an electronic notes system.
- There was overall a good compliance of mandatory and specialist training amongst both midwifery, gynaecology and medical staff, including Cardiotocograpghy (CTG – machine to record babys heart rate and contractions in the womb).
- There was consistent compliance with Venous thromboembolism (VTE) assessments.
- There had been successful recruitment to vacant midwife positions.
- The dedicated maternity ward coordinator role had been introduced which ensured that capacity in the maternity unit, clinical need and staffing was consistently monitored throughout the 24 hour period to ensure women's safety.
- There was 100% compliance with skills and drills training in midwifery and medical staffing, which ensured that staff has the required level of competency to attend to emergency situations

However:

- MRSA screening for elective and non-elective women was consistently below target of 98% target from February 2015 to January 2016 ranging from 75% to 97%.
- Maternity thermometer data was not available at the time if inspection, however it was noted that data collection had only begun in April 2016.
- The most recent audit of compliance in staff recording MEOWS (Modified Early Obstetric Warning Score) scores was 52.3%.

Incidents

- No new Never Events (serious incidents that are wholly preventable) had been reported from March 2015 to March 2016.
- 1403 incidents were reported between April 2015 to April 2016 across maternity and gynaecology services. The top three incidents were obstetrics and gynaecology (457), which covered a range of incidents for example blood loss post-delivery, neo natal (101), which covered incidents such as unplanned admissions to neo natal unit and blood transfusions (85), which covered incidents such as blood wastage or incorrect completion of blood bag tags.
- There was good evidence in learning from incidents. For example there had been two serious incidents in relation to the misplacement of drug charts, which led to a delay in intravenous antibiotics being administered to unwell babies. Following these incidents all babies who required IV antibiotics were escorted from the post-natal ward to the neo natal ward, with the midwife and notes to ensure that charts are handed over from midwife to midwife. Since this had been introduced there have been no further incidents of this kind.
- Three serious incidents reports were reviewed from January 2016. The quality of the reports were good, in that they were thorough, terms of reference defined and robust level of investigation had been completed.
- There was evidence such as letters and records on incident investigations, that duty of candour had been carried out. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The gynaecology clinic provided examples of learning from incidents and how they managed this within a clinic environment. For example an incident form had been completed for an incorrect booking of clinic. This had been fed back to the relevant staff member, who had received additional training and the patient had been contacted to offer an apology

Maternity and gynaecology

- Across maternity and gynaecology there were daily "safety huddles" to ensure that any incidents or patient safety concerns such as staffing were discussed and managed.
- There was evidence of puerperal sepsis (infection related to giving birth) incident forms being completed and investigations had been completed. Between October 2015 to December 2016 six incident forms had been completed, all resulting in no harm to the woman.
- Perinatal mortality and morbidity was discussed monthly at the directorate governance meeting. We reviewed the minutes from the meeting held in February 2016 which showed discussions and case reviews by multidisciplinary teams to consider any changes to practice and to improve outcomes for women.

Safety thermometer

- The NHS maternity safety thermometer allows service providers to determine harm free care, but also records the number of harm(s) specifically associated with maternity care. The service started the maternity safety thermometer in April 2016, which is later than would be expected after being introduced nationally in 2015.Data was not available at the time of our inspection.
- There was clear communication in clinical areas alerting staff to the maternity safety thermometer, and that information would be available once data had been processed and published.

Cleanliness, infection control and hygiene

- In the past 12 months there had been no reported clostridium difficile (bacterium that can infect the bowel and cause diarrhoea) and no Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia incidents in maternity or gynaecology.
- Key performance indicators on the infection prevention dashboard relating to urinary catheters and peripheral line insertion (flexible tube placed into vein) could not be separated out into maternity and gynaecology, as results were presented for the overall womens and childrens directorate. The February 2016 divisional healthcare associated infection scorecard showed that maternity and gynaecology (including childrens) was compliant all areas, including hand hygiene, bed pan audit and isolation of MRSA
- MRSA screening for elective and non-elective women were consistently below the 98% target.Between February 2015 to January 2016 ranges were between 75% to 97%.
- Staff were compliant with the trusts infection control policies and protocols. Staff were observed to practice good hand hygiene, used personal protective equipment appropriately and were bare below the elbows.
- There were daily cleaning checks in place in all of the clinical areas. This included daily cleans of the birthing pools.
- Clinical areas were visible clean and tidy
- Curtains around bed spaces were on a three monthly replacement programme. However staff told us that if curtains became soiled, then they would be able to contact the domestic lead, and the curtains would be changed immediately.

Environment and equipment

- Two Cardiotocograpghy machines (machines to monitor fetal heart rate and uterine contractions) were checked. Both were in date, in working order and clean and tidy.
- Resuscitation equipment in all areas of maternity and gynaecology was in line with national guidance and been checked regularly. We reviewed checklists for previous two months which showed that checks had been completed on a daily basis.
- Neonatal resuscitaires were checked in maternity and obstetric theatres. They were clean, tidy, in working order and had been checked. We reviewed checklists for the previous two months which showed that checks had been completed on a daily basis.
- We looked at various pieces of equipment throughout the directorate for example infusion pumps, and found that they had been serviced and had dates on the equipment when they would require re servicing.
- Each inpatient area had a buzzer entry system. Visitors were required to use the intercom and identify themselves upon arrival before they were given access. Staff had swipe card access and there was close circuit surveillance cameras monitoring clinical areas. This assured us that the environment was safe from possible child abduction.

Medicines

- Fridges were fitted with electronic thermometers which recorded temperatures. All fridges across maternity and

gynaecology had daily recordings of fridge temperatures, and all were within the recommended range, meaning that medications were stored appropriately.
- All patients tablets to take home (TTOs) in the ward areas, were logged so that pharmacy could account for them when completing stock checks.
- We were told a clinical pharmacist visited the ward ''occasionally''. They would undertake clinical checks on patients prescribed medicines.
- Checks to ensure that any known allergies or sensitivities to medicines were recorded accurately on patients' prescription charts within 24 hours of admission. This information is important to prevent the potential of a medicine being given in error and causing harm to a patient. We checked two prescription charts which had been correctly documented, signed and dated by the doctor. This follows trust policy.
- We found that medicines were stored safely and securely. Secure access was limited to nursing staff. Controlled Drugs which require special storage and recording were stored following good guidance procedures including daily checks by two nurses on quantities and records.

Records

- Women kept hand held notes throughout the duration of their pregnancy. Once the woman had delivered , the hand held notes, discharge letter, any surgical notes for example if undergone caesarean section, were returned to the ante natal clinic. The notes were then checked, filed, added onto the patient administration system (PAS) and tracked back to the records library.
- If records were required on weekends and out of hours, for example if a woman attended the emergency department, staff on the labour ward and assessment unit could access the office where the patients notes were stored.
- The staff member retrieving the notes would then check them out on the PAS to the relevant clinical area. This would ensure the appropriate tracking of the notes to ensure that they did not get lost.
- 15 sets of women's notes were reviewed; all had Venous thromboembolism (VTE) assessments completed. This was consistent with the maternity and gynaecology quality report which showed that VTE assessment had been compliant from February 2015 to January 2016.

Safeguarding

- There are three levels of safeguarding children training. Level 1 provides a baseline understanding, Level 2 provides greater knowledge for those working regularly with children and Level 3 provides high level of knowledge for staff working in complex situations and who have to assess, plan, intervene and evaluate needs of children (Working together to safeguard children: HM Gov 2015).Mandatory training for Safeguarding children rates for maternity and gynaecology staff in March 2016 showed that the service met the trusts target for 95% compliance for level one and level two training. Level three was 88.9% for maternity and 89.9% for gynaecology
- Safeguarding adults training across maternity and gynaecology was 95.9% against the trust target of 95%
- There was a clear protocol for management of termination of pregnancy for young people under 13 years of age. These identified the correct process, safeguarding referrals and paediatric care. It also specified and differentiated the legal requirement for children and young people under 13 years of age, specifically around under 13 years of age not able to give consent legally for sexual activities.
- Staff were able to tell us of how and when they would raise a safeguarding concern. There was a clear escalation process in place, in which notifications were made to the community midwife and neo natal unit, including after delivery and referral to social services
- From August 2015 to March 2016, 16 members of midwifery and medical staff had completed specific training on honour based abuse, force marriage and Female Genital Mutilation (FGM). This was in addition to the FGM training included within the mandatory training programme.

Mandatory training

- Maternity and gynaecology were compliant with the trusts target for mandatory training in March 2016.Mandatory training covered a range of topics, such as, fire safety, medicines management and infection control. For the month of May 2016 infection control compliance was 97.4% against the trust target of 80%, medicines management 97% against the trust target of 95% and fire safety at 97% against the trust target of 95%

- Midwives and medical staff completed Cardiotocograpghy (CTG – machine to record babys heart rate and contractions in the womb) yearly as part of mandatory training. The trust held a masterclass for midwives and medical staff to ensure that training was consistent. Staff also had access to an on line update every six months.
- In May 2016 100% of medical staff had completed CTG training, 100% of senior midwives (Band 8 and above), 83% of Band seven midwives, 86% of Band 6 midwives and 80% of Band five midwives.
- Midwives and medical staff also completed specialty specific mandatory training. In May 2016 100% of midwives, consultants, specialty doctors and juniors doctors had completed this additional training, in subjects such as perinatal mental health, maternal resuscitation, breast feeding and skills and drills training (training specifically for obstetric emergences)

Assessing and responding to patient risk

- The trust had completed an internal audit in March 2016 to look at compliance in staff recording MEOWS (Modified Early Obstetric Warning Score) scores. The results showed that only 52.3% of observations were record fully. However, there was an action plan in place. This included the amendment of health care records, which had reduced the number of times staff had to repeat recording MEOWS scores in a number of different locations in the paperwork. The MEOWS audit is carried out quarterly.
- 15 sets of women's maternity and gynaecology notes were reviewed. All had completed MEOWS and there were records in relation to escalation and monitoring. For example we reviewed one set of notes from a woman who had a suffered a significant amount of blood loss. Observations had been recorded and there was a clear documented plan of care in place. However out of the 15 sets of notes, four sets did not have the babies weight recorded. This was escalated to the manager at the time of the inspection.
- Notes contained a clear MEOWS trigger process, for example if sepsis was suspected. This included a flow chart outlining the requirement of frequency of observations and collection of blood cultures.
- The maternity unit had introduced a new Newborn Early Warning Score (NEWS) observation chart in May 2015, in response to a serious incident. The chart had been deigned in in conjunction with medical staff, and ensured that there were clear instructions on frequency of observations, and defined parameters for when to escalate for medical intervention.
- Out of 15 sets of notes reviewed, all NEWS observations had been recorded in line with frequency. One set of observations had required escalation, a review had been completed and a plan put into place.
- During our inspection an emergency situation developed on the labour ward. The emergency alarm was raised. Staff responded promptly. The woman was quickly transferred into the second obstetric theatre with the emergency team in place within minutes (as the first obstetric theatre was still running).
- All midwifery and obstetric staff attended yearly speciality specific training which included skills and drills training, and covered emergency scenarios such as the management of postpartum haemorrhage (PPH), maternal resuscitation and early recognition of the ill patient. The unit had dedicated skills and drill trainers, to also facilitate "ad hoc" sessions for staff .In May 2016 100% of midwifery and obstetric staff had completed the training
- Anaesthetists offered one hour training sessions in the monthly training sessions for midwives, which included management of sepsis, epidural management and critical care
- Maternity and obstetric theatres used the World Health Organisation (WHO) safer surgery checklist. Audit data was displayed in the obstetric theatres and showed results between July 2015 to November 2015 had achieved between 94-100%, against a target of 100%.
- There was a dedicated midwife lead for sepsis. The maternity department sepsis packs were in place along with an early recognition tool. Staff were aware of this tool, and had received training in sepsis management.
- There was a dedicated sepsis box in the clinical area, which provided staff with an algorithm on how to manage women in which sepsis was suspected.
- There were clear in date guidelines for the transfer of mothers and babies to different care settings, for example from home or midwife led care to a consultant led unit. During our inspection we witnessed a transfer from a midwife led unit into labour ward. There was clear handover and management of the woman, who was seen within five minutes of arrival by the obstetrician.

Maternity and gynaecology

Midwifery staffing

- Staffing data compiled between March 2014 and May 2015 showed an average of 1:30-1:31 midwives to birth ratio which was consistently higher than the national average, and not in line with the Royal College of Midwives 2010 guidance of 1:29, however the ratio had improved since our 2014 inspection.
- The trust had recently recruited 20 midwives to bring the ratio to 1:30. The trust had nine whole time equivalent vacancies remaining. These vacancies had been allocated to new midwives due to start in September 2016, with an additional two whole time equivalents recruited to cover known staff who were retiring or due to leave. The review of midwifery staffing had been completed in line with Birthrate plus tool (framework for workforce planning).
- The maternity service had introduced a dedicated maternity ward coordinator who covered 24 hours per day and was supernumerary. This ensured that an oversight of capacity and clinical need was monitored through a 24 hour period.
- The dedicated maternity ward coordinator ensured that there were enough midwives available to deliver care to women and babies. At the start of each shift the coordinator would review staffing levels and clinical need at the morning "safety huddle" (daily morning hand over period). Staffing levels were monitored and reported to the chief nurse.
- The coordinator also monitored "red flag "events (warning signs that there are too few midwives), for example women not receiving full examination in labour. The events were captured on the trusts incident reporting system and manged by the maternity coordinator who would redeploy staff if a red flag event had occurred.
- The maternity unit had introduced a Band seven team leader, who rotated between clinical areas. This developed staff in transferable and flexible skills that could support the service in times of staff shortages or red flag events.

Medical staffing

- Consultant obstetric cover in the delivery suite was 66 hours a week between January 2014 to January 2015. The Royal College of Obstetricians: safer childbirth: minimum standards for organisations and delivery of care in labour (2007) state that a unit that has between 2500 – 6000 births (Mid Essex had 4436 between July 2014 to July 2015) would require 40 hours per week of consultant cover, which the trust was achieving.
- Visible consultant presence consisted of 12 hours Monday to Friday and 9am – 1pm on the weekends. An on call system ran from 8am on a Friday through to 8am on a Monday.
- There was a dedicated "Hot Week' in which one consultant obstetrician was rostered to be purely available for the Consultant-led Unit and Gynaecology Services.
- There were nine consultants, including one locum. One consultant was due to retire in the near future. There were plans to recruit a further two consultants with the replacement post and the replacement of an associate specialist, bringing the total number of planned consultants to 10 once the recruitment was complete.
- There was a dedicated obstetric specialist registrar who was rostered to cover the labour ward 24 hours per day on a 12 hour shift basis.
- The medical staffing skill mix was of a similar proportion of consultants and junior doctors to the England average. Consultants at 36% compared with national average of 35%, registrar group 32% lower than the national average of 50% and juniors at 9% higher than the national average of 7%.
- The middle grade rota had eight doctors, three trainees and five staff grades.
- The Foundation year doctor rota had three doctors on it.This provided adequate cover to the service
- Monday to Friday there was a consultant anaesthetist on duty on delivery suite from 07.45-18.15, and a consultant on call from home for obstetric and paediatrics.
- Staff grade anaesthetists rotated every 12 weeks, which included obstetrics.

Major incident awareness and training

- Maternity and gynaecology services followed the trust's major incident and escalation policy. Major incident information was available for all staff to access on the trust's intranet.
- On a yearly basis the maternity unit would run a random 'emergency simulation'. An example given was a

simulation training session following a recent shoulder dystocia (when the baby's head has been born but one of the shoulders becomes stuck behind the mother's pubic bone).
- There were other escalation polices to staff including the abduction policy. Staff felt confident in reporting mechanisms and that support from managers and the head of midwifery would be available in the event of a major incident.

Are maternity and gynaecology services effective?

Good

We rated this service as good for effective because:

- There was clear engagement with both national and local audits and evidence of self-assessment to benchmark against recommendations.
- There was evidence of improvement from the recent audit of labour epidural analgesia, from the previous year, and the on-going monitoring to become complaint with the Royal College of Obstetricians and gynaecology recommendations.
- The trust had responded to the high level of caesarean rates, through a dedicated project to reduce the number of caesarean rates and increase the number of natural births. This project was known as “project 2%.
- Women were supported in breastfeeding through dedicated midwives, training and a number of clinics, which also supported women who chose to bottle feed.
- Guidelines that were reviewed were in date and had been updated in line with changes, for example the Human Tissue Authority guidance in relation to disposal of fetal tissue.
- There were Good examples of multi-disciplinary working across the trust and external organisation.

However:

- The ratio of Supervisor of Midwives to midwives was below the recommended 1:15 ratio. The ratio of Supervisor of Midwives (SoM) to midwives was 1:17 from January 2015 to February 2016.
- The trust performed below three out of the five standards for the National Neonatal Audit programme (NNAP) 2014.

Evidence-based care and treatment

- In each clinical area there was a dedicated file containing contemporaneous documents logging local and national guidelines, roles and responsibilities of staff, structure of the service and objectives.
- The trust performed below three out of the five standards for the National Neonatal Audit programme (NNAP) 2014. The three areas below the NNAP were: babies having their temperature taken within an hour of birth, babies who had received mothers milk when discharged from the neo natal unit and documented consultation with parent by a senior member of team within 24 hours of admission.
- There were a number of local audits. For example the midwife who ran the body mass index clinic had recently completed an audit looking at weight gain during pregnancy. This was due to be presented at the next internal audit day and at the East of England Maternity Obesity conference.
- There was evidence of self-assessment against recommendations from National Audits. For example we saw evidence from the self-assessment in relation to the recommendations from the national ‘Heavy Menstrual Bleeding’ audit, in which the trust identified good practice such as the dedicated one stop menstrual disorder clinic.
- There was evidence of local audits in response to areas of concerns. For example the audit completed in July 2015 in response to the high level of caesarean rates. There had been a retrospective audit completed which had clear recommendations such as increased Cardiotocograpghy (CTG – machine to record babys heart rate and contractions in the womb) training for midwives and medical staff. This audit had been completed in conjunction with maternity ‘project two per cent’, which was working to reduce caesarean rates and promote normal birth.
- We reviewed number gynaecology guidelines for example menstrual bleeding. All guidelines reviewed were in date, clearly referenced, comprehensive and based on guidelines from the National Institute for Health and Care Excellence (NICE).
- The maternity unit followed the NHS Newborn and Infant Physical Examination (NIPE). Competent

midwives carried out NIPE examinations Monday to Friday and at weekends paediatricians would carry out the NIPE assessments. There was clear criteria for those babies who required referral.

Pain relief

- The midwife led birthing unit offered the women a range of alternative methods for pain relief, such as two birthing pools, aromatherapy and hypnobirthing.
- In the gynaecology clinic alternative methods of pain relief were offered for women undergoing hysteroscopy (inspection of the uterine cavity), these included warming fluid and heat pads
- Patient Controlled Analgesia (PCA) was offered to women undergoing medical terminations on Gosfield ward. This was overseen and supported by the anaesthetic team.
- Staff could access anaesthetists 24 hours per day for the management of pain for example epidurals.
- The recent audit completed in June 2015 for response time for labour epidural analgesia showed an improvement in response to pain times. In June 2014 the response time was 38 minutes, and in June 2015 was 32 minutes. This is against the Royal College of Obstetrics and Gynecology recommendation of 30 minutes. Whilst the trust was not quite achieving the target there had been improvements.
- Midwives on the midwife led birthing unit received training in alternative therapies for pain relief such as hypnobirthing and aromatherapy.

Nutrition and hydration

- The post-natal ward had recently recruited a dedicated breast feeding maternity assistant to support women who were breastfeeding. This post was created following work by the breast feeding specialist midwife. An information leaflet had been produced called "getting off to a good start", which provided prompts and guidance for women when starting to breastfeed. All staff (including bank staff) received a yearly, two day training course on breast feeding.
- Women were given the opportunity to attend a number of infant feeding clinics. These clinics supported women to achieve good feeding, for both bottle and breast fed babies.
- Breast feeding rates for babies at 10 days old ranged from 73% to 74% between January 2016 and May 2016, against a target of 75%.
- Women had access to tea, coffee and biscuits 24 hours per day. There was availability of water at each patient bedside which was supplemented by refreshment round. Women were able to being in their own food and had use of a microwave.

Patient outcomes

- The trust did not have any active maternity outliers.
- There was evidence of improvement for the Newborn screening compliance .The avoidable repeat rates (those that required to be repeated due to insufficient sample) had risen to 8.4% against the recommended target on less than 2%. Additional training had been provided and the rate is currently at 1.8%.
- There were two dedicated midwives and one dedicated neonatal lead nurse who ensured that data was collected and reported, relating to all births between 22+0 and 23+6 gestational age who did not survive the neonatal period. This was in accordance with recommendations from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE Proportions of delivery methods between October 2014 to September 2015 were: elective caesarean 13.8%, which was higher than the England average of 11.2%. Low forceps 6.7%, which was higher than the England average of 3.5%. Ventouse delivery 5.4%, which was lower than the England average of 5.8%, and normal non-assisted delivery of 58.3%, which was lower than the England average of 60.1%.
- The trust had worked to decreasing caesarean rates and had requested the Royal College of Obstetricians (RCOG) to complete an internal review of Caesarean sections. An action plan had been put into place and the trust had run an internal project called 'project two per cent'. The aim was to reduce caesarean section rates and promote vaginal birth. The maternity dashboard results showed that elective clinical caesarean had decreased from 12.8% in April 2016 to 8.4% in May 2016 against a target of less than 7%.This project remains on going.
- The maternity services did not have a high dependency unit for women. Women who required intensive care were transferred to the main high dependency unit or intensive care unit. Between March 2015 to March 2016 there had been one maternal unplanned admission to the intensive care unit.
- Between March 2015 to March 2016 there had been three unexpected admissions to the neonatal intensive care unit. There were clear guidelines in place for

admissions to the neonatal intensive care unit, which included admissions from home birth, labour ward and post-natal ward, and identified the responsibility of each staff group.
- Gynaecology had implemented the 'Enhanced Recovery Programme' for women undergoing hysterectomy. This programme aimed to reduce complications following surgery and expedite recovery. Staff told us that this started in the gynaecology outpatient clinic where women were provided with the enhanced recovery programme information, including the pre load nutritional supplements to take prior to their surgery.
- There was a dedicated Antenatal and Newborn screening midwife who uploaded data into the screening programme database, and attended the Antenatal and Newborn screening programme board meetings. The National screening committee visited in September 2014, in which the percentage of key performance indicators were met.
- There was evidence of updated guidelines in response to the changes made by the Human Tissue Authority (HTA) in relation to incineration of fetal tissue, meaning that women who experience pregnancy loss of less than 24 weeks (including termination of pregnancy) are made aware of the options disposal, with the options of Cremation and burial being the default methods
- The maternity service had recently been awarded level two accreditation by the Baby Friendly Initiative (supporting all women in their choice of infant feeding)

Competent staff

- The ratio of Supervisor of Midwives (SoM) to midwives was 1:17 from January 2015 to February 2016, set against a recommended ration of 1:15. The role of the SoM is someone that midwives may go to for advice, guidance and support. The SoM will monitor care by meeting with each midwife annually, and actively promotes excellence in midwifery care.
- Newly qualified midwives or those new to the trust received preceptorship for one year. This involved internal placements across maternity and gynaecology services and a competency based workbook.
- Staff returning from maternity leave or long term sickness, met with the dedicated practice development midwife who would agree learning outcomes to ensure that staff were competent and up to date in any changes in practice
- Displayed in all areas were "hot topics" of the week which provided staff with bite sizing learning. The topics were also covered in a quiz that was used in mandatory training. A range of topics were covered for example identification of malpresentation and jaundice in babies.
- Medical staff completed appraisal through a dedicated IT system for medical staff. There were designated responsible officers and appraisers in place. The human resources manager monitored appraisals and ensured that they did not lapse. 100% of consultants in the service had received an appraisal.
- Midwifery staffing appraisal compliance for February 2016 was 86.1% against a target of 90%.
- Gynaecology staffing appraisal compliance for February 2016 was 87.4% against a target of 90%.
- Six Medical staff told us that training and teaching opportunities were good, and Consultants were able be flexible to use cases for training and achieving training needs for medical staff

Multidisciplinary working

- The maternity service had introduced a dedicated midwife and administration staff to become the point of contact for independent midwifery services, who may need to refer women into the trust. The trusts risk and governance lead linked in with the independent providers risk and governance lead to ensure consistency in relation to governance arrangements.
- An example was provided in which a woman requested a home water birth under the care of the independent provider, although identified at high risk. The trust worked in conjunction with the provider to ensure the safety of the woman, who delivered in the maternity unit. A further example was seen on labour ward with a woman who had required a blood transfusion had been referred in to the ante natal clinic, and subsequently admitted.
- Staff told us that there were good working relationships across the trust for example the outreach team in intensive care who would come and review women upon request, as well as the neonatal unit staff who would come very quickly if called by a member of staff.
- There was a dedicated obstetrics and gynaecology physiotherapist, who worked Monday to Friday, and was

an integral part of the woman's pathway if they had undergone caesarean section, or sustained third or fourth degree tears. Midwives could refer directly into the physiotherapist.
- There was a dedicated diabetes specialist midwife who linked the diabetes services and maternity services, for example women could refer themselves into the diabetes centre, who then would contact the specialist midwife.
- The trust had good relationships with two other acute providers. This included joint medical training across the different sites.
- There were good relationships with other tertiary centres for women who required referrals, for example cardiac care during pregnancy.
- The maternity safeguarding lead was part of the safeguarding team within the hospital, and there were good relationships between social services, community midwives and hospital staff
- There were good examples of working between specialties. For example staff told us about a recent delivery of a woman with HIV. There had been good multidisciplinary working with the sexual health consultant. Other examples provided were with women who were hepatitis A or B positive, and working with the haematologist.
- There was evidence of positive engagement with the SoM and the Higher Education Institutes, including teaching on student programmes.

Seven-day services

- There was an on call physiotherapist available at the weekend if women needed to be seen.
- Women could access community care over seven days. For example antenatal visits could be done at home on the weekend if women could not make hospital scheduled appointments.
- Postnatal clinics were run seven days a week, particularly for vulnerable mothers and those who had undergone caesarean section; again women could be seen at home or in hospital.
- Scanning services, which were run by the radiologist, were not available at weekends. However, six of the eight consultants were trained and available to scan if it was urgent 24 hours per day, seven days per week .The women would then receive a scheduled full scan appointment in the week with the radiologist if required.
- Staff could access the out of hours social services 24 hours per day, and there was a dedicated direct number.
- There was 24 hour ward clerk cover on the labour ward.
- The chaplaincy service was available 24 hours per day.
- The SoM team ensure that there is access to s SoM at all times, 24 hours per day, seven days a week by participating in a 24 hour on call rota.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training on consent, Mental Capacity Act (2005) and Deprivation of Liberty (DoLS) was part of mandatory training for staff. The trust had policies in place regarding these subjects and staff know how to access them on the intranet.
- In March 2016 78.2% of maternity staff and 95.4% of gynaecology staff had completed Adult safeguarding Level 1 (which included MCA and DoLS training) against a target of 95%.
- There was a dedicated mental health midwife and a dedicated safeguarding midwife to support vulnerable women and staff who cared for these women.
- Women undergoing termination of pregnancy for fetal abnormalities had the HSA1 form signed and dated by two registered medical practitioners, in accordance with Section 1 (1) of the Abortion Act 1967, before a termination was performed.

Are maternity and gynaecology services caring?

Good

We rated this service as good for caring because:

- Staff treated women with kindness and compassion. We spoke with five women in the maternity department and two women on the gynaecology ward during this inspection. The women we spoke to in maternity and gynaecology were consistently positive about the care they received.
- We saw both clinical and non-clinical staff treat women with dignity and respect. Staff respected women's privacy and confidentiality.

- Women and their loved ones were involved in their care and treatment. Staff on the maternity and gynaecology wards gave women explanations about their care and supported them to make informed choices.
- Staff in the maternity service supported bereaved parents well. The midwife with a special interest in bereavement provided bereaved parents with emotional support.
- Results from the friends and family test showed that patients would recommend the care they received on the maternity and gynaecology wards.

Compassionate care

- CQCs survey of women's experiences of maternity services for 2015 showed that the trust performed about the same as other trusts when answering three questions regarding their labour and birth, staff during labour and birth, and care in hospital after the birth.
- Seven women we spoke to were positive about how staff treated them. Six out of seven women we spoke to commented on the caring attitude of staff. One woman on the postnatal ward said staff were "informative, caring and professional." A woman on the gynaecology ward told us that her experience of the ward and its staff had been "fabulous."
- We saw clinical staff in all areas treat women with kindness and compassion. In the antenatal reception area, we saw reception staff greet women in a polite and friendly way. We saw midwives explaining care to women in a compassionate way. One woman on the antenatal ward told us how the midwives had 'rallied round' to support her when she found out that her blood pressure was high. A woman on the gynaecology ward told us that she was 'well cared for' and explained how clinical staff looked after her in a compassionate way when she fainted.
- Staff showed respect for women's privacy and confidentiality. On the postnatal ward, we saw midwives draw curtains to protect women's privacy. Clinical and reception staff in the antenatal reception area were respectful of confidentiality when talking to women.
- Clinical staff on the maternity and gynaecology wards had an approach that was centred around the woman. For example, staff in the maternity department told us how they supported a woman with epilepsy by ensuring that her carer stayed with her throughout the hospital admission. A woman on the postnatal ward told us how staff had met her preferences by giving her breakfast at a time that suited her better than the standard mealtime. On the gynaecology ward, a woman told us that staff had given her 'lots of information' during pre-assessment clinic and had reinforced her understanding of this throughout her stay.
- Results from the friends and family test from February 2015 to February 2016 showed positive results. The percentage of women who would recommend antenatal care at the hospital ranged from 94% to 100%. A score of 100% was achieved in five out of the six months where data was collected in this period.
- The percentage of women who would recommend the care they had during birth ranged from 91% to 100%. The percentage of women that would recommend care on the postnatal ward ranged from 88% to 100**%.**
- Friends and family test results from February 2015 to February 2016 showed that the percentage of women who would recommend care on the gynaecology ward ranged from 90% to 100%.

Understanding and involvement of patients and those close to them

- Staff helped women to understand their care and treatment. The women we spoke to on the maternity and gynaecology wards said that staff gave them explanations about their care. This included information on topics such as pain relief, breastfeeding and exercise after caesarean section.
- Staff encouraged women to be involved in their care and each woman had an individualised care plan. Care reflected women's needs and preferences. For example, one woman on the antenatal ward told us that staff discussed different options for pain relief with her and gave her information on side effects so that she could make an informed decision about the type of pain relief she would prefer.
- We saw posters advertising the local maternity voices group. This was a forum where women and their relatives could share their experiences and suggest ideas for improving services.
- Women told us that their partners and family members were involved in their care. Staff allowed birthing partners to remain with women throughout labour and delivery. The women we spoke to were satisfied with the visiting times for their partners.
- One woman said, "The times are 9am to 9pm but they're quite flexible," while another said staff, "didn't hurry my partner out."

- Staff recognised when women needed extra support to be involved in their care. Care records contained assessments of additional needs such as hearing, speech or sight problems.

Emotional support

- Maternity had a number of specialist midwife such as mental health peri natal, diabetic specialist, VBAC (vaginal birth after caesarean), bereavement, body mass index (BMI) and perineal tear, all of whom ran a number of clinics within the service.
- There was a dedicated 'birth reflections' clinic, which helped women who had felt that they had not experienced the birth that they had planned for, or felt levels of anxiety or stress which related to the birth experience.
- Counselling services following termination of pregnancy or miscarriage was not available on site. However all women were provided information for a local charity service in the area which provided counselling and support.
- Women received emotional support from staff. There were specialist midwives, including a mental health specialist midwife and a midwife with a special interest in bereavement.
- There was a trust wide chaplaincy service, which provided support to women throughout the hospital. This was a 24-hour service providing spiritual support to women of all faiths and none.
- Staff in the hospital faith centre told us that they held baby memorial services twice a year. They invited bereaved parents to attend these services and light a candle.
- Staff in the maternity unit told us how they empowered patients. A specialist midwife for infant feeding and a specially trained midwifery care assistant supported women to feel confident with breastfeeding. Women could join a breastfeeding peer support network to support other new mothers, although senior staff told us that uptake of this voluntary role was variable.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

- There was a process in place for the monitoring and management of delayed inductions.
- The service had recently introduced a telephone triage system for women to ensure women were referred for the most appropriate pathway.
- Maternity consistently met the target for first scheduled first visits. scheduled booking for first visits for women below 12 weeks and six days of pregnancy, were consistently above the target of 95% from March 2016 to May 2016, with the exception of January 2016 in which it was 94.6%
- There were good examples of learning from complaints and staff had worked with women in improving services.
- There were a number of nurse led clinics in gynaecology services including colposcopy, Urogynaecology and coil insertion.

However:

- There was no fast track dedicated pathway for women admitted with gynaecology problems through the emergency department. However the trust had recognised this and was working to produce a patient pathway.
- Staff told us that there were delays in theatre slots for surgical terminations and evacuation of miscarriage up to eight days. This was not in accordance the Royal College of Obstetrician and Gynaecologists , who advise women should have the procedure within five working days of decision to proceed
- There were delays for patients waiting Urogynaecology surgery. In June 2016 there were 23 patients on the waiting list.
- There were on going outlying of women from other specialities, on the gynaecology ward, which at times meant women waiting routine gynaecology procedures were cancelled. Between April 2015 and April 2016 four incidents had been recorded of women who had elective gynaecology surgery cancelled.
- The number of Gynaecology incomplete pathways for May 2016 was 1020. This is higher than expected for an elective list and there were no assured plans in place to reduce this list.
- Staff told us that elective theatre cases were at times delayed due to emergencies, due to only one dedicated obstetric theatre.

Maternity and gynaecology

Service planning and delivery to meet the needs of local people

- The trust offers medical and surgical termination of pregnancy for foetal anomaly. The number of terminations carried out between April 2015 and March 2015 were 106. The number of terminations carried out between April 2014 and March 2015 were 80.
- The termination clinic ran alternate weeks. Women would receive their pre assessment and scan in one visit. No documentation was sent to home address. Staff told us that they would often "slot in" additional appointments to ensure that the five day referral from GP was met.
- Medical management terminations (those completed for fetal abnormality and induced with medications) were managed on Gosfield ward for gestation up to 16 weeks and six days. Women would be cared for in a private side room and have a dedicated midwife for support and clinical management.
- Surgical terminations or evacuations for miscarriage were managed on the day case unit. However staff told us that women sometimes had to sometimes wait up to wait eight days for a theatre slot. This was not in accordance the Royal College of Obstetrician and Gynaecologists, who advise women should have the procedure within five working days of decision to proceed.
- The early pregnancy unit was run from Gosfield ward, and operated Monday – Friday 08.00 to 17.30.There was a dedicated Consultant lead and Band seven Gynaecology nurse. Women were seen up to 16 weeks gestation, and were referred in through their GP, emergency department, or Midwife. Women could not self-refer in. Two days per week, Tuesday and Wednesday, sonographers were available for scans, and consultants would scan on Monday, Tuesdays and Fridays.
- The physiotherapist offered services at both of the post-natal clinics at St Peters in Maldon, and Braintree birthing unit. This enabled women to be seen closer to home.
- There was a dedicated high body mass index (BMI - index for weight for height) clinic. For women with a BMI greater than 40 (morbidly obese) .This clinic was offered at the time of booking at the ante natal clinic. Women were offered regular follow ups, information regarding healthy eating during pregnancy and monitoring of weight gain during pregnancy.
- Women undergoing fetal abnormality screening were able to undergo amniocentesis (invasive pre-natal diagnostic test taking amniotic fluid) at the trust. Women who required Chorionic Villus Sampling (CVS) were referred to a specialist service in London.
- There were a number of nurse led clinics in the gynaecology department, including colposcopy (medical diagnostic procedure to examine an illuminated, magnified view of the cervix and the tissues of the vagina). Urogynaecology (clinical problems associated with dysfunction of the pelvic floor and bladder) and coil insertion (contraceptive device).
- Women were offered counselling and a choice of either local anaesthetic or general anaesthetic for hysteroscopy (inspection of the uterine cavity) procedures.
- The trust had reviewed "peak times" of birthing activity during the year which were June through August. To accommodate for increased capacity and ensure the on-going functioning of the maternity unit, the trust had worked with the local Clinical Commissioning Group (CCG), and had identified staff that could work additional hours.

Access and flow

- Bed occupancy between quarter one 2014/2015 through to quarter three 2015/2016 ranged between 41.7% to 49.9%, below the England average of 55%-60% for the same time period.
- The ante natal assessment ward consisted of 14 beds. All women requiring induction were admitted to the unit. Inductions were assessed by the coordinator on a daily basis who would prioritize the inductions for the day. The unit completed around four planned inductions per day. If inductions were delayed an incident form would be completed.
- Between May 2015 to May 2016 there had been seven delayed inductions recorded. Reasons given were either medical condition of the woman which required further management or high activity in labour ward.
- The ante natal day assessment unit had completed a capacity review to look at the patients pathways and to ensure that the appropriate women were admitted to the unit. The introduction of a dedicated telephone

triage system commenced in June 2016.The service had a dedicated senior midwife from 10am – 6pm daily, who would take calls directly from women, triage them and then refer to most appropriate person, or admission. We were told by the unit manager that as this was a new service, paperwork with the phone number on was in the process of being reprinted, however women were made aware of the service. There was a clear plan to re audit in two months, to see if the service had impacted on capacity within the ante natal day assessment unit.

- There were two obstetric theatres with one dedicated theatre team. The labour ward, post-natal ward and ante natal ward were all in the same building
- There were two obstetric theatres with one dedicated theatre team. An emergency theatre team was available for any obstetric emergency. However if a woman required theatre intervention for a retained placenta, then the elective theatre would stop to accommodate more urgent cases, therefore causing a delay to planned elective cases. Although data was not provided in relation to numbers of women postponed, this was on the risk register and a business case had been put forward to the Board in April 2016 for an additional obstetric theatre team which was declined.
- The gynaecology service did not provide a dedicated fast track service for women who were attending the emergency department. This meant that women attending with gynaecology symptoms would have to wait in the emergency department. We were told that new pathways and guidelines were in the process of being developed, now that the new gynaecology matron was in post.
- Gosfield gynaecology ward has 14 beds. At the time of inspection there were six surgical outliers. Staff told us that outliers were reviewed promptly by their speciality teams and that they had a dedicated 'buddy' ward where they could ask medical staff for review of outlying patients.
- Between April 2015 and April 2016 four incidents had been recorded of women who had elective gynaecology surgery cancelled on Gosfield ward due to bed capacity. Gynaecology cancellations were monitored by the Head of Midwifery and reported to the Executive board. Two beds had been designated as "protected" gynaecology beds. A proforma had been developed to identify suitable women that could be outlied onto Gosfield ward. Staff told us that since the last inspection, and the relocation of the gynaecology ward, bed capacity had significantly improved, with less cancellations and outliers of non-gynaecology women.
- All Urogynaecology patients were seen in outpatients within six weeks. However in June 2016 there were 23 patients on the waiting list. This was managed through regular reviews of lists and caseloads amongst Consultants, and extra lists opened where capacity allowed. A business case had been requested for an additional 14 extra theatre sessions per year to meet the demand, but this had been declined by the trust.
- Data on the maternity dashboard showed that scheduled booking for first visits for women below 12 weeks and six days of pregnancy, were consistently above the target of 95% from March 2016 to May 2016, with the exception of January 2016 in which it was 94.6%
- The number of Gynaecology incomplete pathways for May 2016 was 1020. This is higher than expected for an elective list and there were no assured plans in place to reduce this list.
- Gynaecology referral to treatment times of admitted patients in April 2016 were 72.2% against the England average of 79%. The number of non-admitted referral to treatment times for April 2016 were 94.8% against the England average of 95%.

Meeting people's individual needs

- Carers passports were issued to carers looking after women in gynaecology with dementia. This facilitated them to be involved in the care of the patient, and provide information to staff. Carers were able to stay with the women 24 hours a day.
- Labour ward had a dedicated bereavement room, which was in the midwifery led birthing unit. The room was equipped with a double bed, seating, tea making facilities and microwave. A cold cot was available if women wished to take their deceased baby home
- Staff knew how to access translation services and used the "big word" which is a translation service, which includes face to face translators, sign language and telephone translation services. This ensures that women are treated equally, receive high quality care, are fully informed and involved in decisions about their care and can give informed consent.
- Staff on the post-natal ward gave two examples in which partners had been allowed to stay with the woman to

ensure that women felt supported. One was in relation to a woman who had previously suffered from puerperal psychosis who felt more assured with her husbands presence. The second example was a woman with uncontrolled epilepsy whose mother stayed with her to support her.

- There was a dedicated theatre midwife on the postnatal ward for women undergoing elective caesarean sections Monday though to Friday. This ensured continuity of care with a dedicated midwife overseeing the woman's journey.
- Family planning advice and treatment was available to women following termination of pregnancy. This included inserting contraceptive devices at the time of termination as well as prescribing the contraceptive pill as a tablet to take home, with a referral to GP to follow up.
- Midwives completed mental health assessments for women. Staff referred patients who needed support to the specialist mental health midwife. We saw care records showing that these assessments were completed.
- The specialist mental health midwife provided support to patients throughout the antenatal period and until 28 days postnatally. She made links with other specialists in the hospital, such as the psychiatric team and the perinatal mental health consultant. This meant that patients with a mental health condition had support from a multidisciplinary team of specialists.
- Staff gave an example of a family who did not wish for their baby to go to the mortuary, but straight to the funeral directors. This had been facilitated and appropriate arrangements made. The baby had been collected from the ward by a female undertaker.
- There was a dedicated trust photographer who will meet with bereaved families and produce a boxed set of photographs free of charge. Families were also provided a "memory box" which included foot and hand prints and locks of hair.
- In the gynaecology clinic we saw the use of the 'this is me' document. 'This is me' is intended to provide professionals with information about the person with dementia as an individual. There was also a carers passport, which is a document that encourages staff to work with the carer and as an active member of the team. A staff member explained to us how these documents were used when the patient came into clinic and at the pre assessment phase.
- Discharge letter compliance gynaecology for February 2016 was 96% against a target of 95%.This ensured that women were discharge home in a timely manner and that both the woman and the General Practitioner had information regarding the womans in patient stay.
- Women said staff provided information leaflets to help them understand their care. We saw examples of information leaflets, including a pregnancy guide and a new baby guide

Learning from complaints and concerns

- Between April 2015 and March 2016 Maternity and gynaecology had received 76 complaints. 14 Complaints following investigation were not upheld. Complaints were clearly recorded, with outcomes of investigations, changes in practice and dates that the complaint (including actions taken) had been closed. The common themes of complaints were around communication and clinical care.
- There were good examples of learning from complaints For example in the gynaecology clinic a woman felt that they had not received enough information on having an internal examination. The clinic had responded to this by producing a new information leaflet, with involvement of the woman, to provide women with information about what to expect when having an internal examination. Another example was in relation to a woman who felt that a midwife had not shown compassion when delivering care. The midwife was seen by her supervisor and carried out a reflective piece of work.
- Complaints and investigations were shared with staff across maternity and gynaecology through the monthly newsletter.
- There were posters displaying how to make a complaint and comment boxes in all areas. Comments were regularly reviewed.
- We observed display boards on ward areas reading, 'You said, we did', which demonstrated that the service learnt from complaints and concerns where possible.

Are maternity and gynaecology services well-led?

Good

We rated this service as Good for well led because:

Maternity and gynaecology

We found:

- There was a clear philosophy within maternity to promote natural birth, which supported the "project 2%"". This was supported and endorsed by staff across the maternity unit
- There was evidence of engagement in steering groups in response to the Essex Success Regime. Although in the early phase, the Head of Midwifery (HoM) and Clinical director demonstrated the commitment to ensuring the best service for women
- There were excellent examples of strong leadership both in the HoM and clinical directorate level, but also in the maternity and gynaecology teams, including gynaecology outpatients, maternity unit and early pregnancy unit
- Governance meetings were well recorded and learning disseminated down to staff through newsletters and team meetings
- There were good examples of public engagement for example through forums and the engagement of service users in study days

However:

- HSA4 forms (used to notify government in termination of pregnancies carried out) were not being sent to the Chief Medical Office ,Department of Health, within the 14 days in line with the Abortion Act 1967.This is a breech of Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

Vision and strategy for this service

- There was a clear philosophy through maternity to promote childbirth normally, naturally and healthy, which staff were aware of and engaged in promoting this philosophy.
- Maternity services had been working collaboratively through steering groups for the Essex Success Regime, in relation to the provision of high risk obstetric women and to review how the gynaecology and maternity services will be provided in the new regime.
- Locally across maternity and gynaecology there were positive examples given for the vision of the service for the futures, and changes that staff wished to make to improve a woman's experience. For example the development of pathways for gynaecology patients who attend the emergency department to be able to be fast tracked into the most appropriate area, and the vision of introducing a specialist nurse hysteroscopist to gynaecology outpatients. However this plan was discussed in the previous inspection in 2014, and has yet to be implemented

Governance, risk management and quality measurement

- During the inspection we attended the risk management meeting for maternity. This meeting was held on a monthly basis. There was a clear agenda, and discussions were held including risks, complaints, training and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE).
- Data was reviewed from the maternity dashboard at the risk management meeting, which monitored the quality of maternity provision for women. There was good attendance, minutes were documented, and there were clear actions with defined roles and responsibilities.
- The trust was due to implement a new Information Technology system. This was identified on the risk assurance framework.
- Maternity and gynaecology held monthly governance meetings, with gynaecology separated on the governance report. There were also bi monthly clinical governance meetings for each area. We examined the minutes of the last three meetings which confirmed that discussions about complaints, audit outcome, risk and incident analysis was occurring.
- There was evidence of good governance in relation to information sharing. For example through monthly newsletters, which contained key service messages including risks and updates on new guidelines and current research.
- There was a risk register for both maternity and gynaecology. The register was up to date with clear action plans and ownership of the identified risk. The three top risks for maternity, were Caesarean rates, consultant hours and archiving of Cardiotocograpghy records. These were reviewed on a monthly basis. There was clearly documented evidence of mitigation to risks, for example in relation to lowering caesarean rates. These included identified work streams, audits and individual case reviews.
- Every morning at the daily "safety huddle" in maternity, senior staff communicated risks and key information to staff. This had also been introduced into Gynaecology outpatients.

- HSA4 forms (used to notify government in termination of pregnancies carried out) were sent to the Chief Medical Office, within the 14 days in line with the Abortion Act 1967 and were not able to validate process at inspection due to designated staff on leave. This was escalated at the time of inspection.

Leadership of service

- Maternity and Gynaecology was part of the Womens and childrens directorate. The directorate structure consisted of the Head of Midwifery (HoM), who also held the joint role of clinical director, shared with a medical clinical director .The Matrons, lead nurses and governance leads reported directly to the HoM and clinical director.
- The trust had recently undergone a number of new appointments at senior and board level. Staff told us that there would be a new structure of reporting, but felt confident that they would have access at board level.
- There was clear evidence that recommendations from the previous inspection had been acted upon to improve the maternity and gynaecology services, for example the additional funding to increase staffing levels. However, it was noted that the pathway for women who attended the emergency department had not progressed.
- The leadership team had ensured that changes were communicated to staff through posters and newsletters, and staff told us that they were proud to be working in the service and recognized the benefits of the changes that had occurred.
- Staff told us that leadership form the HoM and Clinical director, was good across the service, and that the head of midwifery was visible, with an open door policy and approachable.
- Staff told us that the Band 7 midwife team leaders and coordinators supported staff and were visible in the clinical areas.
- Across the service we spoke with 28 members of staff. All staff we spoke with told us that leadership at unit level was, “Good” or “Excellent” and that their managers were approachable, supportive and pro-active. We observed that staff in charge of each unit demonstrated clear leadership principles and the trust values.

Culture within the service

- Staff were very open and honest with inspectors because they told us what worked well and what did not. Staff were enthusiastic and strived to provide high quality care. We saw some excellent examples of strong leadership within clinical areas, and staff that wished to drive forward and make improvements in women’s’ care.
- Staff told us that the maternity and gynaecology newsletter recognised staff that had provided outstanding care, or developed service improvements.
- Medical, midwifery and nursing staff worked well together across the service, with one consultant stating that the relationship between the midwives and consultants were “some of the best” that they had seen.
- Medical staff told us that they felt supported and able to work independently to their level of competency and were happy with their job plans.
- The 2016 patient staff survey showed that 78% of staff rated maternity and gynaecology services as excellent or very good. Positive feedback had been identified in dignity and respect at work, and working as a team. Areas that had been identified as requiring further work was predominantly around staff shortages and skill mix, which was being addressed with the successful recruitment of new staff
- Staff were aware of the whistle-blowing policy and encouraged to raise any concerns they might have. They told us they would have confidence in raising concerns and speaking out.

Public and staff engagement

- “Maternity Voices” is chaired by a lay person and is a committee that works with women, clinical commissioning, dulous and a number of staff from maternity services. The committee advises the trust on the maternity service provision.
- Patients, families and carers were encouraged to engage with the service. For example there were suggestion boxes and feedback forms were distributed daily.
- Staff were encouraged to attend regular unit meetings and were provided with up to date literature, for example the monthly newsletter and emails.
- There were a number of initiatives that facilitated public engagement, for example the pregnancy information evening, which would engage services user into the different elements of the service, service users took art in the bereavement study day, and there was a dedicated labour ward forum.

Innovation, improvement and sustainability

Maternity and gynaecology

- The trust was moving to a new Information Technology system at the end of 2016. Staff were aware of this change with some staff attending a different trust that had already implemented the system to learn and share from their experience.
- Across maternity and gynaecology there were clear innovations and improvements that staff were working to implement. For example the plan for introducing an ambulatory model in gynaecology services which would increase the woman's experience and capacity of the service. Staff had visited another trust to look at how ambulatory care worked and conversations had been started with the board on how this could be applied to Broomfield Hospital.
- There was evidence in the 2015 Supervisor of Midwives (SoMs) report on working relationships, to improve aspects of the service that require improvement. For example a dedicated IT SoM project lead to support with the implementation of the new IT system, as well as a dedicated SoM to promote home births and normally delivery in the hospital delivery unit.

End of life care

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

Information about the service

Mid Essex Hospital Services NHS Trust (MEHT) provides care to 380,000 people living in and around the districts of Chelmsford, Maldon, Braintree and Witham. Patients with palliative or end of life care needs are nursed on general wards within Broomfield Hospital, Farleigh Hospice, or at home.There were 1134 in patient deaths between September 2014 and August 2015.

The specialist palliative care team (SPCT) for MEHT are made up of specialist palliative care nurses (SPCNs), consultants and administrative staff. The SPCT provided advice, assessment and treatment to patients across all clinical areas within the hospital. During the period April 2014 to March 2015 there were 682 patients referred to the SPCT of which 67% had a cancer diagnosis and 33% had a non-cancer diagnosis

The SPCT accepts referrals for patients with progressive life threatening illness when life expectancy is likely to be less than one year. Referral criteria include difficult pain and symptom control, complex psychosocial problems and/ or specialist needs related to end of life care.

SPCT provide care seven days a week co-ordinating and planning care for patients at the end of life on the wards. Out-of-hours cover is provided 24 hours a day, seven days a week by one of four palliative care consultants. The Trust has a bereavement office, mortuary and chaplaincy multi-faith centre available to patients and their families/ carer's.

During this inspection we visited 12 inpatient wards and units at Broomfield Hospital; Accident & Emergency, Baddow (Care of the Elderly ward), Braxted (Care of the Elderly ward), Danbury (Oncology ward), Emergency Assessment unit (EAU), Emergency Short Stay (ESS) Felsted (medical ward), Goldhanger (surgical ward), High Dependency Unit, John Ray (orthopaedic ward), Stroke Unit and Terling (medical ward). We observed a nursing handover and a white board meeting handover. The aim of the whiteboard meeting is to plan, coordinate and optimise the social, medical and psychological health of the patients through a collaborative team approach. We visited the mortuary and viewing room, the multi-faith centre, the portering department and the bereavement office.

Care records for 11 people, 39 do not attempt cardiopulmonary resuscitation (DNACPR) records and four prescription charts were reviewed during the inspection. We also spoke with three patients, seven relatives and 52 staff across all disciplines, including doctors, nurses and end of life care health care professionals

End of life care

Summary of findings

- We found the specialist palliative care team (SPCT) and the ward staff to be passionate about ensuring patients and people close to them received safe, effective and quality care.
- The patients and relatives spoke positively about their interactions with the staff involved in their care.
- The trust had responded to the withdrawal of the Liverpool Care Pathway, which had previously been seen as best practice when someone reached the last days and, hours of life. The trust used a holistic document which was in line with the five priorities of care. This care plan, called the 'Last Days of Life Care Plan', guided staff to consider and discuss the patient's physical, emotional, spiritual, psychological and social needs. The care plan also took into account the views of those important to the patient and provided them with an information leaflet about what happens when someone is dying, and what to expect. This document was embedded across the trust in all adult wards.
- The SPCT was led by a consultant in palliative medicine. The SPCT and the trust's end of life care facilitator were focussed on raising staff awareness around EOLC. The SPCT delivered education for medical, nursing and allied health care professionals at Trust induction, Preceptorship programme, Health Care Assistant and Healthcare Professionals study days, and also on the medical training programme. The trust was starting to implement the gold standard framework (GSF), a programme that enables staff to provide a gold standard of care for people nearing EOL by planning care in line with their needs and preferences. Two wards, Baddow and Felsted, had started a pilot phase of the GSF accreditation for acute hospitals. The trust has put in place palliative/end of life care champions in each ward.
- EOLC services were provided by compassionate, caring staff who were sensitive to the needs of patients. The service was delivered by staff who were committed to providing a good service and there was good clinical leadership from a consultant in palliative medicine.
- Since our last inspection visit in 2014 the completion of do not attempt cardiopulmonary resuscitation (DNACPR) forms had improved, and this was evidenced by the internal audit provided by the trust and the records we reviewed during our visit.

However:

- Staff told us that patients who had requested to be cared for in their own homes had experienced delayed discharges. There was no rapid discharge home to die pathway. Patients wishing to die at home could wait five to ten days, and sometimes died waiting. In addition there was no formal audit process of peoples preferred place of death or discharge times.

End of life care

Are end of life care services safe?

Good

We rated safe as good because:

- Staff said they were encouraged to report incidents and were knowledgeable about the incident reporting process.
- Medication for end of life symptom control was prescribed appropriately. syringe drivers (a type of pump that helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin) were used across the wards
- We found good nursing care documentation, nutrition and hydration reviews and documentation standards. End of life care plan documentation was comprehensive and complete in those that we reviewed and staff found it user friendly.
- Staff were aware of their role and responsibilities in relation to safeguarding. The trust's mandatory induction programme provided training from the palliative care team
- The SPCT was clinically led by a consultant in palliative medicine and was appropriately staffed. The trust had put in place an end of life care facilitator which worked across the trust and each ward had a palliative/End of life care champion.

However:

- Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were reviewed. 34 out of 39 had been completed appropriately. In four cases there were little or no evidence of discussion with family or next of kin had taken place. One record had the date of DNA CPR decision incomplete.

Incidents

- There were no serious incidents reported, relating to End of Life Care (EOLC), for the period of March 2015 to March 2016.
- In the period from March 2015 to March 2016, the trust reported 33 incidents relating to the end of life care services across the hospital. Five were recorded as minor harm, two were recorded as moderate harm, 15 were recorded as happening but caused no harm, four as minimal harm, seven as a near miss and two as potential for adverse publicity.
- Processes were in place to investigate incidents, whereby a root cause analysis is completed and learning points identified.
- There were systems and processes in place to report incidents and staff told us they were encouraged to do so.
- Incidents were reported through the trust's electronic reporting system, Datix.
- Any incident relating to end of life care is referred to the End of Life Steering Group for discussion and dissemination.
- Ward staff knew how to report incidents but could not recall any that related specifically to palliative care or end of life care.

Environment and equipment

- Staff were able to access syringe drivers in each ward when they were needed for patients. We reviewed a selection of syringe drivers and the planned preventive maintenance (PPM) schedule which were all tested and in date
- The trust had recently upgraded their model of syringe driver and was in the process of rolling out training to staff.
- Fridge temperatures in the mortuary were consistently recorded on a computer system. An alarm sounded should the fridge temperatures drop below the required temperature. Daily checks were carried out. We checked all fridge temperature logs from January 2015 to June 2016 and there were no out of range temperatures recorded. In the mortuary and wards we visited, equipment such as trolleys, cleaning equipment and personal protective equipment were clean and stored in a tidy manner.
- A viewing room provided families or friends a private quiet space should they wish to spend time with the deceased.

Medicines

- Patients who required end of life care medicines were written up for anticipatory medicines (medications that are prescribed for use on an "as required" basis) to manage common symptoms that can occur at the end of life.

End of life care

- Medication administration records of four patients were completed correctly and signed.
- The syringe driver medication prescription chart was printed on a separate loose form, and was not part of the normal prescription chart. Out of the four syringe driver medication prescription charts we reviewed one record which showed two gaps in the hourly checks.
- The results for the trust of the latest national care of the dying audit published in March 2016 showed that 56% of the medications that patients received had been reviewed in the last 24 hours of life, which is lower than the national average of 65%.

Records

- We reviewed 11 care records. All records had completed nursing care documentation, nutrition and hydration reviews and documentation standards including dates and signatures.
- We reviewed 39 DNA CPR forms across the hospital. Out of the 39 DNA CPR forms reviewed 34 were completed in line with the national guidance published by the General medical Council (GMC) and Resuscitation Council UK. In four cases there was no or limited evidence of discussions with family or next of kin. One record had the date of DNA CPR decision incomplete.
- Patients approaching end of life had a designated end of life care plan. This included a structured approach whereby nurses conducted checks on patients hourly to assess and manage their fundamental care needs. These contained progress and evaluation of the patient's health, and clearly documented care given.
- In one ward we visited we could not always assess if care was provided in a timely manner, as end of life care plans were not always complete. We spoke to the lead nurse about this and they explained that new members of staff had not got used to the procedure of filling out the booklets.

Safeguarding

- All staff we spoke with understood their role with regards to keeping patients safe and reporting any potential safeguarding issues.
- Staff we spoke with demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse.
- Staff told us if they had any concerns they would speak to the trust safeguarding lead or their manager, and knew where to access the trust policy on the intranet.
- Safeguarding adults level one and two training was part of the trust's mandatory training and was provided to all staff.

Mandatory training

- All od the SPCT staff took part in mandatory and statutory training to ensure they were trained in safety systems, process and practices such as basic life support, conflict resolution, fire safety, infection control and health and safety.The team were 100% complaint with mandatory traning.
- End of life/palliative care training was delivered by the specialist palliative care team as part of the trust's mandatory induction programme. New staff received one hour of training on 'the symptoms and principles of palliative care' during induction, and a further training at preceptorship after they had been in post for six months.
- Staff from the faith centre and mortuary presented at the trust induction about the services they provide as part of end of life care in the trust.

Assessing and responding to patient risk

- Ward staff told us that specialist support was available from the palliative care team and confirmed that the team responded promptly to referrals.
- A National Early Warning Score (NEWS) system was in place to alert staff if a patient's condition was deteriorating.11 sets of notes were reviewed and all of the early warning indicators were regularly checked and assessed. Staff would contact the medical team or rapid response team if indicated.
- We saw that patients' documentation was transferred to an end of life care plan when it was recognised the patient was expected to die within days or hours to ensure care in the last days of life was tailored to the patient's needs and those important to them.

Nursing staffing

- Staffing of the specialist palliative care team (SPCT) is in line with the national guidance (the Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse per 250 beds) The trust's SPCT consists of one whole time equivalent (WTE) Macmillan Lead Nurse in

End of life care

Cancer and Palliative care, 3.6 WTE Palliative Care Clinical Nurse Specialist band 7,one WTE Palliative Care Nurse band 6 and 0.38 WTE admin and clerical support band 3.

- The trust has one end of life care facilitator, who was supported by palliative care champions in each ward whose roles included raising awareness of EOL processes, and educating and supporting more junior staff.

Medical staffing

- The trust SPCT has 0.75WTE consultant in Palliative Medicine shared between three consultants.
- Consultant support was available out of hours through the hospital switchboard from the Palliative Medicine Consultant on call.

Major incident awareness and training

- The mortuary was engaged in resilience for the trust and was part of the major incident plan. The environment enabled the isolation of high risk, infectious and contaminated patients. The mortuary staff were clear on the procedures to manage such an event.
- The trust's mortuary has capacity for 104, however contingency plans are put in place to accommodate 116 .The mortuary staff checked and audited fridge space daily and if capacity is above two-thirds full, this would be escalated.

Are end of life care services effective?

Good

We rated effective as good because:

- We observed that staff were aware of evidence-based guidance and best practice. The end of life care management team were using these to develop services. The last days of life care plan incorporated the five priorities set out by the Leadership Alliance 2014 for the Care of Dying People and we saw this was being used across the trust in all adult wards.
- The trust was starting to implement the gold standard framework (GSF), with two wards piloting the GSF accreditation for acute hospitals. Since the last inspection the trust has put in place palliative/end of life champions in every ward.
- Pain relief including anticipatory medication was being managed appropriately, and nutrition and hydration needs for patients were being monitored and documented.

However:

- At the time of ourinspection there was no overacrching action plan created in response to the National Care of the Dying Audit.

Evidence-based care and treatment

- The trust's response to the independent review of the use of the Liverpool Care Pathway (LCP) for the dying patient and the subsequent announcement of the phasing out of the LCP was to create a document called 'Last Days of Life Care Plan'. This was introduced in a phased approach in September 2015 and rolled out to all adult wards in December 2015, with supporting documents including information for relatives and carers about when someone is dying.
- Training for the Last Days of Life care plan was provided through the formal taught workshops, doctors teaching sessions, departmental meetings and on the wards.
- All wards we visited had a palliative/End of Life Care Champion to support with the completion of the last days of life care plan document. A 'care plan guide' was also available on the Intranet.
- The Last Days of Life Care Plan was developed in line with national guidelines, including Improving Supportive and Palliative Care for Adult with Cancer: NICE Guidelines 2004, Care of dying adults in the last days of life: NICE guidelines 2015 and Ambitions for Palliative and End of Life Care: A national framework for local action 2015- 2020.
- The Last Days of Life Care Plan document guided clinicians through a series of prompts to discuss the patient's personal and clinical needs, preferences and, and the amount of intervention they wanted. It guided clinicians to consider the emotional, psychological and spiritual support required.
- We reviewed 11 records which showed conversation with the patient and/or family, recognition of dying, symptom control, and assessment of nutrition and hydration needs.
- The Gold Standards Framework (GSF) is a programme that enables staff to provide a gold standard of care for people nearing EOL by planning care in line with their needs and preferences.

End of life care

- Two wards, Baddow and Felsted, had started a pilot phase of the GSF accreditation for acute hospitals
- At the time of our inspection there was no overacrching action plan created in response to the National Care of the Dying Audit.

Pain relief

- Anticipatory prescribing (medications that are prescribed for use on an "as required" basis to manage common symptoms that can occur at the end of life) followed the draft NICE guidelines for symptom control. We saw four prescription records of patients who were considered to be in the last days/weeks of life were appropriately prescribed anticipatory medicines for their symptoms
- Relatives we spoke to told us that their loved ones received good pain relief and their pain was under control.
- The Specialist Palliative Control Team (SPCT) consultants and nurses were experts in their field and able to provide guidance on the most effective and appropriate treatments and care at end of life, which included pain relief and management of nausea and vomiting.
- The SPCT had two non-medical prescribers that were able to prescribe medications appropriately to support patients at the end of life.
- Where appropriate, patients had syringe drivers, which delivered measured doses of drugs over 24 hours. In the wards we visited, all qualified nursing staff were trained in using syringe drivers and symptom management.
- Senior members of staff told us that the trust uses a different brand of syringe driver to that used in the community. Therefore on discharge some patients' hospital syringe drivers were disconnected and doses of analgesia were given to keep patients comfortable whilst awaiting district nurses to set up the community syringe drivers at home.
- However staff also told us that in most cases they would arrange with district nursing teams to courier in the McKinley T34 syringe pumps that were used in the community via the Red Cross drivers that volunteered for the trust, to avoid the possibility of a delay for a patient to receive effective and continuous pain relief.

Nutrition and hydration

- Results from the latest national care of the dying audit (2014/15) published in March 2016 showed that the trust performed lower than the national average in the hydration and nutrition assessment in the last 24 hours of life. In 46% of cases there was documented evidence that a patient's ability to drink had been assessed and in 49% of cases, patient's ability to eat had been assessed in the.
- We saw evidence in the patients records that nutrition and hydration needs for patients were being met. The end of life care plan which have been rolled out across the trust, included a comprehensive list of nutrition and hydration considerations for staff to address. This included prompts for nutrition and hydration assessment at every review, mouth care, swallowing difficulties and respecting the dying person's choice to eat and drink. Staff we spoke to showed a good understanding of the above.

Patient outcomes

- The results of the latest national care of the dying audit 2014/15 published in March 2016 demonstrated that the trust failed to meet some the required key performance indicators (KPIs) for both clinical and organisational domains.
- Of the four organisational KPIs not achieved, one was seeking the views of bereaved relatives' or friends'. Since the audit the trust has conducted a Bereavement Survey and the results were audited in April 2016. At the time of our inspection the report was not available for us to view, however the SPCT management team told us that the response to the survey was very positive.
- For the clinical indicators the trust scored better on two of the five KPIs.

Competent staff

- Palliative and End of life training is given at the trust induction programme to all staff. This was followed up during the preceptorship training received within the first six months in the role.
- The Specialist Palliative Care Team (SPCT)and the end of life care facilitator told us that they provided training in various settings including trust induction, Preceptorship programme, Health Care Assistant training and Healthcare Professionals study days.

Multidisciplinary working

- We observed a white board multidisciplinary team (MDT) handover led by a ward sister with two doctors, a physiotherapist, occupational therapist, speech and

language therapist and social worker in attendance. Patients with palliative care needs were identified and planning for social care needs were in place. There was good MDT working and we observed the different disciplines working together to identify patients approaching EOL.
- The SPCT worked closely with Farleigh hospice. Weekly joint MDT meetings were held at the hospice, where a member of SPCT would bring new referrals for discussion.
- There is an electronic records system called 'The Advanced Care Register' hosted by the local hospice, which the SPCT team could access. The wishes and preferences of the patient plus other useful information for the professionals who are delivering or coordinating care is recorded. The information is shared with the GPs, out of hours GP service, ambulance service, hospital teams, community teams and local hospice. However the use of this register within the trust is in its early stage and is not being effectively used to coordinate care. Staff told us that there was a delay for clinical staff to gain access and training to the system.

Seven-day services

- The SPCT provided face-to face support seven days per week between the hours of 8am and 6pm
- Out of hours (6pm to 8am) advice for staff regarding symptom management control could be obtained by contacting the Palliative Medicine Consultant on call.
- The mortuary team have an on call rota that covers 24 hours a day to accommodate the needs of the bereaved family.
- The chaplaincy team provided a 24 hour on call, multi-faith seven day service
- The multi-faith centre is open 24 hours seven days a week. It provides a quiet area for people from all faith backgrounds or as well as people with no religious connection.
- The bereavement office was open between 8am and 4pm Monday to Friday. Out of hours processes are in place whereby the Intensive care unit had a 'bereavement' bag containing all the documents required to issue a death certificate along with instructions on how to complete them.

Access to information

- The Accident and Emergency department electronic system "flagged" patients who were on the End of Life Register This meant that staff were made aware accordingly and ensured that care was co-ordinated between the palliative care team and others that were already involved in the patient's care.
- Staff across the trust can access information from the intranet, such as policies and national guidance. On the wards that we visited staff were able to demonstrate that they could easily access information on palliative/ end of life care from the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was part of staffs mandatory training. Staff we spoke with were able to describe the process they would follow should someone be found to not have capacity to agree to treatment or be able to make decisions in relation to their care.
- MCA and DoLS guidance was available on the trust's intranet and associated documents such as the consent policy, dementia policy and safeguarding adults at risk policy.
- 12 DNA CPR forms indicated that MCA assessment required, and this had been completed and evidenced in detail in the patient's records
- The trust-wide DNACPR audit report dated February 2016 looked at 96 DNACPR orders across 22 wards. The rationale for the DNACPR decision was found to be well documented (94%) and forms were consistently signed and dated. 93 of the 96 forms were signed by a senior health professional or countersigned within 24 hours as indicated in the trust's policy. Compared with the audit completed in October 2015 there was 11% increase of patients being involved in the decision (from 44% to 55%) There had been a large improvement in evidencing that the nursing staff have been informed of the decision going from 70% to 95%.

Are end of life care services caring?

Good

We rated caring as good because:

- Throughout our inspection, we observed patients treated with compassion, dignity and respect.

End of life care

- Patients and their relatives spoke positively about the care they received.
- We observed interactions between staff and patients and saw that these were kind, caring and compassionate.
- Patients told us staff protected their confidentiality and respected their dignity and privacy.
- Patients and relatives felt well informed and felt medical staff maintained good continuity of care.
- All ward staff provided emotional support in addition to the palliative care team.
- Patients and their families were involved in decisions about their care and received emotional and psychological support

Compassionate care

- Throughout our inspection, we observed patients treated with compassion, dignity and respect. Medical and nursing staff we spoke to were aware of the importance of treating patients and their visitors in a sensitive manner.
- We spoke with three patients and seven relatives during the inspection. Patients and relatives were consistently complementary about staff attitude and engagement. The comments received from patients and relatives demonstrated that staff cared about meeting patients' individual needs and they had been extremely caring and attentive to the needs of relatives.
- There was good practice of confidentiality. Staff would check with patients before they gave out information. Conversations with relatives took place away from main bays.
- Patients were encouraged to bring in personal effects for their room. We saw patients with photographs from home.
- Each ward we visited had received many thank you cards. These included quotes such as 'Thank you for the caring, gentleness, patience and wonderful care', 'Care and tenderness to my husband was second to none' and 'Always comfortable, never once doubted you were doing everything possible'
- We saw mortuary thank you cards from relatives of deceased reading ' Thank you for your patience' and 'it was a pleasure to visit'
- We met with one patient who wanted to stay at the hospital rather than go to a hospice as the patient felt her care 'could not be any better'.
- The family, of an unresponsive patient, felt the staff were caring and respectful. They described how the staff still spoke to the patient and explained the treatment that was being given.
- Chaplains were available to offer religious and spiritual support. We witnessed the ward staff calling the faith centre for support, and getting an immediate response. On one occasion a patient was unable to attend the faith centre, the chaplains brought the patient a CD player and CDs of their favourite hymns to their bedside.
- We heard of two occasions where ward staff had facilitated the use of the side room so that end of life patients could be visited by their dogs.
- The Last Days of Life Care Plan reflected patients' personalised needs. This meant that the whole team supporting the patient and their carers could provide support in a consistent way.
- Porters and mortuary staff said that the bodies of deceased patients were handled in a compassionate way and there had not been any concerns about the condition of the bodies when they arrived in the mortuary area.
- Relatives could visit their loved ones in a mortuary viewing area. Mortuary staff were on call 24 hours a day. Visitors could spend as long as they liked with their loved ones.
- Religious literature was available upon request. Mortuary staff told us that they would ask the families of the deceased about specific requirements and felt they always fulfilled families' needs.

Understanding and involvement of patients and those close to them

- We reviewed 11 care records, which showed some discussions between clinicians and patients and those close to them. In some cases the views of the family were detailed, while others only stated that the family member understood the plan.
- Patients and family members we spoke with told us they felt involved in the care delivered.
- Relatives and patients informed us that staff would always introduce themselves and felt medical staff maintained good continuity of care, were approachable and kept them fully informed at each stage of their treatment

End of life care

- The Last Days of Life Care Plan document included prompts for discussing issues of care with patients and relatives.
- As part of the Last Days of Life Care Plan discussions a guidance literature is available for patients and their relatives.

Emotional support

- The SPCT, ward staff and chaplain gave emotional support to patients and their relatives. Staff told us they would give them as much time as they needed to talk about their thoughts and feelings.
- The bereavement team understood the importance of emotional support. We heard examples of them sitting with upset relatives outside of appointment times.
- A patient told us that the ward had set up appointments for him to receive support from a councillor upon receiving bad news.
- The chaplain volunteers all had a designated ward. They would walk round their ward and greet patients, offering religious support. They explained that it was equally important to provide emotional support for those with no religious needs.
- Relatives told us they were also offered emotional support. One relative was with seven family members and said they were all offered 'Tea and comfort'.

Are end of life care services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Patients who had requested to be cared for in their own homes had experienced delayed discharges. There was no rapid discharge process in place. Patients wishing to die at home could wait five to ten days, and staff told us that there have been instances where patients died in hospital while waiting for discharge process.
- There was no formal audit process of peoples preferred place of care/death or discharge times.
- End of life care plans were not always complete. We were therefore unable to assess if care was provided in a timely manner.

However:

- Patients approaching end of life could have a side room and visitors have unlimited time with the patient.
- Staff we spoke to were pleased with the new end of life care plans and felt they could individualise care.
- We saw good examples of facilitating patients dying wishes, such as seeing their pets, getting married and visiting their holiday home.
- The responsiveness to the needs of bereaved relatives, by the bereavement, mortuary and chaplain staff was outstanding.
- The bereavement suite had recently been refurbished and provided a quiet comfortable area for relatives
- Complaints were fully investigated, discussed, and lessons learnt.

Service planning and delivery to meet the needs of local people

- All staff we spoke with told us patients approaching the last days or hours of their life, wherever possible, were given the option of being nursed in a side room to protect their privacy and dignity.
- There were no visiting restrictions for family or friends for those receiving end of life care.
- The SPCT provided portable beds for those relatives wishing to stay with their loved ones in a side room.
- Accident and emergency department had a designated room for families to view the deceased. This was also used for conversations with relatives and performing the last offices.
- The EOLC leads told us of how the trust engages with the Clinical Commissioning Groups (CCGs), GPs and other social and healthcare providers in addressing the needs of the local population to provide a joined up EOLC service, through the Mid Essex Locality Group for End of Life Care. The group included clinical, non-clinical and user group representatives from the acute and community settings.
- The EOLC leads spoke positively about the 'transformation workshops' gaining a clear understanding of services in the local area. The sharing of best practices meant patients had a better plan of care.

Meeting people's individual needs

End of life care

- All patients in the last hours/days of life are supported by using of the end of life care plan. The end of life care plan ensured peoples' individual needs were me.t For example we saw staff completing hourly comfort rounds to assess pain, speaking to the patient and relatives present, to assess patient's comfort.
- Patients and relatives found that every stage of their treatment was explained to them, and staff were open and approachable to answer any questions. They were given leaflets and felt fully informed and updated by the staff.
- We heard of how staff facilitated a patient's dying wish to die in their holiday home. The oxygen nurse checked travel updates to ensure they had enough oxygen to make the journey.
- An Abbey pain scale was used to asses and measure pain in people with learning difficulties or dementia who could not verbalise, so that staff can plan appropriate interventions or treatments.
- A symbol of a swan was sometimes placed on the patient's beds to make all staff aware that the patient was receiving end of life care. This was not used on all wards as some preferred to share this information in ward handovers.
- The stroke ward had a family meeting book; consultants used this to record when they had free time. This allowed nurses to book families in to discuss issues around end of life care.
- The bereavement department recently raised money and furnished two rooms in the bereavement suite for relatives. These rooms contained a water dispenser, sofas and soft furnishings.
- There was a multi faith centre, with a prayer room, ablution area, segregation screen and prayer mats for people with a Muslim faith. We saw copies of the Holy Bible and Koran and multi-faith books. There was also support for those with no religious background, including literature and leaflets. The Faith centre manager had recently written a handbook titled ' Best practice and conduct for volunteer chaplains'
- The faith centre had been unsuccessful in employing a dedicated Roman Catholic Priest. Leaders of different faith are happy to cover this area if families feel appropriate.
- There had recently been a civil service and marriage blessing in the faith centre. This was facilitated so a patient, in the last days of life, could have their wedding before they died.
- The faith centre had a prayer book where relatives could request prayer for patients on the wards. They also had a memorial tree where relatives could write prayers and memories on leaves.

Access and flow

- In the period April2014 to March 2015, the SPCT received 682 referrals, 67% were patients with cancer diagnosis and 33% were non-cancer diagnosis.
- An audit conducted by the SPCT in June 2015 showed that there were delays in initiating the referral process to the SPCT. The Audit identified that from initial documented evidence for a palliative care review to actual date of referral, 65% were referred the same day, 12.5% were referred after one day and a 22.5% had been referred beyond two to 13 days, which indicates a significant gap in the referral process.
- Laminated posters were available for staff, to see the procedure for contacting the SPCT. These were not displayed on every ward and some were not updated to show the new working hours.
- Patients wishing to die at home were referred to the hospital discharge team. Ward nurses completed a checklist and this went to the discharge coordinators to triage and put patients on a 'fast-track' discharge. We heard examples where this took up to nine days. Ward staff said they felt frustrated that patients wishing to die at home had to wait 5-10 days, and sometimes died waiting. There was no formal audit process of this fast track process. Staff felt the main issues was a lack of external care providers and it can take up to six days to get a package of care together. Staff told us there were 15 patients waiting for social care packages. There was no rapid discharge home to die care pathway.
- In the event of a death, outside of bereavement working hours, the Intensive care unit had a 'bereavement' bag. This contained all the documents required to issue a death certificate, along with instructions on how to complete them. This would only be used if a family required immediate release of a deceased patient, for religious requirements.

Learning from complaints and concerns

- Staff reported receiving very few complaints in relation to EOL care. In the 12 month period from March 2015 to March 2016, the trust received 11 complaints of which six were upheld or partially upheld. We saw the actions taken and recommendations made, for example of a

complaint made by a family where they were not informed of open visiting hours for their dying relative. This was discussed with the relatives and meeting minutes were documented.
- Complaints were discussed as a standing agenda item in the trust's End Of Life Steering group meeting. We were able to see from the meeting minutes recent complaints concerning EOLC discussed and key learning points shared with staff at ward meetings.
- One relative was able to explain the complaints procedure and has received feedback from complaints in the past. She felt confident in raising complaints, if there were any issues.
- The bereavement team had recently developed a questionnaire leaflet to send out to relatives of deceased patients. The questions were directed to improve areas of end of life care. It was too early to analyse the results.

Are end of life care services well-led?

Good

We rated well led as good because:

- EOL services were well led with evidence of effective communication within and between staff teams. The trust's vision and strategy for the service, which is in draft form, was developed as a system wide locality strategy.
- The visibility of senior management was good and staff felt well supported.
- Risk registers were in place and had actions identified, however, there were no target date for completion of the actions although the risks were reviewed regularly.
- The trust had recently developed a bereavement questionnaire to send out to relatives of deceased patients. The questions were directed to improve areas of end of life care. At the time of inspection, we were told that initial results were positive and the draft report had been submitted to the board; however at the time of inspection we were not able to see the official results.

Vision and strategy for this service

- The trust's draft vision and strategy for specialist palliative care and EOLC was developed as a system wide locality strategy for mid Essex, which has been drafted in line with the Ambitions for Palliative and End of Life Care, a National framework for local action 2015-2020.
- The Mid Essex Locality group (MELG) for end of life is a strategic group that has representations from across health and social care organisations in Mid Essex that are involved in providing care and support for people in the last years of their life.
- 'Transformation workshops' chaired by the medical lead for end of life care, have also been hosted by the trust. Their aim is to establish a best practice regime in the local area by reviewing pathways, scoping common educational systems and looking on how to coordinate end of life care.
- At local level the SPCT were clear about the strategy and vision for palliative and end of life care service. The end of life care facilitator has regular meetings with end of life ward champions to share information at ward level.
- The trust's 'end of life strategy group' met monthly and was accountable to the trust board to deliver palliative and end of life strategies. An end of life care service report was presented to the trust board every six months.

Governance, risk management and quality measurement

- There were a few audits and quality measures in place to monitor the effectiveness of end of life care throughout the trust.
- There was a corporate risk register in place, four risks identified where specifically related to EOL services. There was an awareness of the delays in fast track discharge of patients on end of life care plan although the exact cause and impact of the risk was not specified.
- The inconsistent approach to the recognition of the dying patient across the organisation, provision of Gold Standard End of Life Care and access to appropriate syringe drivers were also listed on the risk register.
- Each risk had control measures in place and a review date but there was no target date for completion of the action on the information received from the trust.

Leadership of service

- The trust has a non-executive director for end of life care. The chief nurse was the board lead for end of life care

End of life care

- The SPCT is lead by a palliative care consultant and consists of one whole time equivalent (WTE) Macmillan Lead Nurse in Cancer and Palliative care, 3.6 WTE Palliative Care Clinical Nurse Specialist band 7,one WTE Palliative Care Nurse band 6 and 0.38 WTE admin and clerical support band 3
- Staff we spoke to throughout the trust were aware of the SPCT. Staff also reported about the good working relationship with them and the support and training they provided.
- The trust introduced the role of an end of life care facilitator in February 2015. All staff we spoke to could tell us about the work of the facilitator, in particular the rolling out of the new 'last days of life care plan' across the trust. Staff spoke positively of this new role and how it has helped in coordinating end of life care within the trust
- All the wards we visited had palliative/end of life champions that assisted with training and information sharing.

Culture within the service

- Staff we spoke with showed a commitment to delivering good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff about the level of support they received from the SPCT.
- Staff had regular one to one meetings with their line manager where they could discuss concerns and any cases they had found emotionally difficult.

Public engagement

- The trust had recently developed a bereavement questionnaire to send out to relatives of deceased patients. The questions were directed to improve areas of end of life care. At the time of inspection, we were told that initial results were positive; however we were not able to see the official results.
- Members of the public and Healthwatch are represented on the trust's end of life strategy group.
- The trust used the system wide, 'start well, live well' locality program to raise awareness about end of life care service.

Staff engagement

- The trust took part in the 2015 NHS staff survey; with a response rate of 25%, which puts it in the lowest 20% of acute trusts in England. Overall, compared to the national findings, there were four negative findings and one positive finding; all other measures were within expectations.
- The trust's end of life leads told us that the 'transformation workshops' have been a very good opportunity to engage with staff and get feedback on end of life care.

Innovation, improvement and sustainability

- All ward staff and members of SPCT, including nursing, medical, allied health professional, demonstrated a strong focus on improving the quality of care and people's experience of end of life care.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The outpatient's services at Mid Essex Hospital Services NHS Trust covered a number of sites, which included Braintree Community Hospital, St Peter's Hospital, Brentwood Community Hospital, St Michael's Hospital and Broomfield Hospital.

The main outpatient area was located in the private finance initiative funded (PFI) atrium at Broomfield Hospital. This was purpose-built and opened in 2010. The rest of the outpatient services were located in the older part of the building. The trust covered a wide range of specialities such as, opthalmology, musculoskeletal, surgical and medical, as well as the St Andrews burns and plastics regional unit at Broomfield hospital.

The trust had 656,000 outpatient attendances during the period April 2015 to March 2016, with 562,639 of those seen at Broomfield Hospital. Outpatient appointments were available Monday to Friday between 8.30am to 5.00pm with regular evening and weekend clinics dependent on speciality, capacity and need.

Diagnostic Imaging services were available across the sites, and offered seven days a week at Broomfield hospital. The service included imaging, ultrasound, fluoroscopy, computerised tomography (CT) and magnetic resonance imaging (MRI).

The last inspection in November 2014 highlighted concerns regarding:- staff shortages, late running clinics, the number of patients waiting for follow up appointments, and a decline in the percentage of patients waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers in the first quarter of 2014.

On this occasion, we only visited Broomfield Hospital. We inspected and observed 19 areas across main outpatients, diagnostic imaging and pathology, and spoke to 37 members of staff including managers, administrative staff, radiographers, nurses, and doctors. We also spoke to 16 patients, and inspected 11 patient records. We reviewed trust policies, procedures, and performance data

Outpatients and diagnostic imaging

Summary of findings

We rated outpatient and diagnostic imaging services to be good because:

- Main outpatients and diagnostic imaging services had strong effective leadership with the exception of the orthopaedic and fracture clinics which lacked nursing leadership and supervision. Specialist clinics such as urology, ophthalmology, cardiology, diabetes and pain services were well managed by their own specialist teams.
- The appointment booking team had good leadership and a risk management system for follow up appointments that were overdue. The trust was performing better than the national average in seeing patients within two-week cancer wait and the incomplete pathway targets.
- We saw evidence of effective multidisciplinary team working.
- There were consultant staff shortages, in diagnostic imaging, neurology and dermatology but there was a continued effort to recruit to the vacant posts. Where there were shortfalls in staffing, there were arrangements in place to access cover. Nursing staff shortages in diagnostic imaging and main outpatients were in the process of recruiting.

However:

- Patients waited on average 27 minutes for their appointment but did not seem unduly concerned by this. The trust reported 35% of patients waited longer than this.
- Although there was good leadership within most of the specialities and main outpatients, there was a lack of connection between the different outpatient departments.
- The percentage of patients receiving treatment within 62 days of referral has continued to decline below the England standard of 85% (72.4% in February 2016).

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safety in outpatient and diagnostic imaging services as good because:

- The orthopaedic clinic stored medicines cupboard keys in a patient accessible location
- Orthopaedic patient's records were not stored securely.
- There was no induction for bank staff in orthopaedic clinic and senior staff were unable to locate any training records during our visit.
- The diagnostic imaging area stored contrast in an unlocked cupboard in an office which was locked when not in use. This was highlighted during our inspection and we were informed this was in the process of being rectified. Although requested, we did not see records of temperature checks for the contrast warmer.
- The ENT and oral/orthodontic clinic did not submit monthly compliance data for personal protection equipment (PPE), this information was not available at the time of inspection, and there was poor adherence to infection prevention and control (IPC) audit from the orthopaedic and fracture and x ray departments.
- There were nursing staff shortages in the orthopaedic and fracture clinic service due to sickness.
- The trust had been unable to recruit to vacant dermatology and neurology consultant positions, this was on the risk register. Continued provision of these services was managed by staff working extra hours.

However:

- Incident reporting was well embedded and there was evidence of learning from investigation.
- We saw evidence of regular cleaning and checking of equipment. However, we found that the checking of resuscitation equipment within the orthopaedic/ fracture clinics was inconsistent.
- Staff had a good understanding of duty of candour and their responsibilities in relation to the protection of vulnerable adults and children. There was appropriate safeguarding trained staff available in outpatient clinics when required.

Outpatients and diagnostic imaging

- The diagnostic imaging department had a regular quality control programme for their equipment from an outside source. Equipment was well maintained in line with the appropriate guidance and legislation.
- A modified surgical checklist was used for any invasive procedures throughout the service.
- Medication and records were stored appropriately in all areas seen other than the orthopaedic clinic.

Incidents

- There was an electronic incident reporting system in place, and staff were aware how to use it. Some staff within the pathology service felt the reporting system was cumbersome and gave up reporting an incident. Additional training regarding incident reporting had been set up within the department.
- Staff received information via e-mails, team meetings and attachments to the duty rotas to enable them to review and learn from incidents.
- There were no never events (a never event is one in which a serious, largely preventable patient safety incident happens that should not occur if proper preventative measures had been taken) for outpatients or diagnostics and therapies reported in the period April 2015 to March 2016.
- The outpatients department reported 147 incidents between April 2015 and March 2016. The majority of these (113) were reported as non-injury incidents, with 22 near misses relating to issues such as; - wrong identification information in notes, and 12 minor injuries mainly due to trips and slips. There were no serious incidents (SI) during that period. An SI can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened
- The diagnostic imaging department reported 242 incidents between April 2015 and March 2016. Incidents were monitored to identify trends, for example inappropriate MRI referrals. There was evidence of an action plan to improve the information to guide referrers and improve junior doctor's current induction to reduce referrer incidents.
- There were six SIs reported by the diagnostic imaging department between April 2015 and May 2016. Four Root Cause Analyses (RCA) were reviewed. There was thorough investigation of these incidents and identification of learning opportunities. Two of the RCAs related to missed opportunities for diagnosis on films reported by an outsourcing company. We were reassured that there were robust audits and evaluation of reports from the outsourcing company used to report diagnostic images.
- Staff in diagnostic imaging were aware of their responsibilities for reporting and who to report incidents to such as; the Radiation Protection Adviser (RPA), the Care Quality Commission (under Ionising Radiation (Medical Exposure) Regulations IR(ME)R) or the Health and Safety Executive (HSE).
- The pathology department reported 228 incidents. Two RCAs were reviewed. In both of these incidents, the investigation was robust and changes in practice and further education was recommended.
- Staff had knowledge of their responsibilities of duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Duty of candour aims to help patients receive accurate, truthful information from health providers. Staff were able to give examples of when duty of candour had been discharged in relation to incidents.

Cleanliness, infection control and hygiene

- Outpatient clinics, pathology areas and diagnostic imaging departments were visibly clean and tidy. There were daily clinic cleaning logs in each outpatient clinic room. These were checked and had been completed consistently over the previous two month records available.
- Staff knew how to access infection prevention and control (IPC) policies on the intranet and there was an IPC link nurse.
- All staff adhered to the 'bare below the elbow' policy. We observed good hand washing technique and there were alcohol gel dispensers available at regular locations.
- Monthly hand washing audits of outpatients and diagnostic imaging were completed between June 2015-May 2016, achieving between 96% and 100% for the data submitted. However, there were exceptions due to non-submission of data from the main outpatient x-ray department and the fracture and orthopaedic clinics on two occasions during this period.

- Equipment used in outpatients was clean and equipment was noted to have the 'I am Clean' stickers in place.
- Appropriate arrangements were in place for disposing of clinical waste in outpatient clinics and the diagnostic imaging department using the yellow clinical waste bags and sharps boxes. The sharps boxes were assembled correctly and the date of assembly clearly marked in line with trust policy.
- There was no policy for isolating patients who were an infection risk in either outpatient or diagnostic imaging clinics. However, staff confirmed that as soon as information was available regarding a possible risk, patients were booked to the end of a clinic to minimise contact with others. Upon the patient's departure, the equipment and environment were deep cleaned. Patients attending without prior knowledge were shown to an enclosed waiting area with a door within the department.

Environment and equipment

- The main outpatients atrium was spacious with sufficient seating and signage.
- The reception desk and automated booking in stations were clearly visible and manned during clinic opening times.
- Food and drink was available for purchase from multiple commercial outlets and there were water dispensers available at numerous locations.
- There was literature available for patients and a dedicated children's play area.
- Outpatients electrical equipment was regularly tested and the date of testing labels were clearly visible.
- There were two bariatric examining couches in the main outpatients clinics. Bariatric weighing scales could be obtained by contacting the manual handling team. However, the diagnostic imaging staff did not know and were unable to locate weight limits on the equipment within the x ray department.
- Personal Protection Equipment (PPE) was available and used where appropriate. Radiation protection lead aprons are checked visually every 6 months and screened annually in accordance with IRR Regulations and audit outcomes are recorded on the department IT system.
- PPE audits of outpatient areas commenced at the trust in February 2016. Submission showed 100% compliance for all areas other than the ear nose and throat (ENT), and oral/orthodontic clinics who have not submitted any data to the audit since inception. This information was not received until after the inspection and we were unable to verify why.
- There were radiation warning signs outside areas used for diagnostic imaging and red bulbs outside rooms which lit up to indicate when equipment was in use.
- Radioactive materials were kept behind locked doors in lead lined bins until safe to dispose.
- There was an engineer responsible for diagnostic imaging equipment and a medical physics expert (MPE) from an external company who completed monthly quality control checks on both diagnostic equipment and the laser equipment used in the opthalmology clinic. Evidence of satisfactory checks was seen.
- The outpatient and diagnostic imaging areas were uncluttered and well signposted with sufficient seating. We did see patients standing in the waiting area near one clinic at the beginning of an afternoon session and the nurse explained that this was unusual and only happened at the start of sessions when patients booked in too early for their appointments.
- There were sealed confidential waste bins awaiting collection left in corridors of the ophthalmology clinic. This could represent a hazard to patients with visual impairment. This was brought to the attention of staff and they were removed.
- We checked five resuscitation trolleys. Four of these were consistently checked according to trust policy. However; the orthopaedic clinic trolley had not been equipment and date checked for 10 days and had six gaps for the daily checks over the previous 20 days. This was of concern as an out of hours service used the clinic overnight to treat members of the public and could access the trolley in an emergency. Failure to perform daily checks meant procedures to ensure equipment was safe for use had not been followed. Senior staff were informed on the first day of the inspection (14/06/2016). However, on re-checking the tag two days later on 16/06/2016, we found this had not been changed indicating no equipment check had been undertaken for 12 days.

Medicines

- We saw medicines stored in opthalmology, orthopaedic, urology, ENT and rheumatology clinics. They were stored in line with trust policy in locked cupboards and medicine refrigerators that recorded temperatures to

ensure medicines were stored at the correct temperature. We reviewed three medicine refrigerator daily checklists and saw they had high to low temperatures consistently recorded daily.

- A range of medicines including eye and ear drops, injectable local anaesthetics and steroids were checked and all were in date.
- The outpatient and diagnostic imaging departments used Patient Group Directions (PGDs) for the prescription and administration by non-medical staff, of medicines used during diagnostic procedures. Patient Group Directions are documents permitting the supply of prescription-only medicines (POMs) to groups of patients without individual prescriptions, by healthcare workers. Prescriptions were signed, and monitored according to trust PGD policy.
- Prescription pads were either kept in locked drawers in clinic rooms or cupboards, and these were monitored by the pharmacy department. In the ophthalmology clinic, a limited number (5) of prescriptions were allocated on a named consultant basis.
- The keys for the medicine cupboard in the orthopaedic clinic were kept in a drawer in a metal trolley in a corridor accessible to patients and visitors. The door to the room where the medicine cupboard was located was unlocked and accessible to the public. We highlighted the inappropriate key storage to the nurse in charge during our visit on 14/06/2016
- In the MRI department, contrast for intravenous injection was kept in an unlocked cupboard in an office. The department lead was informed, and a lockable cupboard was requisitioned the same day.
- Contrast for emergency use was stored in an unlocked warmer within the CT room. The trust had assessed this as being an acceptable risk as the contrast was less likely to cause an extravasation (a leakage of fluid from a vein into surrounding tissue) reaction when warmed. We observed the CT room remained locked when not in use. The records of temperature checks for the warmer were requested but not provided. The stores of contrast were kept in a key-code locked cupboard within the department corridor.

Records

- Paper patient records were used within the outpatient department with the exception of the diabetic clinic which also used an electronic system. Diabetic patients kept their own handheld notes, which contained copies of the electronic diabetic records and ensured both staff and patient had access to the most recent information when visiting clinics.
- Clinic letters were accessible on the secure hospital system, which could be used to compile a temporary set of notes if records were not available. These would then be, tracked and combined with usual notes.
- The percentage of patients seen in outpatients without full medical records available for the period 2014-2015 was 0.04%. Staff escalated non-availability of records to the team leaders and clinic staff confirmed that they were usually able trace notes prior to clinic.
- Monthly monitoring of temporary notes and missing files were reported to the health records manager, and daily management of requests for temporary records were filtered through a dedicated clerk. This was to ensure all possibilities of finding the record were exhausted prior to the decision to open a temporary record.
- We reviewed 11 sets of written patient records and found that they were dated, signed, legible and had the appropriate patient identifying data.
- Patient records were transported in sealed blue crates to and from clinics. Records were stored in locked rooms and not accessible to the public. However, staff left notes unattended in an unlocked room in the orthopaedic clinic and notes for patients awaiting consultation were left face up outside clinic rooms on a metal trolley accessible to the public. This meant there was a risk these records were vulnerable to theft as well as unauthorised access to a patient's confidential and personal details.
- The diagnostic imaging department received both paper and electronic (inpatient only) requests. These were uploaded to an electronic system ensuring traceability.
- Diagnostic images were available electronically (password protected) via the picture archive and communication system (PACS) to clinicians in clinics.
- Pathology received requests both electronically (inpatient requests only) and via paper form. There was an action plan in place to redesign these to reduce paper requests.

Safeguarding

- Staff received training at level two for safeguarding children and vulnerable adults as part of mandatory

training. Safeguarding level two is a requirement for all staff who may come into contact with children or vulnerable adults. Outpatient staff met the trust target of 95% compliance. Diagnostic imaging was 85%, this had been noted in the most recent governance meeting for action.

- The diagnostic imaging department had safeguarding level three trained radiographers and the orthopaedic, diabetes, phototherapy, and maxilla-facial clinics all had their own safeguarding level three trained nurse available when children attended. Safeguarding level three is a requirement for all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- A Registered Nurse (child branch), with level three training attended the dermatology clinic when required and the ophthalmology clinic two-three times per week when children attended, and was always booked to accompany children who needed minor procedures in the outpatient's procedure room.
- Staff felt confident in contacting the safeguarding team for advice on a dedicated telephone number during clinic hours.
- The clinic staff described their actions when a safeguarding concern was noted recently. A child had failed to attend the clinic on numerous occasions for a surgical procedure and staff were concerned. The safeguarding lead was involved and a referral was made to the relevant agencies.

Mandatory training

- Access to mandatory training was via an electronic system and face-to-face sessions. Staff received updates from the electronic system to confirm when training was due to be completed. The outpatient matron arranged face-to-face mandatory training sessions for staff at the end of clinics to minimise impact on availability of staff for clinic cover.
- Outpatient and diagnostic imaging mandatory training comprised of Infection prevention and control (IPC), Mental Capacity Act and Deprivation of Liberty (MCA & DoL), safeguarding level one and two and other mandatory training not identified. Records indicated outpatient IPC at 91.9%, (target 80%), MCA & DoL 95% (target 95%), mandatory training at 90.3% (target 80%). These figures did not cover the specialist clinics not managed by the outpatient matron. Diagnostic imaging achieved IPC 92%, MCA & DoL 88.5%, and mandatory training at 94.6%.
- There was concern that the orthopaedic and fracture clinic senior nursing staff were unable to locate any electronic mandatory training records to confirm their status despite two requests. We saw nurse training records in urology, diabetic and pain clinics, which met trust targets.
- Medical staff training was agreed and arranged through the specialities' division, for example surgery or medicine.

Assessing and responding to patient risk

- Staff performed observations of patients, such as blood pressure, pulse and respirations as required. Nursing staff were trained to perform blood glucose monitoring if indicated.
- Modified World Health Organisation (WHO) surgical checklists were used in the diagnostic imaging areas prior to invasive procedures and evidence of audit of this was seen. This has improved monthly since inspection in 2014. The audit from May 2016 showed 100% compliance. A modified WHO checklist was also used in the minor procedures room in outpatients although audit of this was not seen.
- Radiographers followed IR(ME) regulations and checked previous images before proceeding with a scan or x-ray and were compliant with the Royal College of Radiologists (RCR) standards regarding the use of contrast agents.
- There were Radiation Protection Supervisors (RPS) for each clinical area. Diagnostics and imaging staff annually audited patient dose assessments and the diagnostic reference levels (DRLs) were displayed in each imaging room and audited monthly to optimise radiation exposure. Diagnostic reference levels are used to help manage the radiation dose to patients so that the dose is proportionate with the clinical purpose and can be measured against local and national levels. Evidence of the audits was seen on inspection.
- There were protocols for identifying and fast tracking significant imaging abnormalities. This meant that the referrer and secretary were informed of abnormal images sooner and action could be taken.
- Staff in the clinics we visited were able to describe how they managed a patient who was deteriorating in clinic.

The procedure differed depending on the location or type of clinic. The emergency medical team were bleeped for medicine clinics and diagnostic imaging, the pain clinic sent patients to the emergency department. There was no specific protocol regarding deteriorating patients in outpatients or diagnostic imaging.

Nursing staffing

- Staffing establishment in main outpatients were eight trained staff and 11 band three healthcare assistants. There were two trained nurse and one healthcare assistant vacancies with one trained nurse awaiting a start date. The nursing staffs' shortfall was covered by staff working extra hours on the nurse bank scheme. Agency staff were never used.
- The number of staff required changed from day to day dependent on the number of clinics running that day. The matron adjusted the staff requirements and skill mix according to need.
- Staffing levels were below the establishment of 11 in orthopaedic and fracture clinics, predominately due to four staff on long-term sickness and two vacancies. Four bank staff were regularly required to fill clinic requirements. There were no induction facilities for these staff with the senior nurse indicating new staff should "follow them around".
- The diagnostic imaging department had recruited one registered nurse, which still left them one nurse short of their four trained nurse establishment. Recruitment was on going to staff the new interventional unit, with approval for four trained nurses, for the planned opening in November 2016.

Medical staffing

- The diagnostic imaging department had long-term radiology staff shortages and used agency staff to fill substantive positions. At the time of inspection there were four radiologists in post, with two shortly to transfer from an agency. The shortfall in radiology establishment was being managed by outsourcing reporting and supporting radiographer role extension.
- Medical staffing had long-term vacancies in neurology, dermatology and opthalmology. Locum consultants had been in place long term in dermatology. The neurology consultant shortfall was covered by the existing team adding ad hoc clinics and referring patients to an outreach clinic. Opthalmology specialist nurses were trained to carry out procedures including ophthalmic injections to support medical colleagues. Recruitment for these positions was on going.

Major incident awareness and training

- There were business continuity plans in place to ensure that the delivery of services were maintained in the event of major incident, however there was inconsistent knowledge of the role of outpatient staff in the event of a major incident. Three members of staff we spoke to did have a good understanding and could describe the action to cancel all appointments that day and that the outpatients would act as the overflow for the emergency department and to treat minor injuries. Staff in orthopaedic and fracture clinics were aware that there was a policy somewhere, but were unable to describe their role or that of outpatients in general.
- Some junior staff were less able to discuss their actions or responsibilities and were unable to confirm that they had had any scenario practice.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We rated effectiveness in outpatient and diagnostic imaging services as good because:

- Staff worked to recent National Institute for Health and Care Excellence (NICE) guidance.
- There was evidence of working towards participation in national quality assessments such as Improving Quality in Physiological Services (IQIPs) and Imaging Services Accreditation Scheme (ISAS).
- Diagnostic imaging service operated seven days a week.
- Staff were trained appropriately for their roles and training for extended roles was available.
- Multidisciplinary (MDT) working was evident in several specialities

However:

- The orthopaedic clinic informed us they were unaware of any MDT meetings.

Evidence-based care and treatment

Outpatients and diagnostic imaging

- Staff in diagnostic imaging adhered to clear standard operating procedures (SOPs) as required under Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000. These addressed patient identification using the three points of identification recommendations, the responsibilities of individual members of staff, and set training requirements for staff working in the imaging department.
- Radiation dose levels were on laminated posters in every diagnostic imaging room as recommended by IR(ME)R to ensure dose levels were always available for patient efficacy and safety.
- Radiography staff adhered to guidelines from the Royal College of Radiology to obtain a renal function test prior to administering contrast. We saw evidence to corroborate this.
- Staff in outpatient clinics and diagnostic imaging had access to policies and procedures and other evidence-based guidance via the trust's intranet.
- Staff we spoke with in cardiology, urology and opthalmology were aware of NICE and other guidance that affected their practice and were compliant. In the diabetes clinic we saw evidence of compliance such as recent NICE (2015) guidelines for the management of type one and type two diabetes, which introduced new guidance for managing blood glucose levels and the diabetic foot. The diabetes service has introduced podiatry services to accommodate this.
- The ear, nose and throat (ENT) team were part of the Head and Neck Cancer Network, which collects data on cancer at these sites and best practice evidence and guidance for treatment.

Pain relief

- Pain relief was available to patients having invasive diagnostic procedures, such as anti –spasmodic medication, which was prescribed via a PGD.
- Visual Analogue Scores (VAS) were used in pain clinic to assess pain levels and provide information regarding responses to treatment. A visual analogue score is a self-assessment tool to express a value normally between 0-10 to indicate no pain-extreme pain.
- Cognitive Behavioural Therapy (CBT) was offered in the pain clinic. This taught patients coping mechanisms to manage pain, alongside pain management sessions.
- No pain relief was dispensed in pain clinic but was prescribed as required for collection at the pharmacy.
- Local anaesthetics were used in orthopaedic clinic and the procedure room for joint injections and dermatology procedures.

Patient outcomes

- Patient outcome sheets were completed following an appointment to indicate; further appointment, procedure performed or required, discharge etc. These were given to the receptionist staff for recording and action.
- The pain clinic measured individual patient outcomes such as sleep, medication, numerical pain score and work ability following procedures, to assess their efficacy. These showed an overall 40% improvement on patient baseline scores prior to procedures.
- The cardiac clinic audited several patient diagnostic tests and procedures as part of an IQIP application. IQIP is a 'professionally-led assessment and accreditation program designed to improve services, care and safety for patients undergoing physiological science service tests, examinations and procedures'. Participation in IQIP provides independent assurance that accredited services meet standards for best practice.
- The diagnostic imaging department was working towards participation in the ISAS. The ISAS is a patient focused assessment and accreditation programme designed to help imaging services ensure patients receive consistently high quality services delivered by competent staff in safe surroundings. The process was on-going and involved provision of evidence of practice and regular audit.

Competent staff

- Staff received the appropriate training for their roles and we saw evidence of competency assessments in pathology, and blood glucose monitoring in outpatients.
- New staff were inducted into the clinical areas and this differed depending on the area. For example in diagnostic imaging, induction was three months with staff rotated across the different areas for experience. In the diabetes clinic a member of staff in confirmed that they had asked for their two week supernumerary induction to be extended by two weeks to give them more time to develop confidence. They had clear objectives set, and they were positive about the support that they received for learning new skills.

Outpatients and diagnostic imaging

- Clear orientation and competencies were well established and staff were encouraged to develop additional skills for promotion purposes. Postgraduate studies were supported.
- Specialist nurses led face to face and telephone clinics. A consultant nurse was employed in the diabetic service and we spoke to nurse practitioners for urology, ophthalmology and pain clinics, all of whom had undertaken additional training to increase their knowledge and skills.
- Main outpatient diabetic clinic, urology and ENT/head and neck staff yearly appraisals were between 85-100% and within trust target of 80%.
- Diagnostics and therapies current yearly appraisal rate was at 75%, this was below the trust target rate of 80%. This was identified in the June 2016 governance meeting minutes as an area for improvement.
- Staff were given the opportunity to develop and extend specialist skills appropriate for their role and attend management and leadership courses.
- The diagnostic imaging department had a rolling programme to train sonographers and develop radiographers reporting skills. Four radiographers were being trained in image reporting and two sonographers were due to finish their training in July 2016 with a third in training and another due to start in September.
- ENT staff were participating in further postgraduate specialist education to enhance the knowledge and improve service and one nurse was undertaking a non-medical prescribing course.
- All specialist staff in opthalmology clinics had laser competencies, which enabled them to operate the laser equipment.
- The pain clinic specialist nurse was Cognitive Behavioural Therapy (CBT) trained, to support patients with talking therapy, which enabled them to manage their problems by changing the way they thought and behaved.
- Recent new leadership in the pathology (haematology) department had highlighted the lack of competency assessments relating to equipment and procedures . Recent evidence showed the service was improving with the previous result of 9% increasing to 48%. There was an on-going plan to reach 100%.

Multidisciplinary working

- There were some excellent examples of staff working together for the best interests of patients. For example, the head and neck and urology teams, held multidisciplinary meetings every week involving several other specialists.
- The diabetes team participated in multidisciplinary working with General Practitioners (GPs), dieticians, podiatry, vascular teams and maternity.
- Orthopaedic clinic staff were not aware of any multi-disciplinary working but when questioned admitted that the spinal and pain team had MDT meetings (corroborated by the pain team), and there was a one-stop spinal clinic. We observed a physiotherapist working alongside clinicians in fracture clinic.
- The booking centre staff worked collaboratively with clinicians, clinic staff and managers to ensure that patient's appointment needs were met. Daily meetings were held to assess and manage capacity and risk.

Seven-day services

- The Diagnostic imaging department operates a full service Monday to Friday between 9am to 5pm with MRI extended to 8pm each day. There are also elective CT and emergency MRI and ultrasound sessions held at weekends. Emergency CT and plain film are available 24 hours a day 7 days a week.
- The outpatient clinics were held during the hours of 8.30am to 5pm Monday to Friday. Extra clinics were scheduled at the weekends to meet requirements dependent on staff being available. There were regular evening clinics on Wednesdays to accommodate the respiratory service, which enabled patients with malignant disease to spend more time with the clinician.

Access to information

- The outpatient clinics used mainly paper medical records although some clinics also had an electronic system. The written medical records were stored on site near the main outpatient department and requested prior to clinic date.
- Patients who attended a consultation without their primary set of records were issued a temporary folder. These were tracked and prepared ready for clinic as a primary set of notes. For new patients, the GP referral letter was included along with clinical paperwork for logging the outcome of the consultation.

Outpatients and diagnostic imaging

- Blood results and diagnostic imaging reports and images were available to the doctors via an electronic system.
- The diabetic service used an electronic records system, which generated a hospital to GP letter within 24 hours. The trust aimed to have a clinic letter sent to a patient's GP within five to seven days.
- Patients were asked if they wanted a copy of the letter sent to their GP following their consultation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The diagnostics and outpatients departments achieved the trust target of 95% completion for Mental Capacity Act (MCA) 2005 and Deprivation of Liberty (DOLs) training. This figure was broken down into nursing, administrative, allied health professionals, but did not include medical staff.
- Staff had good understanding of consent. We observed consent for a procedure being explained, and confirmation sought that the patient understood. Staff could give examples of when patients attended with relatives who had power of attorney and issues with consent to treatment. Staff told us that if a best interest's decision were required, the specialist link nurses for learning disability or dementia were involved. However; the fracture clinic senior nursing staff could not demonstrate a clear understanding, and when questioned, did not feel that their patients ever had MCA needs. They confirmed they had never accessed an MCA form but did know it was somewhere on the intranet. When asked how they would manage a patient who was suffering from dementia and refusing treatment they explained that they would "just talk them round"

Are outpatient and diagnostic imaging services caring?

Good

We rated caring within the outpatients and diagnostic imaging as good because:

- Patients were warmly welcomed and treated with respect.
- Patients told us staff were caring and compassionate.
- We saw staff interactions, explanations and discussion with patients to make sure they understood procedures and processes.
- Chaperones were available.

Compassionate care

- We observed medical, nursing and ancillary staff providing care for patients and interacting with visitors and relatives with kindness and respect.
- Staff introduced themselves and their role.
- We saw staff directing and escorting patients to clinic areas. Patients told us that they were treated with respect and comments such as "they've been very good here", and "staff are very helpful, very understanding and very considerate". One patient was so impressed with their care that they specifically waited after their procedure to talk with us. They described their care as 'amazing' and the staff as 'angels'.
- Patients were seen in rooms, which were private and protected patient's dignity.
- We observed staff knocking on doors prior to entering consulting or changing rooms.
- Rooms had either privacy curtains for undressing or separate changing areas.
- Robes were provided for diagnostic procedures or examinations that required clothing removal.
- Nurse chaperones were available and always used in orthopaedic and fracture clinics, and in diagnostic imaging where appropriate.
- Staff were aware that patients had differing cultural, social and religious needs and were able to explain what that meant for their care such as different faiths needing appropriate places to worship and having dietary needs.

Understanding and involvement of patients and those close to them

- The reception staff welcomed patients and gave clear directions and instructions about where to sit and wait and to watch the information screens for their name to show.
- Staff explained what was going to happen to patients and ensured that the patient and their carer or relative understood the information.
- Patients told us that they were involved in the decisions made about their care and were given enough

information to make their decisions. One relative with a power of attorney for a patient with dementia told us how thorough the doctor had been in explaining the treatment and risks.

- The outpatient Friends and Family test for April 2016 was reported as being 82% positive with 7,327 responses out of a possible 26,538. This indicated a higher number of people responding compared to national averages. However, 82% is lower than the national average of positive responses about their experience in the outpatient department. This number had slightly improved on the 79% reported positive in April 2015.

Emotional support

- Clinical nurse specialists were present in clinic if there was bad news to impart, and were heard being supportive and compassionate.
- There were a number of support groups, for example; a 'head and neck support group' was run by patients with input from the clinical nurse specialist. In the urology department, a patient and nurse led group supported patients with prostate cancer.
- Patients we spoke to were complimentary about emotional support offered and all but one patient were very satisfied. The one dissatisfied patient felt that staff in the diagnostic imaging department were not understanding when they felt unable to proceed with a CT scan due to feeling claustrophobic, and made them feel as if they were being unreasonable.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:-

- The trust was exceeding its referral to treatment (RTT) performance targets for incomplete pathway and two-week cancer waiting times.
- Services were set up to meet the needs of patients and there were rapid access and one-stop clinics for some specialities. Other specialities offered telephone clinics and telephone advice lines.
- Complaints were dealt with in a timely manner and there was evidence of a change in practice as a result.
- Staff were committed to ensuring that patients received appointments when appropriate. There were processes embedded to risk assess and monitor patients whose appointments were delayed.

However:-

- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was 72.7% at the end of March 2016. This was considerably lower than the England average of 82% and the target of 85%.
- There was very little patient accessible information available; most was distributed by nurses at appointments, which meant that patients who felt unable to ask for information that might be of a sensitive nature were unable to look for it themselves.

Service planning and delivery to meet the needs of local people

- There were 23,662 patients on the pending list, this number was for all patients awaiting an appointment between six weeks and two years. A weekly trend report identified the patients who were overdue appointments. At the time of inspection, there were 1,596 patients who were more than six weeks overdue a follow up appointment, and 203 awaiting a first appointment. First appointments were triaged by clinicians to risk assess them prior to appointment being made.
- The departments with the greatest number of overdue patients were ophthalmology, neurology, dermatology, rheumatology and respiratory medicine accounting for 1,109 appointments. These figures had improved on those reported (3,619) in the previous inspection.
- The booking manager met daily with senior team members to update and plan access for patients who were likely to breach waiting times, and the chief operating officer (COO) attended regular meetings with the clinical commissioning group (CCG) to revise service planning and referral pathways.
- Some specialities such as breast clinic, rheumatology, dermatology and diabetic were able to offer rapid access clinics and specialist nurses ran telephone clinics and telephone advice lines. This enabled patients to access specialist advice without making a trip to the hospital.
- Staff expedited appointments for patients who required transport and were brought in either late or early, to ensure they were ready for collection.

Outpatients and diagnostic imaging

Access and flow

- Patients attending the outpatients department booked in via an automated system using a barcode on their appointment letter or personal details, or by attending the reception desk. Information was available in different languages on the automated system. There were receptionists available if patients did not want to use the automated system or had difficulties. If patients preferred, their name was not displayed and an identifying number could be used instead to protect their privacy. Waiting times were also displayed on the screens. Staff and patients felt that the system worked well and was easy to use although we did observe one person having difficulty.
- The trust operated a partial booking system for follow up appointments. Appointments required within six weeks were booked before the patient left the clinic. If there was no capacity, the receptionist went back to the requesting doctor for advice. Appointments of longer than six weeks were added to a pending list. Overdue appointments of more than six weeks were referred to the supervising clinician for risk assessment to ensure it was safe to delay appointment. Ad hoc clinics could then be organised to meet capacity if required. When questioned why wait until six weeks had passed before bringing to a clinicians attention, we were told that this was what had been agreed with the clinical teams.
- Following the appointment, patients took their outcome sheet to the reception desk. Follow up appointments of less than six weeks were booked directly and appointments of longer than six weeks were added to the pending list, and sent out nearer the time.
- The trust had a centralized booking management service responsible for all outpatients booking except for the pain clinic. The majority of first appointments were made using the 'choose and book system' (99%), and these were mainly GP or tertiary referrals.
- Referral to treatment (RTT) for incomplete pathways was 96% for the period April 2015 to March 2016. This was higher than the operational standard and the England average of 92% indicating the trust was performing better than average.
- The percentage of people seen within two weeks for urgent referrals was 96%, compared to the England average at 95% % and met the 93% target.
- The did not attend (DNA) appointment rates were lower than the England average The trust was trialling a text reminder scheme for some clinics.
- The new to follow up ratio was 1:2. This was in the lowest quartile nationally and means that the trust had effectively managed to reduce repeated follow up attendance for patients.
- The outpatient diagnostic imaging tests were by appointment only and there was patient choice with the choose and book system.
- Cancellation of clinics with less than six weeks notice was 0.7%, and more than six weeks was 0.9%. The time period for these figures was requested but not provided. Clinicians who cancelled clinics within six weeks were required to offer an alternative date. The main reasons given for cancellations related to late notice changes to rotas.
- Less than 0.5% of people referred for a diagnostic imaging test had to wait longer than six weeks, which was lower than the England average of 1.3% and the standard of 1%.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment had fallen to 72.7% at the end of March 2016 and this was worse than the England average of 82%. %. This was on the trust risk register and there was evidence of a plan in place to commence a monthly breach panel chaired by the lead cancer clinician for the trust which fed into governance and MDT meetings.
- Cancellations of less than six weeks was 0.7%, and more than six weeks was 0.9%. The time period for these figures was requested but not provided. Clinicians who cancelled clinics within six weeks were required to offer an alternative date. The main reasons given for cancellations relate to late notice changes to rotas.
- Trust figures for the period January to March 2016, of appointment time, to time seen average was 27 minutes. Some clinics had longer waiting times, for example; respiratory medicine, haematology, urology and the allergy clinics all had average waiting times of 40 minutes or more. These equated to 35% of patients seen. There had been no change overall since 2014 when this was highlighted as being of concern.

Meeting people's individual needs

- There was a diabetes telephone advice line for patients to contact during the day if they had queries. The specialist nurses responded to messages left on the dedicated answerphone. This service received approximately 30-40 calls per day.
- Community patients were able to download their blood sugar test results to the hospital e-mail system. The specialist nurse would contact patients to discuss any changes in treatment required, which negated the need for a hospital appointment.
- The diabetes service also introduced podiatry clinics within the diabetic centre and increased their vascular multi-disciplinary team working as a result of a national diabetes audit in 2014/2015.
- Patients with learning difficulties or dementia were seen at the start of clinics, to avoid any prolonged waits, which could cause distress. In the Ophthalmology clinic, a quiet room was made available for patients who required a quiet area to wait.
- Loop hearing systems were in place for the hard of hearing in clinics.
- The ophthalmology clinic had a separate booking in desk with a large yellow depiction of an eye for those with visual problems so they did not need to use the automated self-check in system.
- One-stop clinics were operated for urology, spinal clinics and dermatology to provide an effective diagnosis to treatment seamless service for patients.
- There was a telephone translation service available for those who did not speak English and staff told us this worked well. The matron was able to confirm that they did not use members of patient's families to translate.
- Switchboard contacted the local deaf society for sign language translations when needed.
- There was a lack of visible patient information leaflets in the various departments. We did see patient information leaflets in one clinic waiting area but there was no disease specific information routinely displayed elsewhere. When discussed with the outpatient matron, we were told that due; to the main outpatient area being privately funded, there were restrictions on what could be attached to the walls to hold leaflets etc. Some departments had supplied their own leaflet trolleys, which were brought with them for specific clinics, but this was not the case with all clinics.
- There was no information supplied in any other language than English. This was not considered necessary, as the population seen in the clinics was predominantly English speaking although we were unable to ascertain confirmation of this.

Learning from complaints and concerns

- The Patient Advice and Liaison Service (PALS) office was located in the main atrium area. Information about how to make a complaint and PALS was available at the reception desks.
- Staff told us complaints and incidents were discussed at the clinical governance meetings. This was noted in the meeting minutes from 10/03/2016 but no detail of complaint or outcome reported. Outcomes were disseminated to staff verbally at staff meetings and via messages left on the daily duty sheet in main outpatients.
- The majority of concerns related to changed, cancelled or long waits for appointments and delays in clinics. Long wait for appointments was being addressed via the daily meetings of the booking department. Staff told us that they were trying to update the 'information totems' more frequently during clinic sessions to update patients regarding waiting times in clinics. Complaints regarding the lack of wheelchairs resulted in 50 more wheelchairs being purchased for the main outpatient area.
- Staff we spoke with were aware of the local complaints procedure, and were confident in dealing with complaints if they arose. There was evidence of learning from complaints in the phlebotomy department, where complaints regarding staff attitude have resulted in a new two week customer care programme developed at the beginning of 2016 for all new and existing staff.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well led as good because:-

- Within specific areas, there was evidence of exemplary leadership and management.

Outpatients and diagnostic imaging

- The diagnostic and imaging services had well established governance and assurance arrangements in place.
- There was a high level of confidence in the leadership and management of the diagnostic imaging service and staff felt well supported and actively encouraged to develop as professionals.
- The main outpatient matron (seconded position) showed great understanding of the needs of the department and was visible and supportive.
- Risk registers were maintained in outpatients and the diagnostic and imaging services, these were fed to the corporate risk register and the executive team. Senior staff were able to tell us what was on their risk registers and what action was being taken, such as staff recruitment.

However

- There was no joined up working between the clinics managed and those that were managed by the different specialities. We did not see any evidence of communication, meetings or cross directorate working that was not clinically based. This led to an overall lack of cohesion across the outpatients departments.
- The leadership within the orthopaedic and fracture clinics required improvement. There was no formal induction for bank staff working within the department and staff were unable to access training and appraisal information.

Vision and strategy for this service

- Senior management staff were aware of the trust vision and values; however, there were no stated vision or values specifically for the outpatients or the diagnostic imaging department. Senior staff of these areas acknowledged that this needed addressing.
- Diagnostic imaging senior staff had a clear strategy for the future following a departmental review in January 2016, and were actively involved in plans for extending the outpatient x-ray department to include a new interventional suite.
- The junior members of staff were aware of the trust's recent culture events and some had made pledges on the 'never walk by' posters. Most staff were aware of the trust's vision and values.

Governance, risk management and quality measurement

- There were robust arrangements for identifying, recording and managing risks.

Risks were identified on the divisional risk registers for outpatients and diagnostic imaging.. Risks were regularly monitored and there was evidence of updating of risk changes and planned solutions with timeframes. The risk lead was identified and entries were rated correctly and dated. Some clinics had their own risk assessment folders with activity recorded.

- Regular quarterly outpatients and diagnostics and therapies governance meetings were held, these were well attended. The minutes of the last three meetings were seen with the most recent being from 09/06/2016. Recorded information covered operational issues such as appraisals, equipment competencies, staff turnover, risk register, complaints and incidents and clinical audit.
- Diagnostic imaging had a dedicated staff member for clinical governance across the service. Their role included monitoring all incidents and near misses, reporting lessons learnt to the staff, attending the monthly radiation protection advisory group, auditing referrals, and undertaking a full range of risk assessments. Evidence of the audits, meeting minutes and risk assessments was seen on very comprehensive databases accessible by other senior radiography staff.
- The diagnostic imaging department outsourced image reporting and they confirmed that there was good governance in place with sampling of reports for secondary checking. However, there was one known incident of a missed diagnosis of malignancy as a result of their reports.
- NICE guidance recommendations and adherence were monitored in the relevant directorate clinical governance committees.
- Outpatient staff had a clear understanding of their roles and responsibilities and ownership of specific targets such as IPC and cleaning rotas.
- Diabetes clinic held regular morbidity and mortality meetings and fortnightly team meetings, which included review of complaints and incidents. Evidence was seen of the minutes of meetings. A recent documentation audit identified a lack of consistent data recorded, and we saw an action plan had been put in place to address this.

Leadership of service

Outpatients and diagnostic imaging

- There was no clear overarching leadership of all the outpatient clinics.
- There was strong leadership seen from the diagnostic imaging lead and the main outpatients clinic matron. They demonstrated understanding of the challenges to their departments and staff and were able to identify the actions needed address those challenges. Staff had a great deal of respect for these individuals and indicated that they were approachable and supportive.
- The main outpatient's matron visited the clinics every morning and the associate chief nurse visited once a week.
- In the other outpatient clinics not managed by the matron, leadership was difficult to assess as the staff in these areas were managed by different specialties within the separate divisions.
- Staff were aware that they could take their concerns to the management team although none we spoke to had found it necessary to do so.
- The pathology department had recently employed a new clinical lead and staff were positive about some of the changes that had already started such as support for training, competency assessments, audit and documentation reviews.
- However, we felt the leadership within the orthopaedic and fracture clinics required improvement. There was limited knowledge regarding major incident policy, or MCA, bank staff were not offered induction, regular team meetings were not arranged, stating 'lack of time as a reason', and there was a lack of awareness of the results of incidents reported and an inability to give any examples. The location of staff appraisals or mandatory training records were unknown.

Culture within the service

- The diagnostic imaging lead and outpatients matron demonstrated a strong vision for the future of their services. They were aware of the challenges they faced, but had plans in place to develop services and staff.
- Staff in outpatients and the diagnostic imaging departments were positive about their roles and felt the trust was going through a period of change. Staff told us that they were being kept updated through trust intranet, newsletters and information disseminated by their managers. Staff were encouraged to voice concerns and ideas at team meetings and the outpatient matron and diagnostic imaging lead had open door policies.
- Staff within the diagnostic and imaging service felt well supported.
- We observed good working rapport between nurses, doctors and allied health professionals. Staff expressed mutual respect for each other's roles, and spoke of team working being very important.
- Staff told us they had been in their current role for several years and stayed because they enjoyed their job and felt valued by patients and other team members.

Public engagement and Staff engagement

- Staff from ENT told us they had attended a listening event with patients to hear what matters to them and found it very useful. Parking issues were a prominent theme.
- The oncology staff felt they were kept well informed by the executive team and felt the intranet was a great source of information.
- Staff in the opthalmology clinic felt they were well informed of current issues by the trust executive team via newsletters, e-mails and the intranet.
- The trust had a recognition and award scheme (OSCAs) and there were several incidences of staff receiving the awards. The outpatient matron had received an OSCA in 2015 and one of the qualified staff nurses had received 'nurse of the year' with a health assistant as runner up. The phototherapy clinic had received an award for efficiency and effectiveness. An award presentation took place in the main atrium in front of staff and patients during our inspection.
- There was scarce displayed information around the outpatients and diagnostic imaging departments indicating the results of any surveys or outcomes such as friends and family surveys, PALs or invitation to give feedback or join a patient group. Patients we spoke to were unaware of patient representative group survey results.
- There was a patient council group for the hospital and representatives of this were invited to meetings with the outpatients team, but there was no specific outpatient group to represent the patient's voice.

Innovation, improvement and sustainability

- Staff in urology clinic set up a speciality urology twitter group to share best practice and network and recently held a forum on twitter to share professional experiences.

Outpatients and diagnostic imaging

- Diabetes clinic team responded to e-mailed blood glucose results from community patients, which allowed patients access to specialist clinical advice without the necessity of attending hospital.
- Diagnostics imaging department initiated a fast track waiting system to reduce urgent requests from 14 days to 10 days.

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital MUST take to improve

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

Action the hospital SHOULD take to improve

- Safely plan and increase consultant cover in the emergency department from 11 to 16 hours per day as recommended by The Royal College of Emergency Medicine.
- The provider should take action to improve MRSA screening for elective and emergency patients
- The provider should improve Referral to Treatment Times (RTT) for elective patients. The provider must ensure that the trusts referral to treatment (RTT) times are achieved in the four surgical specialities of general surgery, trauma and orthopaedics, ophthalmology and plastic surgery
- The provider should take action to reduce the number of cancelled elective plastic surgery operations and monitor cancellation rates for trauma patients
- The provider should improve the percentage of patients receiving treatment within 62 days of referral.

Outstanding practice and areas for improvement

- The provider should ensure that all resuscitation equipment have identified expiry dates.
- The provider should ensure that glucometers are checked as per hospital policy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

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

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Mandatory training rates, particularly in the emergency department, around (but not exclusive to) advanced adult life support and paediatric life support were significantly below the trust target, with 65% of medical staff completed advanced adult life support training and 33% completed advanced paediatric life support training, which is worse than the 80% trust mandatory training target.

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