Mid and South Essex NHS Foundation Trust

Broomfield Hospital

Inspection report

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Ratings

Overall rating for this service	Inadequate
Are services safe?	**Inadequate**
Are services effective?	**Inadequate**
Are services well-led?	**Inadequate**

Our findings

Overall summary of services at Broomfield Hospital

Inadequate 

Broomfield Hospital is operated by Mid and South Essex NHS Foundation Trust. The hospital provides local elective and emergency services to people living in and around the districts of Chelmsford, Maldon and Braintree. Medical wards provided by Broomfield Hospital include acute monitored and renal, elderly care, acute medical assessment, general medicine, stroke, respiratory, gastroenterology and liver, active home unit for patients medically fit for discharge and frailty assessment day unit.

Between January 2022 and December 2022 medical care had 32,663 admissions including 16,912 emergency admissions. The specialties with the highest number of admissions during the same period were general medicine (9,323), geriatric medicine (7,873) and medical oncology (5,783).

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of medical care and older people's services. The information of concern related to the quality of care provided including patient nutrition, hydration, pressure care and the management of risks.

As this was a focused inspection, we only inspected parts of our five key questions. We inspected parts of safe, effective, caring, responsive, and well-led.

We did not inspect all the core services provided by the service as this was a risk-based inspection. Broomfield Hospital has been rated inadequate overall. As a result of the acquisition, Mid Essex Hospitals location and Basildon and Thurrock Hospitals locations did not retain their location level ratings. When one core service is rated inadequate out of three, this aggregates to an overall rating of inadequate. We continue to monitor all services as part of our ongoing engagement and will re-inspect them as appropriate.

How we carried out the inspection

The inspection team comprised of a lead CQC inspector, an inspection manager, 2 other CQC inspectors and a CQC specialist advisor.

During the inspection we spoke with 31 members of staff and carried out off site interviews with the senior leaders, the services falls team, safeguarding lead, tissue viability nurse and end of life care team. We spoke with 13 patients and 4 relatives. We observed care provided; attended site and staffing meetings, reviewed relevant policies and documents, and reviewed 27 patient records.

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

Medical care (including older people's care)

Inadequate

Our rating of this service went down. We rated it as inadequate because:

- Not all staff had completed mandatory training including safeguarding and conflict resolution training.
- The maintenance and use of facilities, premises and equipment did not always keep people safe.
- Staff did not always complete and update risk assessments for each patient to remove or minimise risk. Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date, or secure.
- The service did not always ensure medicines were in date and safe for use.
- The service did not have enough nursing and support staff and had high vacancy rates, however managers regularly reviewed and adjusted staffing levels.
- People could not access the service when they needed it and waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Staff did not always support patients to make informed decisions about their care and treatment or know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Governance systems and processes were not effective in relation to staff complying with internal quality standards, improving patient care, or patient outcomes.
- Service systems and processes for identifying, recording, and managing risks and performance were not effective.

However:

- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Staff gave patients enough to eat and drink and gave them pain relief when they needed it. Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues, but these were not always managed effectively. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. We found that the service had deteriorated since the last inspection in July 2018.

Medical care (including older people's care)

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Mandatory Training

The service provided mandatory training however not all staff completed it.

Not all staff had received and kept up to date with their mandatory training.

Not all medical staff had received and kept up to date with their mandatory training. Information supplied by the service following our inspection showed overall compliance with mandatory training was 65.36%. Medical staff did not achieve the 85% compliance target for any of the mandatory training elements. For example, the lowest compliance was 16.52% for conflict resolution high risk and the highest was 80% for conflict resolution low risk.

Information supplied by the service following our inspection showed overall nursing staff compliance with mandatory training was 85.54% against the service target of 85%. The lowest compliance was 47.84% for conflict resolution high risk and the highest was 93.98% for handling and moving level 1, with nursing staff achieving compliance with mandatory training in 10 training modules. Staff we spoke with told us they accessed training online and face to face, when possible, but the impact of staffing levels and COVID-19 had affected training opportunities.

The service provided a range of mandatory training, however mandatory training did not include tissue viability, pressure ulcer care and falls prevention. Following our inspection, the service told us it provided additional training that was not part of mandatory training, including face to face training for pressure ulcer management and prevention.

Not all clinical staff completed training on recognising and responding to patients with learning disabilities, and dementia. Information supplied by the service following our inspection showed 50.43% of medical staff completed training in dementia awareness and 55.65% completed training on learning, both of which were below the 95% compliance target set by the service.

Safeguarding

Not all staff had training on how to recognise and report abuse.

Not all nursing and medical staff had completed training specific for their role on how to recognise and report abuse. The service set a safeguarding training compliance target of 95%. All staff had to complete safeguarding training every 3 years or as they joined the service. Nursing and medical staff did not achieve the 95% compliance target for safeguarding adults and children training.

Information supplied by the service following our inspection showed nursing staff achieved 94.56% compliance with safeguarding adults' level 1 and 91.57% for level 2. They also achieved 92.55% compliance with safeguarding children level 1 and 88.66% with level 2.

Medical care (including older people's care)

Medical staff achieved an 74.78% compliance for safeguarding adults' level 1 and 72.38% for level 2. They also achieved 74.78% compliance for safeguarding children level 1 and 71.05% for level 2. All were below the services 95% compliance target.

Following our inspection, the trust provided information on the adult safeguarding level 3 compliance rate for all staff across the medicine core service. The trust wide data showed that 37% of nursing staff and 18% of medical staff had completed this training. This was not in line with the trust target and recommendation of national guidance.

Staff we spoke with knew how to identify adults and children at risk of or suffering significant harm and worked with other agencies to protect them. The service had an up-to-date safeguarding adults' policy with clear guidance on how to recognise abuse and make a referral. The safeguarding adults' policy referenced other key policies in relation to safeguarding that staff could refer to, for example the Mental Capacity Act (2005), domestic abuse and stalking and the services disciplinary policy and procedure. Between February 2022 and January 2023, staff across the medical wards made 41 safeguarding referrals.

Staff gave examples of where they had made a safeguarding referral or had been involved in supporting patients where safeguarding concerns had been raised. Safeguarding details were shared between managers and appropriate staff during shift handovers, so staff could take appropriate actions and be aware of any additional needs.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with explained the safeguarding referral process, and how to access the safeguarding referral forms and phone contacts for the safeguarding adults' team. Staff followed safe procedures for children visiting wards. Staff we spoke with were clear on the ward visiting processes, including who was allowed to visit wards in order to maintain patients' safety and privacy.

Safeguarding leads accessed records from harm free care panels and had close working relationships with other hospital professionals including tissue viability nurses and falls leads. The service had a safeguarding strategy 2020-2022, which staff told us was due for review in 2024, but this strategy was regularly reviewed if there were any changes in safeguarding policy nationally or locally that could affect the service.

The service's safeguarding lead had established relationships with the local authority and social care teams, as well as the integrated care board which enabled them to discuss safeguarding practices, policy and participate in safeguarding investigations.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

All areas we inspected were visibly clean and had suitable furnishings which were well-maintained.

The service performed well for cleanliness and infection prevention and control (IPC). Cleaning audit data we reviewed showed domestic staff routinely achieved above 95% compliance with cleaning activities across the medical wards and demonstrated that all areas were cleaned regularly. Staff could call for assistance if they needed a deep clean of any ward areas, for example if a patient had an infection likely to pose a risk to others or a significant spillage.

Staff followed infection control principles including the use of personal protective equipment (PPE). Data from the services IPC audits in January 2023, showed 9 wards were 100% and one ward 50%. compliant with staff putting on PPE when attending to patients and entering a bay area. Staff we spoke with knew the service's IPC processes. Nursing staff achieved 90.83% compliance with level 2 IPC training and medical staff achieved 75.65% compliance which was below the services 85% compliance target.

Staff had access to a wide range of PPE, handwashing facilities, sanitisers, and antibacterial wipes. Hand hygiene audit data provided by the service following our inspection showed that medical ward staff generally achieved good compliance with hand hygiene. Between November 2022 and January 2023, there were only 2occasions where the wards within the medical division didn't achieve above 90% hand hygiene compliance.

Hand sanitisers and hand washing facilities were readily available throughout the medical wards, and we observed that staff used hand gel and sanitisers before and after episodes of direct patient contact or care. This was in line with *NICE guideline QS61 Statement 3 (2014), Infection prevention and control - Hand decontamination.*

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We noted during our inspection that staff used appropriate cleaning materials when wiping down equipment between each patient use, for example antibacterial wipes. Cleaning staff were proactively engaged in cleaning activities, including ensuring side rooms were cleaned between patient use.

The service set a 90% compliance target for Methicillin-resistant Staphylococcus aureus (MRSA) screening. Information provided by the service following our inspection showed in the 12 months before our inspection compliance with MRSA screening varied across the medical wards. In January 2023, 3 of the medical wards achieved above the 90% compliance target, in December 2022, 5 medical wards achieved compliance, and in November 2022, 4 medical wards achieved compliance. In October 2022, none of the medical wards achieved above the 90% compliance target.

Information provided by the service following our inspection showed that in the 6 months before our inspection there were 2 incidences of MRSA and 27 incidences of Clostridium difficile Infection (CDI) within the medical wards. We noted information in relation to good IPC practice and infection rates displayed on wards we visited during our inspection.

Environment and equipment

The maintenance and use of facilities, premises and equipment did not always keep people safe.

Staff did not always record daily safety checks of specialist equipment. The resuscitation trolley, for use in an emergency was easily accessible on all wards. However, we found staff did not consistently record daily and weekly emergency resuscitation trolley checks. For example, on Writtle ward we found checks not completed on 1, 3, 10 and 18 October 2022, 18 November 2022, 6 and 12 December 2022. We found expired equipment in the emergency trolley on Lister ward including,1 pack flexible yankers expired 4 January 2023, and Sodium bicarbonate expiry date November 2022, and gaps in the daily equipment checklist on the 1,2,7,10,11,12,22,25,30,31 December 2022, and on the 4,6,7,12,15,19,20, 22 January 2023. On the stroke ward we found daily checks hadn't been completed between the 1 and 8 January 2023. This meant we were not assured that equipment was always checked for safety to ensure its fitness for purpose.

The service had suitable equipment to help them safely care for patients, however we found some equipment was out of date for service. For example, on Tiptree ward we found a hoist with no service date displayed, and on the stroke ward a wheelchair with no service sticker. On Lister ward we found a hoist with no service date displayed. On Writtle ward we

found a hoist with no service sticker. On Braxted Ward we found a medicines fridge which was due for service in November 2022, an ECG machine due for service in November 2022 and a manual blood pressure machine due for service in November 2022. This meant we were not assured that equipment was always checked for safety to ensure its fitness for purpose.

Following our inspection, we asked the service to provide details of its equipment asset and service register. Information provided by the service following our inspection showed that there had been an annual increase in the number of pieces of equipment requiring service, this included a range of equipment including, blood pressure monitoring machines, hoists, and other patient equipment.Following our inspection, the service told us that the data we reviewed showed the number of pieces of equipment that remained overdue, and the increasing numbers would be expected the nearer they got to current day. Data we reviewed showed that 10 items were due for review in 2019, 24 in 2020, 39 in 2021, 96 in 2022, and a total of 217 items out of 1,929 items on the asset register were overdue for review at the time of our inspection. Following our inspection, the service told us further information regarding equipment servicing was received from external contractors and their equipment log had been updated to reflect that the equipment has been serviced. There were 186 pieces of equipment showing as overdue on the review on their equipment log and a detailed review of the equipment log against the inventory had been done to understand the current status, and to identify any further actions the trust needed to take. The review highlighted that there was 71 (3.6%) pieces of equipment over for review, and of these, 1 was high risk and 35 medium risk and would be prioritised, and the remaining 35 were low risk. The service told us these would be completed by 31st March 2023.

Patients could reach call bells and staff responded quickly when called. On all wards we visited patients had access to call bells. Staff answered call bells promptly and politely. The staff team communicated positively with each other and worked together to meet patients' needs once a call bell had been activated. Patients we spoke with told us staff were busy at times and sometimes they did have to wait for staff to come to them, but staff always responded to their call.

All wards were accessible and signposted from the hospital's main entrance. All wards we inspected ensured separation between male and female bays. Staff gained access to wards and clinical areas using an electronic swipe card system. Visitors gained access by an intercom which was monitored by staff. This enabled staff to monitor visitors and patients entering the ward. The service had an up-to-date policy for the management of missing and absconding patients, with clear guidance for staff to follow if a patient tried to leave the ward. Between January 2022 and January 2023, the service reported that 15 patients had absconded from the ward areas.

Piped oxygen and suction equipment was available at each bed space, and this was checked daily and documented on the service's electronic audit system.

The service did not have suitable facilities to meet the needs of patients' families. The ward areas lacked space for families and staff however, every ward had a staff room and an office which staff were able to use. Staff we spoke with told us this was especially difficult when managing patients who may require a side room for isolation due to infection or if they were approaching the end of their life. Following our inspection, the service told us Broomfield had 82 side rooms out of 295 beds (28%) for medical wards and the largest number of side rooms across the services three locations.

Staff disposed of clinical waste safely. Sharps bins were dated and signed, and staff ensured clinical and non-clinical waste was disposed of correctly. Staff stored cleaning equipment securely in locked cupboards on all wards we visited.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risk.

Medical care (including older people's care)

Staff used a nationally approved tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning score system (NEWS2) for adults. An early warning score is a guide used by staff to quickly determine the degree of illness of a patient. Staff recorded patient NEWS on a handheld IT device, linked to a centralised patient monitoring system, which alerts staff if the patients NEWS increased or decreased so they could escalate the patient for additional medical intervention where required. The trust had a hospital wide outreach service to support deteriorating patients, this included a dedicated response team, which was also available out of hours and at weekends.

The service undertook monthly audits of NEWS compliance quarterly by the service dedicated Response team in all in-patient wards. Patients were identified by an electronic observation system that flagged any patient who met a set criterion. The patients audited were those with a NEWS of 7 or more (High Risk) and that were likely to need timely reviews and interventions. Audit data provided by the service for November 2022, showed that out of 38 patients 91% were escalated appropriately according to the patients NEWS score and care plan. The service had a dedicated action plan to improve performance including increasing awareness amongst the staff team, increasing audit frequency, and identifying any non-compliance during normal ward rounds.

Staff knew about specific issues but did not always deal with them. For example, staff used the electronic patient monitoring system and Sepsis 6 checklist to manage and escalate patients. However, not all staff had received training in managing sepsis in adults. Information supplied by the service following our inspection showed 82.3% of nursing staff and 50.48% of medical staff had completed training on sepsis 6 in relation to adults. Staff we spoke with knew how to identify sepsis using the electronic patient monitoring systems and used the sepsis 6 checklist to escalate patients. The electronic patient monitoring system notified staff when the sepsis 6 check list was due, or overdue or if the time frame for antibiotic administration was overdue.

The electronic patient monitoring system flagged patients with a red flag (red triangle on the electronic system), which alerted staff to the patient's sepsis status. Sepsis screening compliance using the electronic system increased from 79% in November 2022, to 94% in January 2023. During the same period, there was a decline in the timely administration of antibiotics once the patient received a diagnosis of sepsis or red flag. In November 2022, 100% of patients received a diagnosis of sepsis or red flag and received antibiotics in less than 1 hour. This declined in December 2022 and January 2023, to 67%. The service records audit data from January 2023, showed that staff achieved 57.9% compliance with completing the sepsis 6 pathway. The service had dedicated sepsis clinical nurse specialists and an action plan to improve compliance by providing focused training, ward drop-ins and sharing sepsis audit reports monthly with ward leaders to raise awareness of performance.

Staff did not always complete risk assessments for patients on admission and arrival, using a recognised tool, or review this regularly, including after any incident. During our inspection we reviewed 27 sets of patient records, 5 records showed no bed rail risk assessment completed, 2 had no falls risk assessment completed, 9 had no patient weight recorded, 4 had no pressure ulcer risk assessment completed within 6 hrs and 6 did not have nutrition or hydration assessments completed. This meant that patients were at increased risk of harm as actions that should have been taken to keep people safe may not be implemented.

Information provided by the service following our inspection showed that between November 2022 and January 2023, 6 wards achieved 100% compliance with completion of bed rails risk assessments. Feering ward achieved 66.7% compliance, Felsted ward 65%, Baddow ward 57.1%, Writtle ward 8.3% and the acute medical unit (AMU) 0%. This showed the staff did not consistently record the bed rail risk assessment across all wards.

The service had a member of staff as the dedicated falls lead and an up-to-date action plan to improve the management of falls across the service. One of the actions was to implement a new multifactorial falls risk assessment, and to ensure patient care plans including post falls bundles are in place.

The service carried out falls audits to identify any areas of concern and provide additional support within that area. The service set a falls compliance target of below 6.63 falls per 1000 bed days. Between July 2022 and December 2022, the service achieved below this target each month except for July 2022, where its compliance was 6.91. Between January 2022 and December 2022, information provided by the service following our inspection showed 1,140 falls had occurred across the medical wards, 36 of which involved patients falling from their bed. The highest number of falls was on the acute medical unit (AMU) 193, Braxted ward 166 and Tiptree ward 177. During our inspection we reviewed 27 patient record and identified 2 where staff had not completed the patient falls risk assessment. Following our inspection, the service told us that the two records we reviewed demonstrated an overall compliance 92.6% which was above their internal target of 90% compliance.

We spoke with the services falls lead, ward staff and members of the multidisciplinary team (MDT) who explained that many factors affected the falls rate across the wards. The team had noted an increase in the number of frail elderly patients who were deconditioned when entering the ward and needed a great deal more time and support to enable them to manage their mobility and ambulatory activity. During our inspection we observed MDT staff working with nursing and health care assistants to support patients with their mobility, ensuring they were wearing non-slip socks when standing, had their mobility aids within reach and offering advice to staff to reduce trips, slips and falls on the ward.

Staff completed venous thromboembolism (VTE) assessments, and these were recorded on the services electronic patient observation system and the service set a 95% compliance for VTE completion. Information provided by the service following our inspection showed a decline in overall VTE compliance from 94.57% in October 2022, to 92.97% in November 2022 and 90.84% in December 2022.

Staff did not always complete pressure ulcer risk assessments as part of the patient care planning process. Out of the 27 sets of patient records we reviewed; 4 patients did not have their pressure ulcer risk assessments completed on arrival on the ward and we were not assured that routine reviews of pressure ulcer care were being recorded. Data provided by the service following our inspection showed that between January 2022 and December 2022, the service recorded 284 hospital acquired pressure ulcers, 18 were device related. The highest number of hospitals acquired pressure ulcers was on the AMU 50, 36 on Writtle ward and 28 on Turling ward. The service had 1 band 7 and 1 band 6 tissue viability nurse (TVN) working within the service. The TVN had a target of seeing new referrals either admitted by the urgent and emergency care department or direct to the ward within 72 hours of the referral and was achieving between 95% and 100% compliance against this target. However, due to the complexity and number of patients being referred who needed additional support staff told us that current resources were limiting and did not give them enough time to see all the patients and provide ongoing support to the staff teams.

Staff we spoke with told us they felt the TVN team were responsive to their requests for support, and that more patients with complex needs, poor conditioning, poor skin integrity and increased care needs were entering the wards.

During our inspection ward managers told us they were encouraging staff to complete a new pressure ulcer workbook, as an extra resource to upskill the staff team. Managers were incorporating this into a local action plan to improve

pressure ulcer care. The service had set an action for 80% of staff to complete the workbook by the end of February 2023. Following our inspection, the service told us 333 workbooks were given out to staff, with a total of 81 completed, showing 24% compliance in one week. Following our inspection, the service told us there was no mandated national requirement for additional training and this was a local initiative that was being implemented.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff we spoke with explained the process for contacting the on call mental health team, but explained that whilst this service was responsive, it could be some time before a patient received input from the mental health service or to be moved to a dedicated mental health service facility. We identified a patient with a mental health condition on one of the medical wards, which was not physically designed to meet the needs of patients who may be likely to harm themselves or others. Staff had no access to ligature cutters on the ward, despite the risk of ligature at numerus points and staff being aware of a patient who had recently attempted to self-harm by ligature. Physical risk assessments had been completed and service leaders had raised these concerns within the local integrated care system to try and seek solutions to the issue of high-risk patients being admitted to wards. At our unannounced follow up inspection on 7 February 2023, we found staff had access to ligature cutters and additional guidance was in place to support staff if a patient did attempt self-harm.

Staff shared key information to keep patients safe when handing over their care to others. We observed the staff handover process at ward level which included key information in relation to patient care. However, we were not assured this information translated into actions within the patients nursing and care plans as we noted inconsistent patient record keeping where staff had not completed or updated care records to ensure patients' needs were met.

Nurse staffing

The service did not have enough nursing and support staff and had high vacancy rates, however managers regularly reviewed and adjusted staffing levels.

The number of registered nurses (RN) and healthcare assistants (HCA) did not always match planned numbers. During our inspection the service had enough nursing and support staff to keep patients safe. However, on all the wards we visited the actual staffing levels for nursing and health care assistants were below planned levels. Managers had taken appropriate action to provide cover for any gaps in the working rota and ensured that all patients that required one to one support had this in place. Staffing levels were reviewed regularly by leaders and resources were discussed at key meetings to ensure resources were aligned to patient needs.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service used a safer nursing tool to manage and predict safe staffing levels. Leaders we spoke with told us that recruitment was ongoing, and they had recruited from overseas to fill gaps in the work force. This however was challenging as overseas nurses needed additional support and more time to gain experience in order to ensure competence and meet the needs of patients. Managers told us that filling HCA roles was challenging, and they had lost many staff following the COVID-19 pandemic who had taken roles outside of the service. We were given the example of 8 potential interviewees for the HCA role and only one interviewee came for interview. However, the service was continuing to actively recruit staff to fill any gaps and was positive that it could recruit to its current vacancies.

Ward managers could adjust staffing levels according to the needs of patients. Staff we spoke with told us it was routine for staff to be moved from their ward to other areas to ensure safe staffing levels. Managers we spoke with told us they planned rotas in advance and worked with other managers to fill any gaps in working rotas, but short-term sickness and vacancy rates did affect the ability to provide cover.

Medical care (including older people's care)

The service had reducing vacancy rates. Information shared by the service following our inspection showed in December 2022, the vacancy rate for RNs was 15.90%. Vacancy rates for RNs had reduced monthly from 26.15% in January 2022.

The service had increasing turnover rates. Information shared by the service following our inspection showed in January 2022, the turnover rate was 8.76%. The turnover rate between February and November 2022, increased monthly to 11.76% in November 2022, then reduced to 11.05% in December 2022.

The service had reducing sickness rates. Information provided by the service following our inspection showed that sickness rates fell on a monthly basis from 8.88% in January 2023, to 5.89% in December 2022.

Managers used high numbers of bank and agency staff and requested staff familiar with the service. The service had reducing rates of bank and agency nurses used on the wards. Information shared by the service following our inspection showed in December 2022, the service used 8.3% agency staff and 14.7% bank staff. The use of agency and bank staff in the 12 months before our inspection fluctuated based on the demands within the service and was at its highest in January and March 2022, where agency staff use was 36.7% and 24.8% respectively.

During our inspection we reviewed the staff induction records on the wards for 10 bank nursing staff and found these to be completed but not always signed or dated. Induction covered topics such as orientation to the ward, role within the ward, incident reporting, emergency contacts, identifying current patient group and other key ward details. Following our inspection, the service told us there had been inconsistences in completion of these records at times, but they had reintroduced the forms and expectations regarding auditing compliance.

Information provided by the service following our inspection showed a sickness rate of 3.33% across the MDT, a turnover rate of 27.72% and vacancy rate of 14.96%. Occupational therapy had the highest vacancy rate of 35.88% and a turnover rate of 23.21%, dietitian services had a vacancy rate of 32.95% and the highest turnover rate of 56.84%, physiotherapy had a vacancy rate of 6.58% and turnover rate of 26.31%.

Following our inspection, the service told us that they had reduced their vacancies and had a recruitment process in place. They had reduced their onboarding to 7 days and reduced vacancies by 10.25% over the last year. The service also told us it had an HCA recruitment process in place and had started over the last year to develop trainee nursing associate (TNA) posts, nursing associate posts and apprenticeships, to ensure they had plans to improve the workforce numbers for the future. Since the service started its HCA events in September 2022, they have recruited 35 HCA and had an additional 53 in the recruitment process. In the services pilot recruitment for RGNs from October 2022 to December 2022 they recruited 21 RGN WTE. 11 of these were newly qualified and 8 candidates were placed onto a new staff rotation programme.

The service has had an international recruitment programme which was consistently reviewed as to how to improve the training once the new staff arrive and on the Broomfield site, they have one of their first international recruited nurses as the deputy director of nursing which the service said showed the success of the training that took place.

Medical staffing

The service had enough medical staff managers regularly reviewed and adjusted staffing levels and skill mix.

The service had increased turnover rates for medical staff. Information shared by the service following our inspection, showed the turnover rate was 12.10% in January 2022. The turnover rate showed some variation between February 2022, and December 2022, but never fell below 11.74%. Turnover increased to 15.55% in August, and then reduced

monthly to 15.17% in December 2022. During our inspection we noted that Tiptree ward and Lister ward were staffed exclusively by locum and bank medical staff. Following our inspection, the service told us the variation was accounted for by the fact that the junior doctor change over happens in August hence the increase and the registrar changes take place in December.

The service had reducing vacancy rates for medical staff. Information shared by the service following our inspection showed a vacancy rate of 25.74% in December 2022, this increased to 26.40% in February 2022 and 28.42% in March 2022. The vacancy rate then reduced in April, May and June 2022 and increased slightly in July 2022, to 21.28% from 18.71% in June 2022. Vacancy rates then reduced monthly to 16.12% in December 2022.

The service had reducing sickness rates. Information provided by the service following our inspection showed that sickness rates fell monthly from 5.38% in January 2022, to 3.92% in December 2022.

Information shared by the service following our inspection showed consistent use of bank and agency staff in the 12 months before our inspection. The service used 17.3% bank and 18.2% agency in December 2022. The service used the highest percentage of agency staff in June and August 2022, at 22.9% and the highest percentage of bank staff in February 2022, 24.7%.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. Clinical staff completed a ward induction. However, the service told us this was not documented.

The service medical staffing skill mix showed a higher number of junior doctors in training with a vacancy rate of 20.23% amongst consultants and 44.59% amongst doctors.

The service always had a consultant on-call during evenings and weekends. Out-of-hours medical cover (overnight Monday to Sunday) was covered by the on-call medical consultant from 9.30pm until 7.30am, the medical consultant was contactable by the services switchboard out-of-hours days (Saturday-Sunday).

The on-call medical consultant overnight, was on-site in the morning from 7.30am until they finished seeing all new patients. Following this, the next consultant was on-call from 2pm until 9.30am, and the AMU had 2-3 acute medicine consultants plus 1 geriatrician on-site in the mornings. 1 acute physician was on-site until 5pm to see new patients. There was another on-site covering the services same day emergency care department (SDEC) until 5pm. The service had a 7 day a week out of hours consultant on-call for gastrointestinal bleeds and a respiratory consultant on-call for non-invasive ventilation (NIV). NIV is the delivery of oxygen (ventilation support) by a face mask and therefore eliminating the need of an endotracheal airway. They were on-site Saturday and Sunday mornings on the respiratory ward and renal consultant was on-call for renal advice and on-site Saturday mornings on the dialysis unit and renal ward.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date or secure.

Patient notes were not always comprehensive. The service used both electronic and paper patient records, the paper records were separated into nursing and medical records and easily accessible for staff.

Medical care (including older people's care)

We reviewed 27 sets of patient records and found that they were not always clear, up-to-date, and comprehensive. Staff did not always complete risk assessments and associated care plans in the records we reviewed. For example, in 7 of the records, fluid balance charts were incomplete, 6 records showed no patient weight recorded, 5 records had no bed rails risk assessment completed, 4 records were not always legible, dated and signed and 3 records did not have holistic nursing assessments completed.

Electronic records were password protected and only authorised members of staff could access them. On some wards paper records were stored in a lockable notes trolley whilst on others they were stored in an open file holder outside the bays. This meant that patient notes were not always kept secure and could be accessed by those who were not authorised to do so. Following our inspection, the service told us that it was normal practice for the nursing records such as food and fluid charts, comfort rounds, repositioning charts etc to be kept at the patient's bedside. This was standard practice to ensure that nursing staffing and health care assistants had access to records that were used multiple times each day to record care delivered and that it would be impractical to lock them away from the bedside.

Following our inspection, we asked the service to provide us a with their most recent record audit. The audit showed in January 2023, there were inconsistencies in completing records, for example 71.3% of notes were legible with roles defined, 88.6% of entries were dated and timed, 93.6% had wound assessment completed, or have any specific individual needs been documented 71.4%. This reflected our observations during the inspection, where we noted staff inconsistency in record completion.

Medicines

The service did not always ensure medicines were in date and safe for use.

Staff did not always follow systems to ensure medicines were in date and safe for use and did not always complete medicines records accurately and keep them up to date. The service had an up-to-date administration of medicines policy and procedure due for review in July 2024.

Staff reviewed each patient's medicines regularly and provided advice to patients and where appropriate their carers about their medicines. There were daily multidisciplinary team meetings to assess and review patients' treatment, including their medication. During our inspection we observed a clinical pharmacist was reviewing all patient medication charts.

Staff recorded the patient prescription and administration of medicines on a paper-based document on all the wards we visited. At the time of our inspection, the service had plans to implement an electronic medicine prescribing system at Broomfield hospital. The service's quality performance report from January 2023, stated the roll out of electronic prescribing was significantly delayed at this location due to Wi-Fi infrastructure on the site and would be implemented when the Wi-Fi programme was completed as a priority.

Staff stored medicines safely on the wards we visited. Medicines were stored in locked cupboards and fridges behind locked doors or in medicines trolleys that were secured. However, we found medication in cupboards and in medicines trolleys that were out of date. We escalated this concern with the service who took immediate action to dispose of all out-of-date medication across the medical wards and provided assurances on how they planned to avoid this happening again going forward. Following our inspection, the service provided a copy of its medicines audit from August 2022 to November 2022, which had not identified any out of date medicines in these areas and showed that audits were not effective in identifying risks.

Staff did not consistently record the temperature of medicine fridges. For example, on Writtle ward we found gaps in the staff daily checks for the 9,10,16 and 21 January 2023, and the fridge temperature out of range on the 11 January 2023, with no evidence to show this was escalated in line with the services administration of medicines policy and procedure. We also found that on 1,3,4 November 2022 and 4,19 December 2022, the medicines storage room temperature exceeded the required temperature range, there was no evidence to show this had been escalated in line with the services administration of medicines policy and procedure. We found on Feering ward medicine storage room and fridge temperatures were not consistently recorded. Room temperatures were not recorded on December 7 and 8 2022, November 15, 2022, and 20 January 2023, and the fridge temperature check not recorded on the 8 December 2022.

Controlled drugs (CD) we reviewed were securely stored in accordance with the Misuse of Drugs (Safe Custody) Regulation 1973 with no omissions.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we spoke with knew what incidents to report and how to report them. The service had a policy for the Management of Incidents and Serious Incidents, which was due for review on 20 October 2022, but the review date had been extended until March 2023. Between February 2022 and January 2023, the service reported 24 serious incidents. The wards that reported the highest number of serious incidents were Writtle ward 6, Terling ward 4 and both Tiptree ward and the AMU reported 4. The service told us that two of these investigations had not been completed in line with the serious incident framework timelines.

Leaders we spoke with told us one of their challenges was dealing with a backlog of incident reports that still needed closure or investigation due to work loads and capacity. Records from the care group governance meeting on 4 January 2023, stated that there were 242 overdue incidents and 14 serious incidents, weekly meetings were in place to review these and where appropriate close them down. The highest number reported incidents in December 2022 related to falls, hospital acquired pressure ulcers, discharge pressure ulcers / on admission staffing and workforce. These incidents aligned with the concerns we received prior to our inspection.

Staff we spoke with had a clear understanding of the services incident reporting system and knew how to report incidents. During our inspection we noted staff escalating 2 incidents in relation to staff non-compliance with the services administration of medicines policy and procedure. Staff escalated the incidents appropriately using the services incident reporting system.

The service had not reported any never events throughout the medical wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers investigated incidents. Patients and their families were involved in these investigations. We reviewed 3 serious incident investigation reports which showed the service had investigated the incidents, engaged patients and relatives in the investigation process and sent duty of candour letters. The duty of candour letters provided details of what went

wrong and the actions the service would take to reduce incidents of a similar nature. Incident reports also showed that staff apologised early in the investigation process or at the time of the incident taking place whilst encouraging patients and relatives to engage in the process. Action plans in relation to the incident investigations were comprehensive and shared with the wider care teams to encourage learning.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback from incidents during ward meetings and the actions and findings from serious incidents were presented at the department of medicine for older person (DMOP) clinical governance group meetings.

Is the service effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Nutrition and hydration

Staff generally provided food and drink to patients including those with special nutrition and hydration needs, however they did not always complete patient records to demonstrate this had taken place.

Staff provided food and drink to patients including those with special nutrition and hydration needs. During our inspection we noted that patients on all wards we visited had access to fresh drinking water that was within reach. We noted patients had snacks, biscuits, fruit, and various beverages within reach on their bed side cabinets or tables. Patients we spoke with told us that staff routinely asked them if they needed additional food or drinks and that the food was nice, and they had options to choose from each day.

The service did not provide protected mealtimes. We noted mealtimes were busy and that routine care rounds and visits from professionals to the wards took place during mealtimes. Following restrictions during the COVID-19 pandemic, staff told us the number of dementia support volunteers had dropped and they significantly missed the 'feeding buddies' that used to contribute to the service to help patients at mealtimes.

Staff we spoke with told us that staffing shortages affected their ability to meet all the patients' needs and that there were sometimes delays in being able to support patients at mealtimes, but they always checked to ensure patients had a meal and drinks.

Staff interacted positively with patients during mealtimes, and we observed the 'red tray' system in place. Staff used the red tray system to identify patients who needed additional support with eating and drinking or a specialist diet, for example blended or moulded meals (meals that are blended then reformed to look like their original form). Any patient who needed a red tray had this recorded in their patient record, and above their bed side, nursing staff also clearly identified and documented patients in need of additional support during staff handovers. Hostess staff we spoke with were clear on their responsibilities in relation to supporting patients to ensure they had the right meals, and they recorded any instance where patients had not completed their red tray meal on a central data base and alerted the ward staff to any patient who they were concerned about or who had not eaten their meal.

On 25 January 2023, we observed lunch time activity on Braxted ward and saw that one member of staff was responsible for supporting 4 patients with their nutrition and hydration needs over that lunch time. Two patients were in a bay of the ward dedicated for the care of patients with COVID-19, and 2 patients were in another bay. This meant that

by the time the member of staff had finished supporting the first patient, the meals of the other 3 patients were beginning to get cold. Following our inspection, the service told us that at this time there were mealtime companions on the ward and nurses and health care assistants all assisting with feeding patients. A nurse was handing out medicines as the medicine was required to be given with food and there was sufficient staffing to ensure that all patients were assisted with eating and drinking on each of the days of our inspection.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff had access to the patient malnutrition universal screening tool (MUST). Following our inspection, the service provided data from its January 2023 MUST audit showing compliance with referral to a dietitian where a patient scored greater than 2 in the MUST score. 6 wards achieved 100% compliance, 3 wards achieved 80% and 75% compliance and the final 3 wards showed between 33.3% and 50% which meant we were not assured that staff were completing documentation or making timely referrals to a dietitian.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. During our inspection we reviewed 27 sets of patient records and noted that in 6 patient records staff had not always completed the patient's nutrition or hydration assessment or the patient's fluid chart. We escalated this to the leadership team during our inspection. They told us they were engaged in a quality initiative to improve patient record completion and nutrition and hydration compliance across the ward areas. Information provided by the service following our inspection showed that between 1 January 2023 and 30 January 2023, 1 ward achieved 100% compliance with recording patient nutrition and hydration, 5 wards achieved between 90.3% and 94.2% and the remaining wards achieved between 77.6% and 89.3%. Despite observing staff actively supporting patients with their eating and drinking, we were not assured the documentation in relation to patient care was consistent. This meant that patients were at an increased risk of harm as information would be inaccurate and any risks may not be escalated and acted upon.

We noted during our inspection a limited number of additional resources and equipment to aid patients to eat and drink, for example plate guards, nonslip plate mats, and specialist drinking cups. We discussed this with the leadership team during our inspection, who told us this was part of the ongoing quality project, and they were in the process of precuring and testing equipment, but wanted to ensure that due to costs, and ensuring the equipment was appropriate they were in the process of purchasing this.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff we spoke with told us that therapy teams, for example speech and language therapists, and occupational therapists were responsive to their requests for support, but there was a shortage of therapy staff across the service which meant they had to wait at times for the additional support to be available.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff checking on patients' pain levels and asking whether they required pain relief. Patients we spoke with told us that staff would ask them if they were comfortable and provided additional pain relief when required.

Staff prescribed, administered, and recorded pain relief accurately. We reviewed 27 sets of patient records and noted that staff routinely recorded the patients pain assessment, and patient pain relief was prescribed and administered on time.

Patients received pain relief soon after requesting it. However, we did note that 1 patient record had no pain assessment recorded and 1 patient was not given their medication on time.

Competent staff

The service made sure staff were competent for their roles

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. During our inspection, managers told us there had been an increase in the number of new and overseas nurses due to the services ongoing recruitment and this meant that the skills mix on wards was at times difficult to manage. Information supplied by the service following our inspection showed that 100% of nursing and medical staff had completed their professional revalidation.

Managers we spoke with told us they gave all new staff a full induction tailored to their role before they started work. The service told us that local induction was carried out on the wards and departments for all agency and bank staff who attended the ward or department/dept for the first time and was managed at ward/site level. Managers should document an induction check list held on the wards and audit this through the nurse in charge checklist. Clinical staff completed a ward induction. However, the service told us this was not documented. We were therefore not assured that all bank and agency staff had completed a full induction for the areas they were working.

During our inspection we reviewed the staff induction records on the wards for 10 bank nursing staff and found these to be completed but not always signed or dated. Induction covered topics such as orientation to the ward, role within the ward, incident reporting, emergency contacts, identifying current patient group and other key ward details. Following our inspection, the service told us there had been inconsistences in completion of these records at times, but they have reintroduced the forms and expectations and are auditing compliance.

Information provided by the service following our inspection showed 67.61% of nursing staff and 94.02% of medical staff had received an appraisal.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, the service held meetings at key times throughout the day to discuss bed capacity and flow. These were supported by staff from the discharge team, flow coordinators, nursing, and medical staff as well as site team representatives. There was a focus on discharge, capacity, and flow, and working as a team to maintain services across site.

Staff worked across health care disciplines and with other agencies when required to care for patients. Patient records we reviewed showed that the service staff team worked with external social care services and integrated care teams to meet the needs of patients and plan for additional services or equipment on discharge.

Staff referred patients for mental health assessments when they showed signs of mental ill health such as depression. Patients had their care pathway reviewed by relevant consultants. Our review of patient records demonstrated consultant carried out timely reviews of patient care, with management plans in place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment or know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Medical care (including older people's care)

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with during our inspection knew how to recognise and assess patients who may lack capacity under the Mental Capacity Act (2005). We observed staff discussing the mental capacity needs of patients during safety huddles and handovers and staff we spoke with understood the principles of the Mental Capacity Act (MCA).

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff interacting with patients and noted they gained consent before to any care or treatment.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Staff clearly recorded consent in the patients' records. However, we reviewed 27 patient records and 5 do not attempt cardiopulmonary resuscitation records (DNACPR). We found 1 patient mental capacity assessment which staff had not signed, one DNACPR with no evidence of multidisciplinary to the decision, and 2 with no MCA documentation to support a decision.

Staff made sure patients consented to treatment based on all the information available. The service had a clinical audit programme 2022/2023, with high-level projects aimed at providing assurance on quality, risk, and safety to the services board, including addressing areas of high risk. The service had a high-level consent audit in place at the time of our inspection, the outcomes were due to be published in March 2023.

Nursing and medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Information shared by the provider following or inspection showed nursing staff achieved 95% compliance with MCA training at level 1 and 92% compliance with level 2. Medical staff achieved 77% compliance with MCA training at level 1 and 72% compliance with level 2.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. The service had an up-to-date policy titled, Application of the Mental Capacity Act of 2005 (MCA) policy which set out the services process of monitoring compliance with, and the effectiveness of the policy. This included the requirement for a quarterly summary of number of assessments completed and a 6-monthly audit. We reviewed the audit feedback from November 2022. The audit showed that it took an average of 6 in-admission days, for documentation of the MCA form. This meant that a patient admitted in the stroke ward had a possibility to have their rights and their ability to make decisions on their own behalf compromised, for an average of at least 6 days. 83% of the completed MCA forms had not mentioned the conversation with the patient that led to the decision to deem a patient as 'without capacity' which the service said indicated a preconceived notion bias and incomplete documentation.

During the audit documentation regarding discussions with the patient's lasting power of attorney (LPA), personal assistant or close relatives was also reviewed, but this information was not included in 33% of any of the notes reviewed. The audit also found that if a decision was communicated to the patient's LPA or family, then there was also a low-rate of 69% of subsequent communication of medical-discussions or rationale for the decision.

Staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. However, the DoLS was not always renewed weekly as required. During our inspection we identified 2 patient's DoLS records had expired even though they were still required to be in place. The service had an up-to-date MCA action plan to improve MCA and DoLS awareness, carry out spot checks on MCA and DoLS compliance, increase staff awareness of MCA and DoLS by training and sharing of MCA and DoLS information with the staff teams.

Following or inspection, the service told us there was a process that was followed where the ward sends the safeguarding team the DoLS document, and they made sure the documentation was completed correctly and complied

with the code of practice before they were sent to local authorities. When the DOLS was first completed the service has 7 days for urgent authorisation to inform the local authorities. Nationally local authorities were under pressure to process DoLS and had a backlog. They automatically gave the service another 7 days authorisation. This meant the service got 14 days DoLS approval.

Is the service caring?

Inspected but not rated

We inspected but did not rate caring

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Throughout our inspection we noted staff providing sensitive and respectful care. Staff closed curtains and introduced themselves to patients during each interaction.

Patients told us that staff treated them well and with kindness. During our inspection we spoke with 13 patients and 4 relatives. Patients and relatives told us that staff were kind and listened to their needs. One patient and their relatives told us they were unhappy with their patient experience, and we signposted them to the services complaints process. All the patients we spoke with told us that staff were busy on the wards and that sometimes they had to wait for staff to come when they needed help, but that the staff always came, and they appreciated how hard the staff were working.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff supporting patients with additional mental health support needs and noted that they provided care appropriate to their needs and held respectful interactions with the patients.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff interacting with patients using appropriate language and checking that they had understood conversations regarding their care. We observed staff supporting a patient who was being discharged to their home. They were providing reassurance, explaining what was going to happen and asking if they had any questions about their discharge. Staff spoke with relatives respectfully and we noted family speaking with the staff team to get updates on the patient's care and wellbeing. Staff shared appropriate information. For example, one relative asked nursing staff about a patient that had been unsettled. The nursing staff gave the relative reassurance, explained what additional support they had provided, updated them on the patient's wellbeing and asked if the relative had any more questions or feedback that they could use to help the patient.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Wards we visited often provided care for patients who were living with dementia, and we noted at times these patients may be confused or unsure of their surroundings. Staff approached patients with kindness and reassurances, guiding them to their bay and ensuring they were settled before leaving them.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff we spoke with understood the emotional and social impact of a patient entering a ward. As the wards were often mixed groups of patients with differing needs, staff recognised those patients who needed additional support during their inpatient stay and patients who may be more isolated socially. We noted at staff handover that staff routinely discussed the social and emotional needs of patients, for example if they had visitors, if they had additional social care needs or if they were showing any behaviours which may need to be escalated to the services on call behavioural support team, who could provide additional support for any patients showing confused or disruptive behaviour.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff updating relatives with appropriate information relative to the patient's needs.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Staff had access to additional communication aids, for example pictures and symbols and a phone application which could be used for translation services. We noted that staff talked respectfully to relatives when they were approached for information and communicated appropriately in terms that the relatives could understand and checking they had understood the conversation and asking if they had any additional questions.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had a dedicated patient experience team, patients and relatives could leave feedback through speaking to the staff team directly or by completing the friends and family test after discharge. Patients and relatives could also use the web forms on the services web page to share their experience or use the patient advice and liaison service or complaints services to share their experience.

Staff we spoke with explained how they would encourage patients and relatives to leave feedback and if they were aware of any complaints, they would manage these locally where possible for an early resolution.

Staff told us that the COVID-19 pandemic had significantly affected communications with family and relatives, as visiting was completely restricted. Relatives could complete a letter to a loved one on the services web site, and they did encourage the use of technology to engage with relatives where they could. However, visiting times were now improved and they felt more able to have meaningful interactions with relatives and improved communication regarding the patients care needs.

Staff supported patients to make informed decisions about their care. The patient records we reviewed during our inspection showed that where possible, patients and relatives had been involved in making advanced decisions about their care.

Medical care (including older people's care)

Patients gave positive feedback about the service. Information from the services friends and family test (FFT) included feedback from patients. One patient feedback said, “I received nothing but kindness and sincere help, I really appreciate the care I received”. Another patient's feedback said, “Care, service, food everything perfect”, another said “All staff at Broomfield were very caring and the hospital spotless”.

Is the service responsive?

Inspected but not rated

We inspected but did not rate responsive.

Meeting people’s individual needs

The service took into account patients’ individual needs and preferences.

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs. The service provided one to one support for patients with additional support needs. We noted during our inspection that one-to-one staff were engaged with patients, actively supervising them, or engaged in activities, for example supervised walks around the ward area.

As part of a dementia project, some of the wards, for example Writtle Ward, covered fire exit doors with vinyl stickers to make them look like a bookcase. This helped distract patients who may persistently make their way to the doors to try and leave the ward. Staff had access to a range of sensory distraction resources, for example twiddle muffs held by patients which they could touch, roll and pull, and toy dolls which was assessed by staff for appropriate use to distract any harmful patient behaviour. However, on most wards there was a lack of breakout spaces for staff to use when supporting patients with any activities.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. We reviewed patient records and found where patients living with dementia had a “This is Me” booklet staff had completed this within the patient record.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation serves and staff explained they had access to a phone application that could also help translation where a patient’s first language wasn’t English.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Hostesses we spoke with explained that patients had a choice within the menu, appropriate to their dietary, cultural, or religious beliefs.

Staff had access to communication aids to help patients become partners in their care and treatment. This included pictures and symbols and a telephone application which could be used for translation services. Staff could also request additional equipment to help with people who had a hearing impairment, but there was no hearing loop on the wards and none of the staff we spoke with had completed training in British Sign Language (BSL) or Makaton. Following our inspection, the service told us there was no national requirement for staff to be trained in BSL or Makaton and whilst this may be ideal, this would be over and above expectation.

Medical care (including older people's care)

Access and flow

People could not access the service when they needed it and waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times patients did not always access services when needed or receive treatment within agreed timeframes and national targets. Between February 2022 and January 2023, the services bed occupancy average was 93.6%. Information provided by the service following our inspection showed that between January 2022 and December 2022 medical care had 32,663 admissions including 16,912 emergency admissions. Performance in relation to referral to treatment (RTT) within 18 weeks for admitted patients had declined during the same period from 79.03% to 55.24%. Medical oncology had shown a decline monthly against the 18 RTT from 85.17% in December 2022, to 59.21% in December 2022.

The service developed a respiratory and frailty virtual ward in the community that supported patient admission avoidance and helped avoid patient admissions from the services urgent and emergency care (UEC) department. The virtual ward supported discharge from the service across the region and the integrated care services. Information shared by the service following our inspection showed that between July 2022 and December 2022, 106 patients used the virtual ward to avoid admission and 314 accessed the frailty ward.

An urgent care response team (UCRT) operated 7 days a week working closely with the local NHS ambulance trust to assist with the avoidance of patient admissions. The service used a minor injury unit in the community with a partner agency, and a day assessment unit for frailty which accepted referrals from primary care services and operated a 'Pull Model' from another local hospital UEC department to reduce admissions. The service was part of the acute frailty network in 2019/2020 which allowed for transformation of their frailty services and was re-establishing fully integrated acute frailty units following the impact of changes from the COVID-19 pandemic.

Managers and staff worked to make sure patients did not stay longer than they needed to. Information provided by the service following our inspection showed that the average non-elective length of patient stay between January 2022 and December 2022 was 7.77 days and elective 3.59 days for elective. The service had a dedicated site team and flow coordinators that worked alongside ward staff and with external agencies to improve patient flow and monitor discharge times.

Managers monitored that patient moves between wards were kept to a minimum. Information provided by the service following our inspection showed that between January 2022 and December 22, 4,795 patients were moved ward between the hours of 10pm and 6am. The service moved patients only when there was a clear medical reason or in their best interest, managers we spoke with told us they only moved patients when it was safe to do so. Between January 2022 and December 2022, there were 12,399 ward moves across the medical wards, the highest on general medicine 9,169 and geriatric medicine 1,591.

Managers and staff started planning each patient's discharge as early as possible. The service had an up-to-date management of discharge policy to promote the safe and timely discharge of all patients admitted to service. The services integrated discharge team worked long side the flow coordinators, site, and ward staff to manage patient discharge. Managers monitored discharge performance and staff were encouraged to report any delayed discharges. The service aimed to discharge patients before 12 noon on the day of discharge and complete a comprehensive discharge summary to support the discharge process. The service audited performance against discharge summaries and used a best practice tool from the Emergency Care Improvement Support Team (ECIST) to try and achieve patient

discharges before 12 noonam. Data provided by the service following our inspection showed that in December 2022, Lister ward achieved 100% compliance with completion of the patient discharge summary, the stroke ward achieved 28.2% compliance. Staff we spoke with explained the factors likely to affect discharge including medicines, transport, care planning in the community and access to ongoing care packages.

Following our inspection, we asked the service how many patients were medically fit for discharge that didn't achieve discharge, and the number of patients who died waiting for discharge by month, over the last 6 months and specifically on the 24 & 25 January 2023. The service told us they were unable to split this data by location.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. In the 3 months before our inspection the service reported 5 delayed discharged in line with its incident reporting policy. The relative risk of patient readmission had reduced from 8.95% in January 2022, to 5.83% in December 2022.

Managers worked to minimise the number of medical patients on non-medical wards. Medical staff reviewed any medical patients on non-medical wards (Outliers). Patients that were being cared for outside of a specialty were seen by the consultant on the ward where they were residing. The service had a senior member of the medical team responsible for oversight of any patients being cared for outside of their specialty ward. Information provided by the service following our inspection showed that at the time of our inspection there were 58 outliers on 24 January 2023, and 59 outliers on 25 January 2023. Between August 2022 and January 2023, data provided by the service showed 10,952 outliers, the highest being reported on geriatric medicine 5,632 and 3,254 relating to general medicine. The service had an evaluation project in place to establish if the care received by medical outliers was equal to the care received by patients admitted to medical wards, this was due to be completed by the end in January 2023, and no details were available at the time of our inspection.

Learning from complaints and concerns

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

Patients, relatives, and carers knew how to complain or raise concerns. Patients and relatives, we spoke with knew how to make a complaint. One family we spoke with were considering making a complaint based on their experience and knew about the patient advice and liaison service (PALS). The service had a dedicated patient experience team, patients and relatives could leave feedback through speaking to the staff team directly or by completing the friends and family test after discharge. Patients and relatives could also use the web forms on the services external website or use the PALS or complaints services to share their experience.

The service did not display information about how to raise a concern in patient areas. We did not see any complaints information displayed on the wards we visited. Staff explained that much of the written information and leaflets had been removed during the COVID-19 pandemic due to infection control, but they were in the process of bringing these documents back onto the wards. Following our inspection, the service told us that complaints and PALs information was included in the patient placemats that were used for patient trays. This meant that it was at every bedside for patients and visitors to clearly see.

Staff we spoke with knew the services complaints policy and told us that managers encouraged them to deal with complaints openly at the time they were made, to seek early resolution.

Medical care (including older people's care)

Managers investigated complaints and identified themes. Information provided by the service following our inspection showed that between January 2022 and December 2022, the service received 134 complaints in relation to its medical wards and at the time of our inspection 41 complaints were under investigation. Key themes from complaint investigations included lack of information, lack of communication with relatives, staff not answering telephones, delays receiving outpatient test results, staff communication skills, attitudes, accessible services for those with disabilities and availability and accessibility of information. The service was responding to this feedback including providing staff training, looking at digital information systems and improving accessible services.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with knew how to deal with a complaint, managers we spoke with told us they aimed to resolve these as soon as possible and get an outcome for the complainant without them having to go through the formal process where possible.

Managers shared feedback from complaints with staff and learning was used to improve the service. We reviewed incidents and clinical effectiveness reports that were shared with ward staff at team meetings and during staff handovers where appropriate on the ward areas. Reports we reviewed from November 2022 and December 2022, included recommendations for learning, staff training, and actions staff must take to reduce similar complaints. We noted emails that were shared across the medical division reminding staff of the importance of them reporting complaints and being aware of safety bulletins to improve patient care and reduce complaints.

The service provided us with feedback from a complaint they had managed and engaged with a patient and their relatives which had contributed to the services quality improvement project on nutrition and hydration.

Is the service well-led?

Inadequate

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

Leadership

Leaders had the skills and abilities to run the service. Priorities and issues were not always managed effectively. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Ward management had a clearly defined structure, with lines of accountability, roles, and responsibilities. Medical wards fell under care group 2 in the managerial structure and nursing services were led by a director of nursing, and deputy director of nursing. An associate director of nursing led a team of matrons across the wards, supported by a nurse in charge on each ward. The chief medical officer led medical provision supported by a clinical director of general medicine and local services, with a clinical lead for the care of the elderly and a clinical lead for general medicine and a medical director for local services.

The local leadership team told us of the complexities and changes in structure that followed the merger of the service with two other local services. The team were aware of the current challenges across the service, including staffing levels, embedding governance processes and the new leadership structures that were still being embedded.

Medical care (including older people's care)

Ward staff we spoke with were supportive of the local leadership and told us how supportive and experienced they were. Several staff had worked in the service for long periods and had experienced various roles to achieve leadership positions. These staff told us that senior leaders gave them opportunities to develop their skills and knowledge through mentoring and shadowing.

Managers and leaders told us they were coping with increased numbers of patients with increasingly complex needs and that the COVID -19 pandemic had taken a toll on staff, which they were still managing. Leaders told us that staffing levels and skill mix due to the increased number of overseas nurses and the lack of additional multidisciplinary staff did have an impact on the patient experience. Health care assistant recruitment had been challenging, and the service was in the process of trying to recruit additional staff into these roles to provide the additional support required for the complex patients entering the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and was in the process of developing a strategy to turn it into action.

The service's clinical strategy called 'Your care in the Best Place', had been in place since 2018. The clinical models developed as part of this strategy included medical specialities: Cardiology, Respiratory, Renal medicine, Stroke and other specialties.

Following our inspection, leaders told us that medical specialities would be working on developing their individual clinical strategies in the next 12 months. The local services purpose was to provide a safe and caring service to their patients, an environment that encourages growth of staff and an unrelenting focus that keeps the patients they care for at the centre of their work on a daily basis.

To underpin the local services purpose, the service had a set of values including, excellent, we go all-out for excellence and put delivering exceptional care at the heart of everything we do. Compassionate, we act with care and compassion toward ourselves, patients, colleagues, and our communities. Respectful, we appreciate the value of each other and nurture positive relationships. We ensure all voices are heard and respected.

Within local services they had 8 strategic priorities which were focused on keeping patients safe, improving the quality and access to care for patients, promoting respectful behaviours, engagement and partnership working.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.

Staff we spoke with told us they felt respected and valued by local managers. However, staff told us they were extremely weary and that there appeared no end to the challenges they faced. Staffing levels and the complexity of patient needs had contributed to low morale amongst some of the staff we spoke with. The COVID-19 pandemic had taken a great deal of effort to manage, and patients were still being admitted with COVID-19, which given the existing challenges on the wards made it increasingly difficult for staff to manage priorities.

There was a culture of team working amongst staff and the COVID-19 pandemic had meant that staff worked across different specialisms meeting new teams and forging new relationships. Multidisciplinary team working was evident on all the wards we visited, and we observed mutually respectful interactions between the staff teams. Staff focus was on patient care and safety, however, gaps in the workforce meant that staff were not always available to ensure all tasks and priorities were met, for example staff not completing patient records or updating audits.

We noted that protected mealtimes were no longer in place and that many of the volunteers we had met at previous inspections to support patients living with dementia or additional care needs were no longer visible on the wards. Staff told us there was a strong focus on capacity and flow and push to discharge patients to provide more bed space. This had affected the culture in the service and on the wards, we visited we found them to be busy and often hectic environments. The loss of the protected mealtimes demonstrated that the culture had shifted, as the staff worked so hard to ensure the patients were moved or seen by other professionals in case, they missed their opportunity for a scan or review.

Many of the staff we spoke with had worked for the service for long periods and described it as great place to work. Other staff we spoke with told us that staffing issues had been a long-term problem and the health care assistant role was difficult to fill, as many had left to work in the hospitality industry.

Governance

We were not assured that governance systems and processes were effective in relation to staff complying with internal quality standards, improving patient care, or patient outcomes.

The service had a governance structure, which local leaders described as a ward to board process, sharing information and risk form ward level operations to board level oversight. Ward and departmental meetings fed into speciality meetings, then the divisional board, care group board and then governance subgroups. The governance subgroups included the quality governance group, infection control committee and safeguarding committee. These groups fed upwards to the board sub committees, quality governance committee and then the services board and met on a monthly basis. However, the service was not compliant in a number of areas related to patient safety and risk, for example the completion of patient records and managing risks. We were therefore not assured that governance systems and processes were effective in relation to staff complying with internal quality standards, improving patient care, or patient outcomes.

We reviewed governance meeting records from October, November, and December 2022, which showed that staff discussed quality and performance to identify any emerging risks and review existing risks across the service. Areas covered included staffing mix and levels, harm free care, falls risks, incidents, pressure ulcer prevalence and shared learning and other key information.

Local leaders told us one of their challenges was dealing with a backlog of incident reports that still needed closure or investigation. Records from the care group governance meeting on 4 January 2023, stated there were 242 overdue incidents and 14 serious incidents, weekly meetings were in place to get these closed down. The highest number of reported incidents was in December 2022 related to falls, hospital acquired pressure ulcers, discharge pressure ulcers / on admission staffing and workforce.

Management of risk, issues, and performance

We were not assured service systems and processes for identifying, recording, and managing risks and performance were effective.

The service had systems and processes for identifying, recording, and managing risks, issues, and mitigating actions. The service had an up-to-date risk register, that included risks in relation to increased number of patient falls, recruitment, staffing levels, medical and consultant provision, the physical environment and building standards alongside other areas of risk. Leaders and managers, we spoke with were aware of the services risk register and which risks related to their respective areas. Risks were regularly reviewed at the monthly governance team meetings.

Medical care (including older people's care)

The service had invested significantly in local ward audit systems to capture performance and risk data at ward level; however, we were not assured that the systems and processes were effective in relation to staff complying with internal quality standards, improving patient care, or patient outcomes.

There were processes to manage current and future performance and the service produced monthly performance reports, accessible to leaders and managers within the care group. We reviewed the services performance management report form December 2022, this provided leaders and managers with performance data on a range of quality and performance outcomes from the ward areas. At ward level, staff completed a range of daily audits using a handheld IT tablet, which leaders and managers were able to use to monitor the quality of the service, performance targets and staff compliance with internal standards. However, during our inspection we found inconsistencies that should have been identified and acted on through the internal audit system. For example, staff not completing daily and weekly emergency resuscitation trolley checks, not completing patient fluid and nutrition records, falls risks and pressure care. We also found out of date medicine and fridge temperatures not been recorded or escalated when out of range.

In addition, information provided by the service following our inspection showed that at the time of our inspection items of equipment were out of date for review showed that despite the internal audit and systems not all risks were effectively managed.

Areas for improvement

MUSTS

Medical Care

- The service must ensure that all staff complete mandatory training. (Regulation 18 - (1))
- The service must ensure that equipment is maintained in line with manufacturers guidance and that all equipment, including emergency equipment, is serviced, and checked for safety. (Regulation 15 - (19e))
- The service must ensure that all staff complete patient records to ensure they are accurate, up to date and legible and that all risk assessments are completed to maintain patient safety. (Regulation 17 - (1(c))
- The service must ensure that staff follow the services administration of medicines policy and procedure to ensure medicines are in date, stored appropriately and that staff complete safety checks on fridge and room temperatures. (Regulation 12 - (1(g))
- The service must ensure that there is enough and suitable equipment to promote patient independence with eating and drinking. (Regulation 12 – (1(f))
- The service must ensure that mealtimes for all patients promote the opportunity for them to eat and drink safely and ensure that staff meet patients' nutritional, and hydration needs, having regard to the patient's well-being (Regulation 9 – (3(i))
- The service must ensure it has effective governance, risk and performance measures in place. (Regulation 17 – (1-2 (a) (b) (c))

SHOULDS

Medical Care

Medical care (including older people's care)

- The service should consider increasing the number of side rooms on wards to provide additional space for patients and relatives. (Regulation 15 – (1(c)).

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, 2 CQC inspectors, and a CQC specialist advisor. The inspection team was overseen by Antoinette Smith, Interim Deputy Director of Operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	S29A Warning Notice
Surgical procedures	
Treatment of disease, disorder or injury	